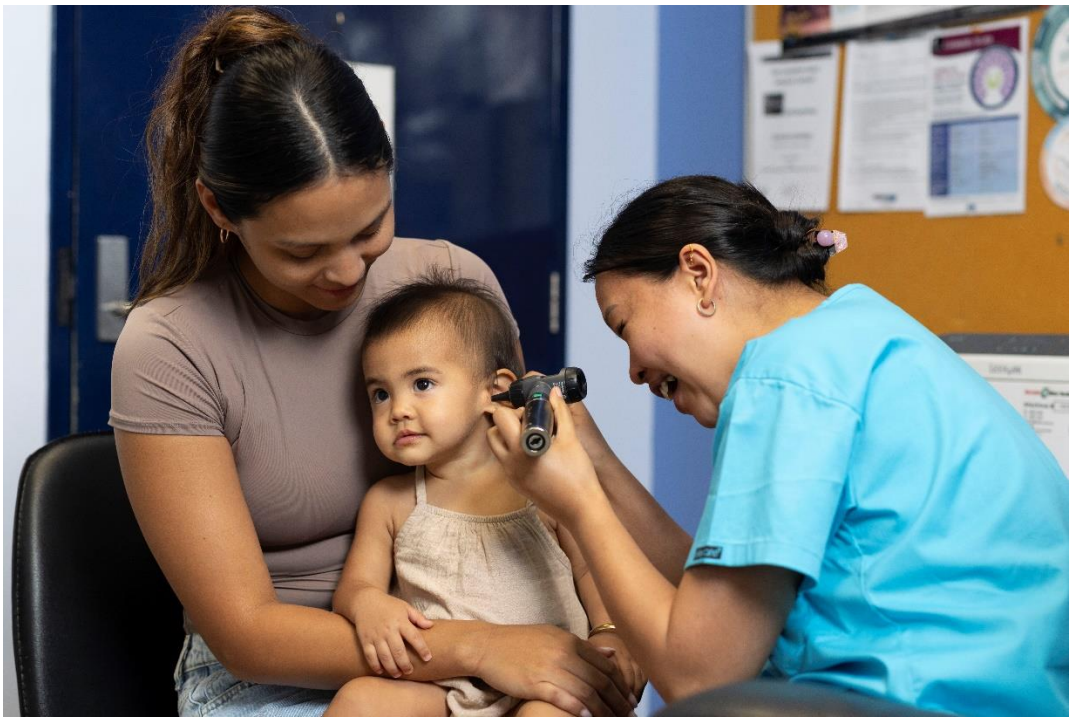
Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

FINAL REPORT

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We acknowledge the traditional custodians of their lands upon which we walk, reside, and work. We pay our respects to First Nations peoples of the Northern Territory and value the continued connection to culture, Country, and waterways and their contributions make to the life of our vast region.

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List of Abbreviations

ABS..... Australian Bureau of Statistics

ACCHS..... Aboriginal Community Controlled Health Service

ACCHO..... Aboriginal Community Controlled Health Organisations

Anyinginyi Health..... Anyinginyi Health Aboriginal Corporation

AHP..... Aboriginal Health Practitioners

AHPRA..... Australian Health Practitioner Regulation Agency

AIHW..... Australian Institute of Health and Welfare

AMSANT..... Aboriginal Medical Services Alliance Northern Territory

ANMF..... Australian Nursing and Midwifery Federation

APNA..... Australian Primary Health Care Nurses Association

AOD..... Alcohol and Other Drugs

ARF..... Acute Rheumatic Fever

ARHEN..... Australian Rural Health Education Network

ASGS-RA..... Australian Statistical Geography Standard – Remoteness Area

ATSIHP..... Aboriginal and Torres Strait Islander Health Practitioner

ATSIHPBA..... Aboriginal and Torres Strait Islander Health Practice Board of Australia

BGL..... Blood Glucose Level

BLA..... Basic Life Support

BMI..... Body Mass Index

CAAC..... Central Australian Aboriginal Congress

CALD..... Culturally and Linguistically Diverse

CATSINaM..... Congress of Aboriginal and Torres Strait Islander Nurses and Midwives

CDC..... Curriculum Development Committee

CDU..... Charles Darwin University

CRANA*plus*..... Council of Remote Area Nurses of Australia *plus*

DDHS..... Danila Dilba Health Service

DHAC..... Australian Government Department of Health and Aged Care

DOB..... Date of Birth

EBA..... Enterprise Bargaining Agreement

ECG..... Electrocardiogram

FIFO..... Fly-In Fly-Out

FTE..... Full Time Equivalent

GN..... Graduate Nurse

GNP ..... Graduate Nurse Program

GNPE ..... Graduate Nurse Program Expansion

GNTP ..... Graduate Nurse Transition Program

GP ..... General Practitioner

Hb ..... Haemoglobin

HbA1c ..... Haemoglobin A1c, also known as glycated haemoglobin

HESA ..... Health Education South Australia

IAHA ..... Indigenous Allied Health Australia

IBL ..... Inquiry-based Learning

ICU ..... Intensive Care Unit

IEAG ..... Internal Expert Advisory Group

IM ..... Intramuscular

INR ..... International Normalised Ratio

IV ..... Intravenous

KWHB ..... Katherine West Health Board

MEC ..... Maternity Emergency Care

Miwatj Health ..... Miwatj Health Aboriginal Corporation

Marthakal Homelands ..... Marthakal Homelands and Resource Centre Aboriginal Corporation

Mala'la Health ..... Mala'la Health Service Aboriginal Corporation

Menzies ..... Menzies School of Health Research

MJD ..... Machado Joseph Disease

MSF ..... Multisource Feedback

NG ..... New Graduate

NGN ..... New Graduate Nurse

NGRN ..... New Graduate Registered Nurse

NHMRC ..... National Health and Medical Research Council

NMBA ..... Nursing and Midwifery Board of Australia

NSW ..... New South Wales

NT ..... Northern Territory

NT Health ..... Northern Territory Health

NT PHN ..... Northern Territory Primary Health Network

OLDCARTS ..... Onset, Location, Duration, Aggravating / Relieving Factors, Treatments, Associated Signs & Symptoms

PHC ..... Primary Health Care

POC ..... Point of Care

PoCT..... Point of Care Testing

PRC..... Peer Review Cycle

PRISMA ..... Preferred Reporting Items for Systematic Reviews and Meta-Analyses

RA ..... Remote Area

RAHC..... Remote Area Health Corps

RAN..... Remote Area Nurse

REC..... Remote Emergency Care

REWS ..... Remote Early Warning Score

RHD..... Rheumatic Heart Disease

RHWSA..... Rural Health Workforce Support Activity

Red Lily Health..... Red Lily Health Board Aboriginal Corporation

RFDS..... Royal Flying Doctor Service

RN ..... Registered Nurse

RRGs..... Regional Reference Group

QAAMS ..... Quality Assurance for Aboriginal and Torres Strait Islander Medical Services

SA..... South Australia

SC ..... Steering Committee

SEGNP ..... Scoping the Expansion of a Graduate Nurse Program

SEM..... Structural Equation Modelling

SEWB ..... Social and Emotional Wellbeing

Sunrise Health ..... Sunrise Health Service Aboriginal Corporation

SNAP ..... Subacute and Nonacute Assessment and Pathway

STI ..... Sexually Transmitted Infection

The Framework..... The *National Rural and Remote Nursing Generalist Framework 2023–2027*

TTP ..... Transition to Practice

TPPPC..... Transition to Professional Practice in Primary Care

U/A..... Urine Analysis

UDRH ..... University Department of Rural Health

UNICEF..... United Nations Children's Fund

WA ..... Western Australia

WHO ..... World Health Organisation

WHS ..... Workplace Health and Safety

Wurli-Wurlinjang Health ..... Wurli-Wurlinjang Aboriginal Health Service

Vic. ..... Victoria

Modified Monash Model

MMM..... Modified Monash Model classifies locations into seven categories (MM 1 to MM 7) based on geographical remoteness and town size.

MM 1 ..... MM 1: Major Cities

MM 2 ..... MM 2: Inner regional areas

MM 3 ..... MM 3: Outer regional areas

MM 4 ..... MM 4: Remote areas

MM 5 ..... MM 5: Very remote areas

MM 6 ..... MM 6: Very remote areas with a population of less than 1,000

MM 7 ..... MM 7: Very remote areas with a population of less than 200

Executive Summary

Overview

The Graduate Nurse Program Expansion (GNPE) is a strategic, evidence-informed initiative aimed at addressing the critical and ongoing workforce shortages within Aboriginal Community Controlled Health Services (ACCHS) across the Northern Territory (NT). Initiated by the NT Primary Health Network (NT PHN), the GNPE builds on the foundation of the successful Central Australian Aboriginal Congress (CAAC) Graduate Nurse Program (GNP). This pilot program was developed by CAAC Medical Director Dr Sam Heard, with the first intake commencing in 2021, in response to workforce deficits and skill mismatches among existing nursing staff. Over a three-year period, Senior Clinical Educator Joeleen Brown further developed and strengthened the GNP framework, which now underpins the GNPE. Significant components of the expansion have been directly shaped by her contributions and are reflected throughout the design.

The GNPE responds to pressing systemic issues, including high staff turnover, overreliance on expensive agency nurses, and the absence of structured transition pathways for new graduate nurses (NGN) into remote practice, challenges that contribute to a healthcare system that is both financially unsustainable and culturally disconnected from community needs.

Co-designed in partnership with ACCHS and key stakeholders, the GNPE delivers a structured, culturally responsive transition-to-practice pathway. It aims to embed NGNs within remote communities, thereby fostering a locally grounded, stable, and culturally safe nursing workforce suitable for broader rollout across the NT.

The workforce challenge

Remote health services experience annual staff turnover rates exceeding 160%, with most remote services reporting up to 355% (Veginadu et al., 2024). In 2025, agency nursing accounted for up to 80% of the workforce in some regions of the NT, costing individual services between A$100,000 to A$2 million annually, (personal communication, NT PHN, 2024). These workforce gaps compromise continuity of care, contribute to cultural disconnection, and strain overstretched permanent teams (Veginadu et al., 2024).

Despite national growth in the nursing workforce, the number of nurses working in very remote areas (MM7) has stagnated or declined between 2013 and 2022 (Ajayi et al., 2024). New graduates are underrepresented in these areas due to a lack of structured support, fear of clinical isolation, and perceived readiness gaps. Without targeted pathways into remote practice, these trends are expected to worsen (Hart et al., 2014; Lea & Cruickshank, 2015b).

Program objectives

The GNPE aims to expand the CAAC GNP model to other remote NT ACCHS' in order to achieve the following objectives.

- Establish a structured and supportive transition-to-practice pathway for NGNs entering remote practice.
- Reduce dependency on agency staff by building a skilled, culturally competent, and stable remote nursing workforce.
- Improve recruitment, retention, and clinical outcomes through context-responsive education and support mechanisms.

Methodology

The GNPE was developed using a participatory action research (PAR) framework, in order to guide engagement, design, and implementation. A PAR approach emphasises collaboration, mutual learning, and iterative feedback cycles, enabling ACCHS' and other stakeholders to co-lead the development process and shape the program based on local realities.

The methodology included four key stages:

1. Engagement and Governance: The establishment of a Steering Committee, Curriculum Development Committee, and Internal Expert Advisory Group with representation from the NT PHN, Aboriginal Medical Services Alliance Northern Territory (AMSANT), Charles Darwin University (CDU), Menzies School of Health Research (Menzies), Flinders University, and ACCHS'.
2. Evidence and Needs Analysis: Market research, including a desktop review, stakeholder interviews, a literature review on remote new graduate (NG) nursing programs, and a national survey of undergraduate and early-career nurses.
3. Consultation and Co-Design: Three rounds of consultation with ACCHS' across the Big Rivers, East Arnhem, and Top End regions were conducted to ensure cultural safety, feasibility, and contextual adaptation.
4. Iterative Design and Feedback: Program drafts were reviewed through cycles of feedback with ACCHS' and advisory groups in order to refine components such as cultural safety training, clinical placements, and support structures.

The co-design approach was foundational to the development of the GNPE. Aboriginal Community Controlled Health Services and partner organisations actively contributed through three structured rounds of consultation. Regional reference groups established in the Big Rivers, East Arnhem, and Top End regions played a critical role in ensuring that the program design was culturally appropriate, operationally feasible, and

tailored to the workforce needs of each service. Notably, Sunrise Aboriginal Health Service (Sunrise Health), Katherine West Health Board (KWHB), and Wurli-Wurlinjang Aboriginal Health Service (Wurli-Wurlinjang Health) collaborated to develop a joint pilot implementation model, while services such as Miwatj Health Aboriginal Corporation (Miwatj Health), Red Lily Health Board Aboriginal Corporation (Red Lily Health), and Mala'la Health Service Aboriginal Corporation (Mala'la Health) provided detailed input and expressed interest in future rollouts. This sustained engagement embedded local priorities and service realities into the program's design, curriculum, and implementation framework.

Results: Program structure

The GNPE is a structured 18-month program with the following components:

- Orientation: A two-week foundational workshop focused on cultural safety, Primary Health Care (PHC) principles, and clinical skills.
- Cultural Safety: Delivered in partnership with Aboriginal mentors and health practitioners, supported by Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) standards and Indigenous Allied Health Australia's (IAHA) Cultural Responsiveness Framework.
- Education & Training: Integration of accredited courses (eg. Remote Emergency Care/ Maternity Emergency Care [REC/MEC], University short courses), weekly tutorials, and quarterly study blocks.
- Mentorship & Support: Remote Clinical Educators, peer networks, structured supervision, and resilience training.

Results: Implementation and governance

Establishment – Governance and initial staffing

The establishment stage is focused on creating the governance and coordination structures necessary to support the successful rollout of the GNPE. A key priority is the formation of an overarching Governance Committee. This committee would provide strategic oversight, ensure alignment with cultural guide culturally responsive implementation, support evaluation, and ensure that the program aligns with community priorities and health workforce objectives.

Initial funding proposals will be sought as a submission to the Australian Government Department of Health and Aged Care (DHAC) and to the National Health and Medical Research Council (NHMRC) under its Partnership Projects scheme. it is recommended that a GNPE Program Coordinator be employed through an NT-wide organisation (such as NT PHN, AMSANT, or CDU). Upon funding approval, the Program Coordinator will lead preparations for rollout. This position will play a critical role in coordinating activities across services,

maintaining program momentum, facilitating communication among stakeholders, and supporting the development of program materials and implementation resources.

Stage 1 – Initial rollout

The first implementation stage will involve the three ACCHS in the Big Rivers Region:

1. Sunrise Aboriginal Health Service;
2. Katherine West Health Board;
3. Wurli-Wurlinjang Health.

A Remote Clinical Educator will be recruited to support the first implementation region (Big Rivers), with Sunrise Health tentatively identified to host and coordinate this role across three participating services. This stage will also involve early engagement with ACCHS to confirm site readiness, define local implementation roles, and prepare for NGN recruitment.

Each service will recruit two NGNs, contingent on the employment of a shared regional Remote Clinical Educator. Based at Sunrise Health, the educator will support on-the-ground supervision, clinical education, and professional development across the three sites. A regional governance subcommittee will be formed with representatives from each service to provide local oversight and coordinate the delivery of Stage 1.

NGN recruitment will include interviews and selection processes led by each service in collaboration with the GNPE Program Coordinator. Orientation will begin with a two-week centralised program in Katherine, followed by a one-week on-site induction at each clinic. Once deployed, NGNs will be supported through structured supervision, mentoring, and continuing education.

A formative evaluation will be conducted during this stage to assess early implementation progress, identify strengths and challenges, and refine program processes. This will inform adjustments in preparation for Stage 2.

Stage 2 – Expanding the GNPE to three additional ACCHS'

In Stage 2, it is proposed to expand the program to three other ACCHs',

4. Mala'la Health Service Aboriginal Corporation (Maningrida)
5. Red Lily Health Board
6. Miwatj Health Aboriginal Corporation

Each service will employ its own Remote Clinical Educator, responsible for providing localised, culturally responsive supervision and clinical education to support the successful transition of NGNs into remote practice. These educators will ensure consistent, high-quality support that reflects the specific context and needs of each community.

The expansion will build on the structures and lessons established during Stage 1, benefiting from the governance, coordination, and evaluation processes already in place. This phased approach allows for careful refinement, stronger regional collaboration, and sustainable integration of the GNPE across a broader footprint of remote health services.

Results: Funding and sustainability

A key economic driver for the GNPE is the high costs associated with agency nursing. ACCHS spends between A$100,000 and A$2 million annually on agency staff, not including additional expenses such as travel and accommodation (NT PHN, 2023b). Following the COVID-19 pandemic, agency rates have doubled or tripled, often exceeding A$7,000 per fortnight per nurse. Despite these elevated costs, health services report that the skill level of agency nurses is frequently not aligned with the clinical demands of remote settings.

This financial burden is compounded by high staff turnover and the associated cost of repeated recruitment, onboarding, and lost productivity. In contrast, investment in the GNPE—through structured support, local training, and retention incentives—offers a more cost-effective and sustainable solution. By building a stable, culturally competent workforce, the GNPE has the potential to reduce agency reliance, improve continuity of care, and redirect substantial savings toward workforce development and service quality improvement. The report identifies three major funding opportunities.

7. A funding proposal to the Australian Government Department of Health and Aged Care;
8. A proposal for a new University Department of Rural Health; and
9. A submission for a National Health and Medical Research Council Partnership Project.

Anticipated expansion NG nursing program outcomes

- Improved NGN retention and reduced turnover.
- A culturally safe and clinically competent remote area (RA) nursing workforce.
- Strengthened continuity of care in remote Aboriginal communities.
- Decreased reliance on agency nurses and associated cost savings.
- Enhanced capacity of ACCHS' to train, mentor, and retain staff.
- Greater inclusion of First Nations nurses through targeted recruitment and mentorship.

Conclusion

The GNPE presents a feasible, cost-effective, and community-driven solution to the NT's remote nursing workforce crisis. By investing in early-career nurses, supporting culturally safe practice, and embedding NGNs in ACCHS, the GNPE addresses both the immediate and structural drivers of workforce instability. Its success will rely on continued collaboration, flexible design, and sustained investment in local capacity.

1. Introduction

The Graduate Nurse Program Expansion (GNPE) Scoping and Co-Design Project emerged as a strategic response to the ongoing workforce shortages affecting Aboriginal Community Controlled Health Services (ACCHS) in remote Northern Territory (NT). The need for such a sustainable solution has become evident due to the stresses on remote health services including excessively high turnover rates, increasing reliance on agency nursing, resultant increased salary costs, and limited access to structured graduate pathways.

Building upon the successful Central Australian Aboriginal Congress (CAAC) Graduate Nurse Program (GNP), the proposed GNPE has been designed to provide a structured transition pathway for New Graduate Nurses (NGN) into remote area (RA) nursing roles. By integrating mentorship, professional development, and cultural safety training, the GNPE aims to strengthen workforce retention and improve health outcomes in remote Indigenous communities. It is the result of collaborative efforts between ACCHS, the NT PHN, universities, and government stakeholders. Through co-design and extensive consultation, the program has been tailored to address the unique challenges of remote healthcare settings while ensuring long-term workforce stability.

1.1 Background and rationale

1.1.1 The remote context

While often conflated with rural health, remote health has distinct characteristics. Remote settings are marked by greater distances, geographical isolation, limited healthcare access, fewer services, and smaller, more mobile populations (Wakerman et al., 2017). These areas also have a higher percentage of Aboriginal and Torres Strait Islander residents. Compared with metropolitan areas, remote populations experience shorter life expectancy, higher rates of disease and injury, and greater hospitalisation rates (AIHW, 2024a; AIHW, 2024c). Social determinants such as lower income, fewer educational opportunities, and poor access to Primary Health Care (PHC) exacerbate health disparities. Significant funding and resource disparities persist even before considering the higher cost of delivering healthcare to isolated areas (Zhao et al., 2019). Indigenous Australians, who constitute a large proportion of remote populations, face additional health challenges. Although death rates among Indigenous people have fallen over time, the age standardised death rate was higher than for non-Indigenous Australians in 2021–2023 (AIHW, 2024b), and the gap in health outcomes between Indigenous and non-Indigenous populations has widened (Close the Gap Campaign Steering Committee, 2019). Between 2021–2023, 58% of deaths of Indigenous Australians aged under 75 years were from potentially avoidable causes, 3.3 times the rate of non-Indigenous Australians (AIHW, 2024c). Contributing factors include historical and ongoing socioeconomic inequities, exclusion from participation in society, and inadequate access to culturally safe healthcare (AIHW, 2024b). Despite these challenges, Indigenous people in remote areas report higher levels of wellbeing, likely due to stronger cultural connections

and opportunities for traditional practices such as caring for Country and participating in ceremonies (AIHW, 2024c; Cairney et al., 2017).

1.1.2 Role of a remote area nurse

In many very remote areas, registered nurses, often called remote area nurses (RAN), along with Aboriginal and Torres Strait Islander Health Practitioners (ATSIHP) are the main providers of health care, generally with visiting general practitioners (GP) and allied health professional (AIHW, Aitken et al., 2023; Argent et al., 2022; 2024b; Lenthall et al., 2020). In most very remote communities, there are no resident GP. RANs work in an advanced practice role, dealing with acute and chronic health conditions, as well as organising health promotion and public health activities, often accomplished in a cross-cultural situation that operates with separate language, knowledge, and cultural systems to that of the health care providers (Aitken et al., 2023; Argent et al., 2022; Lenthall et al., 2020). A key difference between the role of an Registered Nurse (RN) and that of an RAN is non-emergency client consultation, estimated to be approximately 80% of a RAN's workload (Lenthall et al., 2024). While GPs are extensively educated on consultation skills, this is generally not a skill included in undergraduate nursing education. In the revised RA nursing Model of Consultation (Lenthall et al., 2024), a holistic model mapped against the *National Rural and Remote Nursing Generalist Framework 2023–2027* (Office of the National Rural Health Commissioner, 2023), has been included in the GNPE curriculum.

1.1.3 Crisis in staffing

There is a crisis in staffing in remote Aboriginal communities, with an annual turnover of 162% of non-Indigenous clinical staff, excluding agency staff (Veginadu et al., 2024). Turnover increases with distance from a regional centre. For the most remote communities, turnover of all staff has been reported at 355% per annum (Veginadu et al., 2024). Recent analysis of nursing and midwifery numbers in Australia showed a substantial increase of over 77,000 nurses and midwives, nationally, (26% of the total nursing and midwifery workforce) between 2013 and 2023. This increase primarily occurred in metropolitan areas (27%) and regional centres (36%). Though the metropolitan and regional workforce has grown at a faster rate than other regions, the percentage of rural and remote nurses (MM3–7) in the national workforce has declined by 2.6%. 'Very remote areas' (MM7) was the only geographic classification that had fewer nurses and midwives in 2022 than 2023 (2,534 nurses and midwives, 0.9% of the workforce and 2,537 nurses and midwives, 0.7% of the total workforce, respectively). The NT had the slowest growth of nurses and midwives at 13%, compared with the other States and the Australian Capital Territory (Ajayi et al., 2024).

1.1.4 The stronger rural health strategy

The *Stronger Rural Health Strategy* seeks to address the unique healthcare challenges faced by rural and remote communities, with a goal of delivering an additional 3,000 nurses by 2028 (DHAC, 2021). A key

component of this strategy is enhancing the role of the nursing workforce. To support this, the Australian Government funds the Australian Primary Health Care Nurses Association (APNA) to implement the Nursing in Primary Health Care Program, which comprises three main elements:

1. Transition to Practice Program: Designed to support both newly graduated and experienced nurses transitioning into primary health care settings.
2. Building Nurse Capacity Clinics: Aims to recruit and assist primary health care organisations in establishing nurse-led models of care.
3. Chronic Disease Management and Healthy Ageing Workshops: Offers training and education to nurses in managing chronic diseases and promoting healthy ageing in primary health care settings (APNA. 2025).

While the Transition to Practice Program offers valuable support, its focus appears to be on nurses working in general practice, which are largely absent in very remote Indigenous communities in the Northern Territory. Similarly, the Building Nurse Capacity Clinics initiative targets clinics working within one of Australia's five priority health areas—cardiovascular health, diabetes, cancer control, injury prevention, and mental health. Although this may benefit larger health services, its relevance to smaller, very remote clinics is limited. The Chronic Disease Management and Healthy Ageing Workshops also seem more applicable to larger clinics, making their practical utility in very remote settings questionable.

1.1.5 Use of agency nurses

Agency nursing companies have become one of the main sources of staffing in parts of the ACCHS sector, with ACCHS in the Top End of the NT reporting that 50% – 80% of their current workforce are agency staff (NT PHN consultation, February 2023). This shift from long term contracts to an increasing use of agency-based staff commenced after the Northern Territory Emergency Response in 2007 (Zhao et al., 2019) and accelerated due to nursing shortages and changes in work expectations. This trend has two main implications:

1. The increased cost of maintaining health services due to higher agency fees charged by private agency nursing companies (NT PHN consultation, February 2023).
2. Difficulties in maintaining continuity of care and the resultant poorer health outcomes (Moscelli et al., 2024; Van Walraven et al., 2010).

Since the COVID-19 pandemic, the rates charged by private agencies have reportedly doubled or, in some instances, tripled. Health services indicated that they spend between A$100,000 to A$2 million or more per year on agency staff. This amount is in addition to wages, travel, or other related expenses ((Northern Territory Primary Health Network (NT PHN), 2023b).

Services have also reported that although the expense has increased, the clinical experience of agency nurses was not commensurate with the rates being charged, but more representative of demand for staffing. Health services must weigh safety and quality concerns, as to whether it's better to have a RN present without certain skills, and the additional pressure that puts on the remaining permanent or longer-term nursing staff. Lacking alternatives, health services must engage agency nurses who lack the key requirement of having completed CRANA*plus* REC or MEC courses in order to temporarily fill urgent staffing gaps (Northern Territory Primary Health Network (NT PHN), 2023a).

Despite the appeal of the vocational challenges and rewards of remote area nursing to a significant number of NGNs, barriers such as the requirement of them having several years of experience and specialised RA nursing education have hindered their pursuit of becoming RANs. This has led many NGNs to explore alternative career paths, citing timing concerns and the anticipated increased difficulty of transitioning to RA nursing roles over time (Hart et al., 2014).

The persistent maldistribution of the health workforce, extremely high nursing turnover rate, and the expense associated with using agency nurses, have had a profound impact on quality of care. The Mason (2013) workforce review identified the imperative to create a coherent pathway for rural and regional education and training. The 'graduate pipeline' is a key approach used for recruiting, entry to practice, training, and retaining a skilled nursing and midwifery workforce (Rogers et al., 2023).

1.2 Central Australian Aboriginal Congress Graduate Nurse Program

With its first intake in 2021, the CAAC Graduate Nurse Program (GNP; Pilot) was developed by Dr Sam Heard, the Central Australian Aboriginal Congress (CAAC) Medical Director. Developed as a response to staff shortages and skill mismatches amongst trained nurses, this initiative intends to build a skilled nursing workforce for CAAC town and remote clinics (S. Heard & J. Brown, personal communication, 2005). With its initial framework developed over 3 years (2021–2024), the CAAC program expanded by Senior Clinical Educator Joeleen Brown became the basis for the GNPE, with significant aspects of its proposed expansion resulting from her direct input, as outlined in this document.

The CAAC GNP is a two-year intensive training and development initiative specifically designed for NGNs. Its primary focus is to equip NGNs with the skills and confidence needed to practice nursing in a clinical setting, with the overarching goal of enhancing recruitment, building a skilled workforce, and preparing graduate nurses for a rewarding career in Primary Health Care and Aboriginal health. The program offers NGNs the opportunity to progress either towards Remote Area Nursing or Specialty Practice—specialising in Men's Health, Women's Health, Child Health, and Chronic Conditions (renal or diabetes), and paving the way for participants to become a proficient and confident specialised nurse (CAAC, 2024).

The CAAC model cannot be replicated across the NT without securing sustainable funding, with this factor a prime consideration for any future programs.

The CAAC Program objectives are to:

- Equip graduates with practical clinical experience in order to enhance and refine their clinical knowledge and skills, thus enabling them to practice safely, confidently, and professionally within their scope of practice;
- Foster a supportive learning environment for graduates, providing ample opportunity by which to develop and enhance their clinical skills;
- Enhance cultural responsiveness in nursing practice by which to ensure graduates can effectively engage with diverse patient populations;
- Foster the development of critical thinking skills among graduates, thus enabling them to make informed and evidence-based decisions in clinical settings;
- Strengthen graduates' abilities in time management and organisational strategies in order to ensure efficient and effective patient care;
- Improve communication skills and promote teamwork abilities such as to facilitate seamless collaboration with colleagues and other healthcare professionals;
- Encourage continuous personal and professional development, emphasising the importance of resilience in the nursing profession;
- Cultivate a culture of reflection in practice, motivating graduates to constantly strive for improvement in their clinical performance; and
- Facilitate the smooth integration of graduates into their workplace and teams, promoting a positive transition into the professional healthcare environment (CAAC, 2024).

CAAC GNP Structure

Introduction to Primary Health Care Practice

The Introduction to Primary Health Care Practice program serves as a supportive clinical pathway, empowering Graduate Registered Nurses to acquire essential skills and knowledge in PHC and Aboriginal Health. This comprehensive program aims to prepare nurses for a potential transition into remote area nursing or a specialised area within a PHC scoping and co-design projects.

Remote Practice

The CAAC program has 6 month rotations:

- Urban clinics (one 6-month rotation);
- The Alice Springs Hospital/Urgent Care (one 6-month rotation): this rotation offers the opportunity of gaining acute care nursing skills; and
- Remote clinics (two 6-month rotations): The specific locations of these clinics is determined based on appropriate staffing in order to ensure clinical support coverage.

Specialty Practice

In the NT, specialty practice takes place in 6-month rotations at:

- Urban clinics (two 6-month rotations);
- The Alice Springs Hospital (one 6-month rotation); and
- A speciality area (one 6-month rotation) (CAAC, 2024).

Transition into the Remote Practice Pathway

In the second year of the GNP, participants build upon the strong foundational knowledge and skills gained in their first year, fostering further growth in Remote Area Nursing. As part of this pathway, they will have the invaluable opportunity of working for 12-months across two remote CAAC clinics. This clinical pathway is intentionally designed to equip participants with the essential skills and knowledge needed in order to transition confidently into Remote PHC Practice. Recognising individual learning needs, the program incorporates extensive training and development in order to support participant successes (CAAC, 2024).

Transition into the Speciality Practice Pathway

In the second year of the GNP, a specialised journey is offered through the Transition into the Specialty Practice Pathway. This pathway aims to enhance the foundational knowledge and skills gained in the first year of the GNP program, as well as provide the participants with hands-on learning in a specific area of expertise. With a focus on seamless and safe transitions, the program ensures the participant gains the necessary skills and knowledge by which to excel in their chosen speciality practice.

This program has been successful in providing a pathway for NGN's to practice within CAAC, as well as developing their skills and scope of practice. The program is thus having a major positive impact on both the staffing levels within the CAAC and the quality of the nursing practice. Twenty-one participants have chosen Specialty Practice Pathway, with a retention rate of 76% (16). Many of these NGNs are currently in senior roles within CAAC (J. Brown, personal communication, January 24, 2025).

2. Scoping and Co-Design of a Graduate Nurse Program Expansion

2.1 Aim and objectives

The aim of this project was to scope and co-design` an evidence-informed New Graduate Nursing Program or programs, with and for remote Aboriginal Community Controlled Health Services in the Northern Territory.

The project objectives were:

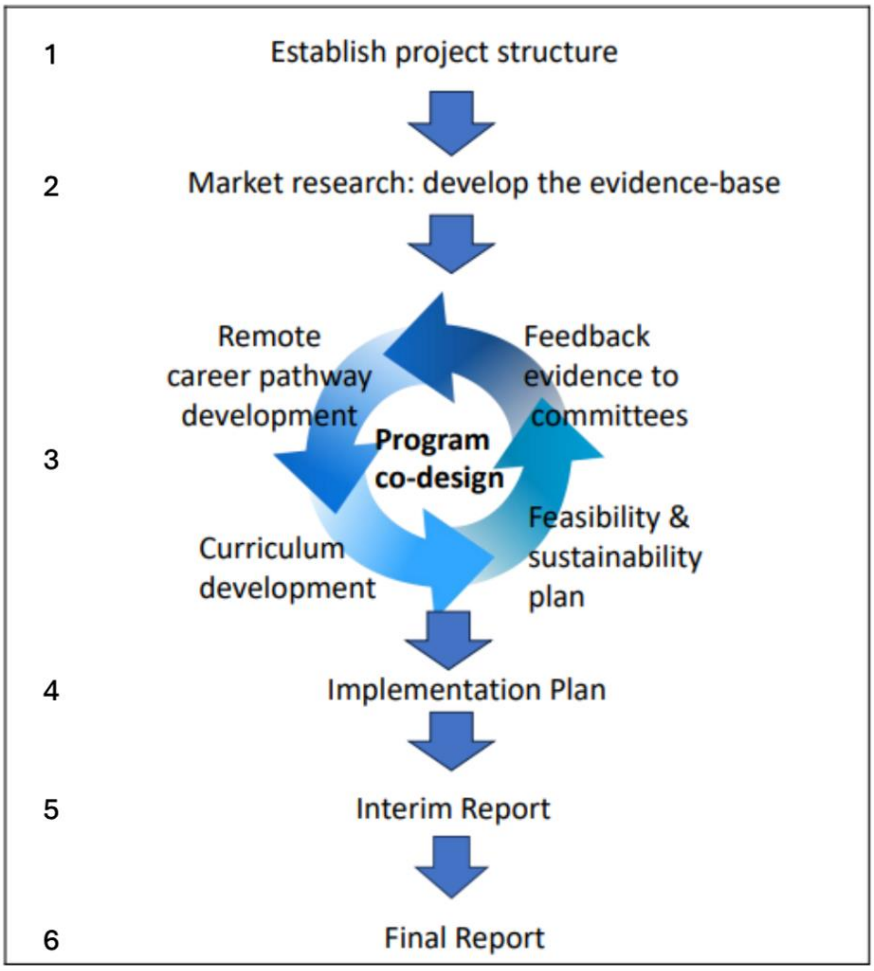
- To address persistent workforce shortages, particularly in remote locations and expand the Central Australian Aboriginal Congress GNP across the NT;
- To establish a structured and supported pathway for graduate nurses to develop into remote area nurses within non-government health services;
- To scope and co-design an evidence-informed program framework that meets the needs of NGNs and health services in remote communities; and
- To calculate the costs of and identify potential funding sources for these programs.

2.2 Methodology

The project adapted (Cummings & Worley, 2005) action research participatory organisational change model (Figure 2.1) to meet the project objectives above and to meet the requirements of extensive consultation and change.

The model in Figure 2.1 has four main steps, 1) establishing the project structure, 2) market research, 3) program co-design, and 4) creating the implementation plan, with Step 3 involving three cycles of consultations, thus allowing reference groups to learn from and inform participant groups. Step 4 was the implementation plan, Step 5 the interim report and step 6 the final report. Steps 1 and 2 are detailed in this section, while Steps 3 and 4 can be found in Section 3.5 and 6, respectively.

Figure 2.1. Participatory organisational change model.



2.2.1 Establishing the project governance

The project was commissioned by NT PHN, led by CDU and has many stakeholders. Robust project governance was established in order to fulfil the contractual obligations and maximise impact with the range of stakeholders. The project governance included:

1. A steering committee (SC) with representatives from NT PHN, CDU, Menzies School of Health Research (MSHR) and AMSANT.
2. A curriculum development committee (CDC), including the Senior Clinical Educator from Central Australian Aboriginal Congress (CAAC) and Senior Lecturers from Flinders University.
3. An expert advisory group (EAG) which included representatives from CDU, MSHR, NT PHN and AMSANT.

4. Community-controlled reference groups. It was planned to have four ACCHS reference groups: 1) Arnhem Land, 2) Big Rivers Region 3) Barkly and 4) Central Australia. However, none of the in Central Australian ACCHS had the capacity to participate in the project. The three health services in the Big Rivers Region, Sunrise Health, KWHB, and Wurli-Wurlinjang Health participated as a group. Those ACCHS consulted individually included

    - Mala'la Health, North East Arnhem Land, NT;
    - Miwatj Health, East Arnhem Land, NT;
    - Red Lily Health, West Arnhem Land, NT;
    - Anyinginyi Health Aboriginal Corporation (Anyinginyi Health), Tennant Creek and Barkly Region, NT; and
    - Marthakal Homelands and Resource Centre Aboriginal Corporation (Marthakal Homelands), North-East Arnhem Land, NT.

    Other health services and organisations consulted included:

    - Northern Territory Department of Health;
    - Central Australian Aboriginal Congress;
    - Danila Dilba Health Services (DDHS), Yilli Rreung, greater Darwin region, NT; and
    - The NT branch of the Australian Nursing and Midwifery Federation (ANMF).

2.2.2 Market research and needs assessment

Step 2 of the Participatory Organisational Change Model involved:

1. Desktop review and scoping of:

    - successful selection factors for a remote GNP including recruitment and retention;
    - factors contributing to success and challenges to the CAAC GNP; and
    - factors contributing to the success of, and challenges to, graduate nursing programs across Australia, drawing from relevant documents, including key policy papers such as the *National Rural and Remote Nursing Generalist Framework 2023–2027*;

2. Interviews with participants and key personnel in the GNP;
3. Surveying student and graduate nurses regarding their needs and the perceived value proposition of an NG nursing program in remote area nursing;
4. A literature review of graduate nurse programs in Australia, with a focus on rural and remote, and the identification of those Australian universities that provide rural and remote placement opportunities;

5. Program co-design that entailed iterative data collection and feedback to the ACCHS and relevant committees in regards to the results of the market research, needs assessment, and the main issues and plans identified, including proposed career pathways, such as to inform a culturally appropriate program framework; and
6. The development of a feasibility and sustainability plan for a GNP that involves the joint mapping and development of:

    - The organisational changes needed, both NT-wide and for each health service;
    - A Remote Area Nurse graduate program plan and economic analysis; and
    - The additional strategies needed by which to ensure retention post-program.

3. Results: The Evidence Base for a GNPE in Remote Northern Territory

3.1 Literature review on new graduate nurse programs for remote area nurses

A comprehensive literature review was conducted in order to synthesise and map literature on NG nursing programs, with a focus on remote area nursing. The review identified five key themes, the attributes of NGNs, transition theories, organisational considerations, program structure and key factors, and challenges for NG nursing programs in remote areas.

3.1.1 Attributes of new graduate nurses

NGNs are expected to be 'practice ready' upon entering the workforce, yet research has shown that many feel underprepared for the realities of clinical practice (Aggar et al., 2017; El Haddad et al., 2017; Missen et al., 2016b). While their academic preparation provides a strong theoretical foundation, many NGNs experience a disconnect between classroom learning and the complex demands of patient care. This gap often leads to heightened stress, anxiety, and a sense of inadequacy, with some NGNs even considering leaving the profession (Aggar et al., 2017; El Haddad et al., 2017; Missen et al., 2016b). In addition, nurse managers and other stakeholders sometimes hold unrealistic expectations—expecting NGNs to hit the ground running, which can further exacerbate the challenges these new practitioners face (Murray et al., 2020).

3.1.2 Transition theories

Several theoretical models help explain the complex journey from student to practicing nurse. For instance, Kramer's *reality shock theory* describes an initial phase of enthusiasm (the 'honeymoon' period) that is followed by disillusionment as NGNs encounter the stark realities of clinical practice (Kramer, 1974, in El Haddad et al., 2017; Graf et al., 2020). According to Bridges' three-stage transition theory, individuals experience a process of letting go of the familiar, moving through a neutral zone, and eventually embracing a new identity (Bridges, 1980, in Graf et al., 2020). Similarly, Benner's *novice-to-expert model* outlines a progression from reliance on rules and guidelines to the development of intuitive, expert clinical decision-making (Benner, 1984, in Graf et al., 2020). Duchscher's stages of transition—summarised as "doing, being, and knowing"—have been described as key to understanding how NGNs progress toward competence and confidence (Duchscher, 2008 in Graf et al., 2020). These models collectively offer a framework that can inform the design of supportive, stage-specific interventions in NG nursing programs.

3.1.3 Organisational considerations

The success of NG nursing programs hinges on strong organisational commitment. Health services must articulate a clear purpose and value proposition for their programs, ensuring that expectations for NGNs are realistic and that robust support structures are in place (KPMG, 2023). Effective programmes are characterised by proactive leadership, consistent resource allocation, and a well-defined selection process that identifies candidates with resilience and adaptability. Additionally, comprehensive marketing strategies are essential to attracting suitable applicants and aligning recruitment timelines with broader workforce planning. Without such organisational commitment, NGNs may struggle with professional isolation and inadequate support, potentially leading to higher turnover rates (Henderson et al., 2019; Phillips et al., 2015).

3.1.4 Program structure and key factors

Successful NG nursing programs typically adopt an incremental approach to training. They start with comprehensive orientation and onboarding processes that ease NGNs into clinical practice, followed by a gradual increase in clinical responsibilities as confidence and competence build over time (Cusack et al., 2024). Key elements include structured mentorship from experienced preceptors, continuous opportunities for reflection and critical thinking, and integrated continuing education initiatives. These programs also address workplace challenges such as incivility and stress by fostering peer support networks and implementing regular, constructive feedback mechanisms (Brunelli et al., 2022; Fowler et al., 2018). By aligning program design with the unique needs of NGNs—especially in rural and remote settings where additional challenges exist—healthcare organisations can improve retention, clinical performance, and overall job satisfaction.

3.1.5 Challenges for NG nursing programs in remote areas

NG nursing programs in rural and remote areas face a range of interrelated challenges that can impede the successful transition of NGNs into practice. Programs often struggle with inadequate resources, including a lack of structured support systems, insufficient preceptor training, and limited access to continuing education. These issues are compounded by logistical challenges such as scarce accommodation options and minimal infrastructure, which further hinder effective program delivery (Calleja et al., 2019; KPMG, 2023).

NGNs in rural settings frequently encounter greater clinical responsibilities due to the limited availability of senior staff and specialist support. This heightened responsibility, coupled with professional isolation from multidisciplinary teams, contributes to elevated stress levels, burnout, and concerns over clinical decision-making (Aggar et al., 2017; Lea & Cruickshank, 2015a).

The abrupt transition from academic environments to high-pressure remote and rural clinical settings often results in intensified transition shock. NGNs experience significant challenges, including feelings of isolation,

frustration, and unpreparedness, which are worsened by inconsistent mentorship and variable qualities of feedback (Calleja et al., 2019; Fowler et al., 2018).

In addition to clinical and operational difficulties, NGNs must also navigate cultural dynamics unique to rural and remote areas. Developing cultural competence is critical for effective care, particularly when serving Indigenous communities, yet many programs fall short in preparing NGNs for these roles (Green et al., 2024; KPMG, 2023).

Collectively, these challenges underscore the need for tailored, well-resourced, and context-specific support strategies to improve NG nursing retention and ensure high-quality patient care in rural and remote healthcare settings. For the full review see Appendix A.

3.2 Survey of undergraduate nurses and NGNs

To obtain information on preferences for a graduate nurse program for remote ACCHS in the NT, a Qualtrics survey was distributed to 2nd and 3rd year nursing students, NGNs, and registered nurses who had completed a new graduate nurse program in the previous three years. The return rate was relatively poor, with only 52 responses. The cohort was predominantly female and primarily within the 25–34 age group, aligning with early to mid-career professionals. Indigenous representation was minimal, suggesting opportunities for targeted outreach to Aboriginal and Torres Strait Islander groups.

Survey respondents demonstrated distinct preferences regarding program attributes and demographics. They favoured either urban or remote locations over regional zones, indicating a polarisation between city and isolated areas. Victoria and the Northern Territory were the most preferred State or Territory connections. The most valued program attributes included a friendly, supportive team environment and excellent job prospects, alongside practical aspects like manageable workloads, personal support, and rotations. Conversely, longer program duration, subsidised accommodation, and community or family integration support were the least valued. Overall, a supportive work environment and job prospects were prioritised over logistical and community-related factors, such as accommodation or relocation assistance. For detailed results see Appendix B.

3.3 Consultations with Aboriginal Community Controlled Health Services

A key requirement of the scoping report was to co-design the program with ACCHS in the Northern Territory. Those ACCHS' who agreed to participate included ACCHS in the Big Rivers Region, including Sunrise Health, KWHB and Wurli-Wurlinjang Health. Other ACCHs consulted included, Red Lily Health, Marthakal Homelands and Resource Centre Aboriginal Corporation, Anyinginyi Health Aboriginal Corporation and Miwatj Health.

Unfortunately, consultations were not completed with Anyinginyi Health and Marthakal Homelands, due to changes in staffing in both organisations, and consultations unable to be rescheduled. Further consultations should be undertaken following the publication of this report. See *Appendix C. Aboriginal Controlled Health Services* for a description of ACCHS and their activities.

Several smaller health services declined to participate due to their lack of capacity in the face of heavy service needs. These included:

- Laynhapuy Homelands Aboriginal Corporation;
- Urapuntja Health Service Aboriginal Corporation;
- Ampilatwatja Health Centre Aboriginal Corporation; and
- Pintupi Homelands Health Service (Kintore).

Three rounds of consultation were undertaken with participating ACCHS. Other key organisations were also consulted (Table 3.1).

Table 3.1. Schedule of consultations.

Round 1	**Region / Sector**	**2024**
Mala'la Health Service Aboriginal Corporation	Yilli Rreung (greater Darwin) region	March
Sunrise Aboriginal Health Service	Big Rivers Region (Eastern Katherine region)	March
Katherine West Health Board Aboriginal Corporation	Western Katherine region and Victoria River District, Big Rivers Region	March
Wurli-Wurlinjang Health Service Aboriginal Corporation	Katherine township and surrounding communities	March
Red Lily Health Board	West Arnhem Land	March
Central Australian Aboriginal Congress	Alice Springs and remote Central Desert communities	March
Flinders Rural and Remote Health	Flinders University of Rural and Remote Health	March
Anyinginyi Health Aboriginal Corporation	Tennant Creek and the Barkly Region	April
Miwatj Health Aboriginal Corporation	East Arnhem Land	April
Marthakal Homelands Health Service	North-East Arnhem Land	April
Wurli-Wurlinjang Health Service Aboriginal Corporation	Katherine township and surrounds	May
Round 2	**Region / Sector**	**2024**
Red Lily Health Board	West Arnhem Land	May
Sunrise Aboriginal Health Service	Big Rivers Region (Eastern Katherine region)	May
Katherine West Health Board Aboriginal Corporation (KWHB)	Western Katherine region and Victoria River District, Big Rivers Region	May

Round 2	Region / Sector	2024
Wurli-Wurlinjang Health Service Aboriginal Corporation	Katherine township and surrounding communities	May
Central Australian Aboriginal Congress	Alice Springs and remote Central Desert communities	May
Danila Dilba Health Service	Yilli Rreung (greater Darwin) region	May
Miwatj Health Aboriginal Corporation		May
Round 3	**Region**	**2024**
Danila Dilba Health Service	Yilli Rreung (greater Darwin) region	June
Red Lily Health Board	West Arnhem Land	October
Miwatj Health Aboriginal Corporation	East Arnhem Land	November
Danila Dilba Health Service	Yilli Rreung (greater Darwin) region	November
Mala'la Health Service Aboriginal Corporation	Yilli Rreung (greater Darwin) region	November
Sunrise Aboriginal Health Service	Big Rivers Region (Eastern Katherine region)	December
Katherine West Health Board Aboriginal Corporation	Western Katherine region and Victoria River District, Big Rivers Region	December
Wurli-Wurlinjang Health Service Aboriginal Corporation	Katherine township and surrounding communities	December
Australian Primary Health Care Nurses Association	National	March
Australian Nursing & Midwifery Federation	National	May
Transition to remote practice Program Coordinator, Katherine West Health Board	Western Katherine region and Victoria River District, Big Rivers Region	July
JK Constructions Northern Territory	Northern Territory Building Company	August
Northern Territory Health	Northern Territory	August
Northern Territory Health Nursing and Midwifery Executive Committee meeting	Northern Territory	August
Australian Rural Health Education Network	National	August
Council of Remote Area Nurses of Australia plus	National	August
Royal Flying Doctor Service, Port Augusta	South Australia	November
Flinders Clinical supervisor educators	Flinders Rural and Remote Health	On-going
Northern Territory Health, Big Rivers Region	Big Rivers Region	November
Northern Territory Health, East Arnhem Region Health Service	East Arnhem Region	November
Australian Nursing & Midwifery Federation	National	November

3.3.1 Big Rivers consultation feedback

The three health services in the Big Rivers Region, Sunrise Health, KWHB, and Wurli-Wurlinjang Health, agreed to develop a joint program. As of mid-2025, the KWHB Enterprise Bargaining Agreement (EBA) only allows them to employ nurses at N4 level. To enable them to be deliver the GNPE, they would need to alter their EBA to allow employment of N2 and N3 nurses. Negotiations are planned to be finalised in September

2025. Wurli-Wurlinjang and Sunrise EBAs already allow them to employ nurses at N2 and N3. See Table 3.2 for an explanation of nursing levels in the NT.

Table 3.2. Northern Territory nursing career structure.

Level	Details
Nurse 2 (N2)	Registered Nurses: Nurses at this level are responsible for providing direct patient care, administering medications, and collaborating with multidisciplinary teams to develop and implement patient care plans.
Nurse 3 (N3)	Clinical Nurses or Clinical Midwives: A role that encompasses advanced nursing responsibilities.
Nurse 4 (N4)	Nurse Specialist: This roles' duties include: • Providing specialised knowledge and skills in management. • Offering sound professional advice to assess, plan, review, evaluate, and coordinate comprehensive client care and designated service programs; • Contributing to the management of resources within their area of responsibility; and • Ensuring the delivery of high-quality patient care and services. Note: Remote Area Nurses are usually employed at this level.
Nurse 5 (N5)	Nurse Coordinator (Management): A higher level of responsibility and expertise, with a focus on autonomous decision-making and leadership. Note: Health Centre Managers are N5 positions.

All organisations emphasised the difficulty in supporting staff in remote locations and the importance of additional support for NGNs for the program to be successful. It was collectively proposed that in the Big Rivers Region, the GNPE be overseen by a joint Governance Committee of the three organisations. To enable the GNPE to be implemented, the organisations required the employment of a Remote Clinical Educator, preferably by Sunrise Health, who would work across the three organisations. In order to allow for additional support, it was suggested that an overall Program Coordinator be employed to assist with the implementation of the GNPE across the ACCHS. Whilst the ACCHS seek the NT PHN in order to lead marketing, the PHN role enables support and amplification of marketing impact through existing tools and networks and suggest consideration of the Program Coordinator's role contributing to the program profile and marketing.

A separate meeting was held with two individuals from the PHC team at the NT Department of Health, who advised not to undertake regional hospital placements, as the focus of the GNPE should be on PHC rather than any hospital activity. However, this view was not universal and it is thus recommended that further discussions be undertaken with NT Health.

3.3.2 Mala'la Health consultation feedback

Mala'la Health currently employs 24 staff members across various employment models and rotations. There were concerns about placing an NGN in a remote community. Some of the staff would prefer employing more experienced nurses who are new to remote. However, there is clear interest about accessing the final report

in order to help guide the potential adoption or adaptation of the proposed framework. This would enable the organisation to align its practices with recommended standards and improve outcomes.

One significant challenge faced by the organisation is the absence of a Remote Clinical Educator by which to support NGNs. This gap highlights the need for additional resources to provide structured guidance and foster professional development among NGNs.

Mala'la Health is also interested in understanding the evaluated outcomes of the staged implementation of the Graduate Nurse Program. Insights from this evaluation could offer valuable lessons and inform future strategies to enhance support and integration for new graduates within the workforce

3.3.3 Miwatj Health consultation feedback

A joint meeting was held with the Miwatj Health representatives, the Nhulunbuy and Gunyangara Primary Health Care Practice Manager, the Director of Nursing and a clinic manager. NT Health representatives including the Regional Executive Director East Arnhem Region Health Service, the Regional Director East Arnhem Mental Health Alcohol and Other Drugs (AOD) and Social and Emotional Wellbeing (SEWB) Services, the Director of Nursing of Nhulunbuy Hospital and the Director of PHC. This group was also joined by the Associate Vice-Chancellor East Arnhem Region, CDU.

Miwatj Health was supportive of the GNPE. The organisation needs additional time to work on details of internal logistical support, particularly accommodation, travel, and backfill. The NGNs are likely to be based in Nhulunbuy where there would be greater support than more remote placements. They could commence employing two NGNs in January or July 2026.

NT representatives were also supportive of the program and of NGNs doing short term placements at the hospital.

3.3.4 Red Lily Health consultation feedback

Feedback from the Red Lily Health indicated that the remote nursing workforce culture is increasingly shifting toward a locum-like model, characterised by temporary staffing arrangements. This trend, while addressing short-term workforce needs, poses challenges to long-term stability and continuity of care in remote areas. Improved support systems and enhanced working conditions have been shown to positively correlate with an increased retention of nursing staff, highlighting the importance of creating a sustainable and supportive work environment (Red Lilly Health Executive, consultation feedback, October 2024).

High staff turnover remains a significant issue, impeding the ability to build trust with key stakeholders and communities. This lack of continuity often leads to operational challenges, including an increased likelihood of medical evacuations, which strain resources and disrupt the quality of care. Red Lily Health is well-positioned

to integrate the principles of the GNPE into its health service expansion strategy. This integration would allow for the development of a skilled and culturally competent workforce while addressing the unique needs of remote health care. Graduate Nurse placements could be tailored to align with individual career goals, fostering professional growth and ensuring that nurses are equipped for success in their chosen specialties.

To further enhance retention, Red Lily have endorsed a A$10,000 retention bonus and relocation cost reimbursement, an incentive aimed at attracting and retaining nursing talent in remote locations. As part of their strategy, two Jabiru-based NGNs may be employed in January 2026, marking a significant step toward building a robust and dedicated nursing workforce in the region.

Red Lily Health's preference for governance was a Top End Governance Committee. Red Lily Health's preference would be for NT PHN to lead marketing. The PHN role would enable support and amplification of marketing impact through existing tools and networks and suggest consideration of the Program Coordinator's role contributing to the program profile and marketing. Like other health services they require funding for a Remote Clinical Educator.

3.3.5 Anyinginyi Health consultation feedback

Anyinginyi Health has expressed strong support for the GNPE and has proposed the potential employment of two NGNs in 2026. They believe they can provide NGNs with a robust experience in working within an ACCHS. However, as with other organisations, they would require the addition of a Remote Clinical Educator in order to support the program effectively. Anyinginyi Health also sees value in NGNs undertaking a placement at Tennant Creek Hospital as part of their training and development. They emphasised the importance of cultural safety and of including Aboriginal Health Practitioners as RANs' mentors and educators. Unfortunately, the final round of consultations could not be completed due to staff changes. It is therefore recommended that further consultations be conducted following the dissemination of this report to ensure comprehensive engagement and alignment with the program's objectives.

3.3.6 Marthakal Homelands consultation feedback

Marthakal Homelands would be able to support one NGN in 2026, and have accommodation available. Due to their small size, it was suggested that NGNs undertake placements at Miwatj Health to gain more acute experience. There is also potential for placements at Nhulunbuy Hospital. Unfortunately, due to staff turnover, final consultation not completed. It is therefore recommended that further consultations be conducted following the dissemination of this report to ensure comprehensive engagement and alignment with the program's objectives.

3.3.7 DDHS consultation feedback

DDHS has expressed strong support for the GNPE and its objectives. As part of its commitment, DDHS is willing to offer its Darwin-based clinics for two-week placements of NGNs, providing them with valuable hands-on experience in a culturally safe and community-focused environment. These placements could provide a valuable opportunity for NGNs primarily working in remote communities to take a break and gain experience in Darwin.

DDHS has indicated the possibility of employing two NGNs in 2026, further showcasing their dedication to fostering the development of early-career nurses. Additionally, to enhance their supervisory capacity, the organisation sent four staff members, to the clinical supervisor workshop held in March 2025. This reflects their proactive approach to ensuring high-quality mentorship and support for emerging healthcare professionals.

3.4 Summary of consultation with ACCHS

There was widespread support from the health services consulted in regards to the development of an GNPE. There was great variability in the capacity of services to first consult with the project, and then to consider the implementation of such a program in the face of maintaining already stretched and stressed services. It was apparent that flexibility in the design and implementation of this program are necessary. For example, Big Rivers ACCHS' were desirous of a collaborative program.

3.5 Other consultations

3.5.1 Australian Nursing and Midwifery Federation consultation feedback

The NT branch of the ANMF noted that their several of their current Enterprise Bargaining Agreements (EBA) only permitted them to employ nurses at N4 and above. As the GNPE requires health services to employ N2 and N3 NGNs, EBAs with some ACCHS' such as KWHB are currently being negotiated to include the employment of N2s and N3s.

3.5.2 Royal Flying Doctor Service consultation feedback

The Royal Flying Doctor Service (RFDS) in South Australia has highlighted the significant costs associated with employing agency staff, reporting an average of A$7,000 per fortnight per nurse in agency fees, in addition to wages and on-costs. This aligns with the agency staff costings detailed in this document. The financial strain is further exacerbated by recruitment agencies marketing rural nurse positions as 'Travelling Nurse' roles, which often result in low levels of commitment and investment from agency staff. Additionally, RFDS noted intense

competition between agencies, with instances where nurses accepted contracts with one agency only to break them in favour of offers from another agency with little notice.

The high turnover of agency staff has placed a considerable orientation workload on permanent staff, adding to operational challenges. To address these issues and better prepare nurses for the demands of rural and remote work, RFDS has proposed incorporating specific topics into the curriculum. These include Mental Health Emergencies, Suicide Watch and Self-Harming (aligned with the National Keep Children Safe Program), Safety Planning, Trauma-Informed Care, and practical workshops on Radio and Satellite Communications, as well as the Phonetic Alphabet.

4. Proposed Features of the Graduate Nurse Program Expansion

4.1 Organisational commitment and expectations

The effectiveness of the GNPE depends on clear program purpose, strong organisational and management support, and executive sponsorship (KPMG, 2023). In contrast, insufficient organisational commitment can negatively impact NGN well-being and patient safety (Henderson et al., 2019). Key enablers include investment in preceptor training, professional development, and workload management (Murray et al., 2020; Wise et al., 2023). Strong leadership and inclusive workplace cultures further enhance NG nursing outcomes by fostering collaboration and reducing professional isolation (Lea & Cruickshank, 2017; Wardrop et al., 2019).

Clear role expectations and structured support are needed for successful NG nursing transitions, helping NGNs integrate into professional practice as they progress through their program (Calleja et al., 2019; Ohr et al., 2020).

4.2 Marketing

The initial marketing strategy for the CAAC NG nursing program leveraged online platforms, proving effective in its first year. However, a decline in applications in the second year underscored the need for a more targeted recruitment approach (KPMG, 2023). Research has highlighted that NG nursing programs which emphasise career advancement, community engagement, diverse clinical experiences, interdisciplinary collaboration, culturally rich work environments, and meaningful contributions to Indigenous health care are more appealing to applicants and can strengthen recruitment efforts (Fowler et al., 2018; Green et al., 2024). As part of the marketing efforts, candidates will have the opportunity to nominate the ACCHS where they wish to work.

It is proposed that marketing and recruitment activities be ACCHS-led, as ACCHS are the subject matter experts in their respective communities and organisations. Their deep understanding of local workforce needs, cultural considerations, and community engagement is essential for developing recruitment strategies that are effective, culturally safe, and responsive to local priorities.

The NT PHN will support and amplify these efforts by leveraging its networks and experience in workforce promotion to extend the program's reach. This support may include:

- Sharing job opportunities through established NT-wide platforms,
- Assisting with the development of promotional materials, and
- Coordinating outreach efforts to ensure broad visibility.

All marketing activities will be undertaken in close collaboration with ACCHS in order to ensure messaging remains culturally appropriate and aligned with the priorities of participating services.

Strategic timing is critical; aligning marketing initiatives with national and NT graduate program application cycles will ensure greater awareness and prevent NGNs from prematurely committing elsewhere (KPMG, 2023). The Northern Territory Health intakes as of 2025 vary across regions:

- Alice Springs Hospital: intakes every two months;
- Katherine Hospital: intake dates dependent on service need;
- Royal Darwin and Palmerston Hospitals: four intake dates throughout the year (January, April, August, October);
- Tennant Creek Hospital: intake dates dependent on service need;
- Gove District Hospital: rotations may be available through the Royal Darwin and Palmerston Hospital program.

To maximise accessibility and flexibility for participants, it is proposed that the GNPE have two intakes in 2026—January and August—to align with NT Health's intake schedule and provide multiple entry points for graduates entering the workforce.

In order to ensure ongoing effectiveness, recruitment strategies will be regularly reviewed based on application trends, feedback from graduates, and ACCHS workforce needs. Insights gained from these evaluations will inform continuous improvements in marketing approaches, ensuring long-term sustainability.

4.3 Selection

The selection of NGNs will be a collaborative process, with NT PHN supporting ACCHS by shortlisting applications received through its marketing channels and outreach efforts. These shortlisted candidates will be presented to the respective ACCHS; for consideration. However, the ACCHS retain full autonomy to shortlist and select candidates through their own direct recruitment processes.

All ACCHS expressed a strong desire to be actively involved in the selection process, thus ensuring recruitment will align with local workforce needs and priorities. Several ACCHS also recommended that candidate interviews take place in remote community settings, allowing both candidates and health services to make more informed decisions—an approach that may improve retention rates. Most ACCHS emphasised the importance of prioritising the recruitment of First Nations nurses to strengthen the Aboriginal and Torres Strait Islander health workforce. Effective selection processes prioritise adaptability, resilience, and strong interpersonal skills, ensuring candidates can thrive in demanding healthcare environments (Phillips et al., 2015). The key criteria typically includes academic performance, clinical experience, and core nursing competencies (Aggar et al., 2017).

In rural and remote settings, emphasis is placed on adaptability, resilience, and commitment to long-term service in underserved communities (Fowler et al., 2018; Green et al., 2024). A strong interest in First Nations health is a key criterion for ACCHS', ensuring alignment with culturally safe care. A useful tool for selection could be the *Very Remote Practitioners' Work Motivation Scale* (Tyrrell et al., 2018). Exploring the motivations associated with the long-term retention of health professionals in very remote Indigenous Australian communities, this scale identified eight motivations:

1. Remote living location preferences;
2. Clinical self-containment;
3. Intercultural interest;
4. Challenge-seeking;
5. Personal demand preferences;
6. Clinical competence;
7. Relationship imperatives; and
8. Lifestyle preferences.

The tool consists of a 33-item, eight-subscale assessment, designed to identify candidates most likely to remain in very remote communities. Participants respond using a 6-point rating scale (from 1 = very unlike me to 6 = very like me). See Appendix D.

NT Health follows a priority selection process, which prioritises Aboriginal and Torres Strait Islander applicants above NT-registered undergraduate nursing students.

To expand the recruitment pipeline, marketing efforts could also target nursing members of Rural Health Student Clubs. A list of universities that offer appropriate undergraduate nursing courses and have active Rural Health Student Clubs is included in Appendix E.

4.4 Incremental program

The initial three to six months of placements are particularly challenging for NGNs, often marked by low confidence, stress, and anxiety due to the perceived level of responsibility exceeding their competence (Cusack et al., 2024; Fowler et al., 2018; Graf et al., 2020; Henderson et al., 2019). Typically lacking critical thinking depth and clinical judgment in the early months, NGNs necessitate a structured, incremental approach to program design (Murray et al., 2020).

Optimally, NG nursing programs should prioritise skill development early on, gradually introducing critical thinking and advanced practice as confidence grows. Longer program durations—beyond 12 months – with ongoing mentorship and professional development, are especially beneficial in rural and remote settings, where broader scopes of practice require extended adaptation (Brunelli et al., 2022). While the CAAC's GNP is

two years, survey responses indicate that many potential applicants would prefer a shorter program. in order to balance the desire for a shorter program and the need to develop advanced skills, an 18-month program is recommended. This proposal was supported by the ACCHS' during the consultations.

4.5 Orientation, onboarding, or induction program

There is strong evidence that a structured induction and/or orientation programs are associated with improved recruitment and retention (Graf et al., 2021; Lea & Cruickshank, 2017; Missen et al., 2016a; Ohr et al., 2020). In order to support the ACCHS', it is proposed that an initial two-week orientation program be delivered in Darwin or Katherine, with support from NT PHN, CDU and the participating ACCHS'. Most ACCHS' have their own onboarding or induction program, however, some may need assistance from the NT PHN in developing or revising these.

4.6 Support

Comprehensive support systems—including professional, clinical, intellectual, personal, emotional, and peer support—are essential for NGNs as they transition into practice (Adams & Gillman, 2016; Ankers et al., 2018; Lea & Cruickshank, 2015b; Murray et al., 2020; Parker et al., 2018). Constructive feedback, strong workplace culture, and structured mentorship enhance clinical judgment and confidence, reducing anxiety and burnout (Aggar et al., 2017; Cusack et al., 2024; Parker et al., 2018).

Support will be critical to the success of the GNPE. However, high staff turnover and the reliance on agency nurses present challenges for many ACCHS' in establishing and maintaining consistent support structures.

To strengthen support systems, it is proposed that:

1. A Program Coordinator role will be established within an NT-wide organisation, such as NT PHN, AMSANT, or an educational institution, to oversee implementation and sustainability. The appropriate host organisation will need to be determined through further discussion and negotiations, by which to ensure alignment with existing roles and responsibilities.
2. A Remote Clinical Educator will be employed in the Big Rivers Region as an initial step, with the potential to expand by adding three additional educators at:
    - Mala'la Health Service Aboriginal Corporation
    - Miwatj Health Aboriginal Corporation
    - Red Lily Health Board Aboriginal Corporation

Further engagement with these organisations will be required to confirm feasibility, resourcing, and alignment with local workforce needs.

Peer support is also recognised as an important element of emotional and professional reinforcement, helping NGNs manage transition shock and workplace demands (Gardiner & Sheen, 2017; Mellor et al., 2017). Structured peer networks foster knowledge exchange, resilience, and job satisfaction, particularly in rural and remote settings, where professional isolation can be a barrier to retention and development (Calleja et al., 2019; Green et al., 2024). It is recommended that peer support mechanisms be incorporated into the initial orientation process, though further consultation is required to determine the most effective approach.

4.7 Continuing education

Accessible continuing education is essential in NG nursing transition programs, enabling nurses to adapt to evolving healthcare environments, maintain competencies, and improve patient outcomes (Adams & Gillman, 2016; Aggar et al., 2017; Ankers et al., 2018; Brunelli et al., 2022). Integrating ongoing education fosters lifelong learning, professional growth, and high standards of care (Fowler et al., 2018; Phillips et al., 2015).

In remote settings, where nurses face professional isolation and limited resources, structured workshops, online courses, and professional development programs help bridge knowledge gaps and build clinical confidence (Calleja et al., 2019; Green et al., 2024; Henderson et al., 2015). Institutional support, including financial assistance, mentorship, and structured development programs, is crucial to promoting ongoing learning (El Haddad et al., 2017). In consultation with the ACCHS' and other stakeholders, the programs listed in Table 4.1 were recommended for inclusion in the GNPE.

Table 4.1. Training Modules Recommended for Inclusion in Graduate Nurse Program Expansion

Program	Mode/Notes	Available from	Website
NT Remote Locum Program eLearning Modules	Online	eLearning | NT Remote Locum Program	https://ntrlp.com.au/
Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare	Podcast	Menzies School of Health Research	https://www.menzies.edu.au/page/Resources/Ask_the_Specialist_Larrakia_Tiwi_and_Yol%C5%8Bu_stories_to_inspire_better_healthcare/
Understanding Vaccines and the National Immunisation Program (HESA Accredited)	Online	Immunisation Learning Courses, SA Health	https://www.sahealth.sa.gov.au/
Framing Indigenous Health	A 1-week face-to-face program	Flinders University	https://www.flinders.edu.au/study/short-courses/framing-indigenous-health
Remote Advanced Nursing Practice	A 1-week face-to-face program	Flinders University	Flinders University
Cultural responsiveness training	Module 1 and 2 online; Module 3 face-to-face	IAHA	https://iaha.com.au/iaha-consulting/cultural-responsiveness-training/
Graduate Certificate	To be offered after the first six months		

HESA: Health Education and Services Australia; IAHA: Indigenous Allied Health Australia; SA: South Australia; NT: Northern Territory.

4.8 Preceptors or supervisors

Preceptorship and mentorship are critical for NGNs, particularly in the first three months, as experienced nurses help transition them from task-based care to holistic nursing practice (Graf et al., 2021; Hussein et al., 2019). However, effective preceptor selection and training are essential in ensuring structured and supportive transitions. Inconsistent or inadequate training often leads to an *ad hoc* approach, especially in resource-limited rural and remote settings (Fowler et al., 2018).

Social learning and inquiry-based learning (IBL) enhance clinical facilitators' ability to support NGNs by promoting active learning, critical thinking, and problem-solving (Donnelly et al., 2023). Collaborative discussions, reflective practices, and shared learning experiences further strengthen facilitator confidence and effectiveness in guiding new graduates (Brunelli et al., 2022).

In order to enable effective preceptorship and/or supervision, a three-day clinical supervisors' workshop was conducted in March 2025 to:

- develop supervisory skills for effective clinical support;
- build effective strategies for developing critical thinking and clinical reasoning;
- develop understanding the GNPE curriculum; and
- build and sustain a community of practice.

It is suggested that the pilot program consider scholarships to preceptors and/or supervisors for undertaking an appropriate award in clinical education.

4.9 Reflection and critical thinking

Reflection and critical thinking fosters clinical reasoning, confidence, and adaptability (Aggar et al., 2017; Ankers et al., 2018). Reflective practice bridges the gap between theory and application, helping NGNs analyse experiences, identify improvements, and build resilience (Brunelli et al., 2022; Cusack et al., 2024). Critical thinking supports sound clinical decision-making, especially in high-pressure settings. The use of inquiry-based learning is recommended (IBL) as it enhances problem-solving and analytical skills, while social learning and structured debriefing improve holistic patient assessment and adaptability, particularly in resource-limited environments (Calleja et al., 2019; Donnelly et al., 2023; Henderson et al., 2015).

The ACCHS' consultations emphasised the significance of reflection and critical thinking. There was broad agreement that reflective practice, along with the development of critical thinking and clinical decision-making skills, are essential attributes for RANs.

4.10 Effective feedback

Effective feedback reinforces learning, enhances clinical confidence, and guides professional development (Ankers et al., 2018; Gardiner & Sheen, 2017). In rural and remote settings, structured feedback is even more critical for supporting NGNs and ensuring competence (Calleja et al., 2019). The use of multisource feedback (Brunelli et al., 2022; Hussein et al., 2019) from supervisors, peers, patients, and Aboriginal Health Workers or Practitioners is recommended. Several ACCHS' also emphasised the importance of feedback from Aboriginal Health Practitioners and community members.

4.11 Incivility, bullying, and horizontal violence

NGNs frequently encounter workplace incivility, aggression, bullying, and horizontal violence, impacting their confidence, job satisfaction, and teamwork (Mammen et al., 2018; Masso et al., 2022). Workplace incivility is defined as "low-intensity deviant workplace behaviour, with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. These behaviours are characteristically rude, disrespectful, and discourteous, displaying a lack of regard to others" (Mammen et al., 2018, p. 591). Such environments contribute to stress, isolation, and poor patient outcomes (Mammen et al., 2018). Zero-tolerance policies, supportive workplace cultures, and access to essential resources are important in addressing these challenges (Hussein et al., 2019; Murray-Parahi et al., 2016). Feedback from multiple ACCHS' indicated that incivility, bullying, and horizontal violence escalated during periods of staff instability and heightened stress, highlighting the need for targeted strategies such as support and self-care.

4.12 Workplace health and safety

The issue of poor workplace health and safety (WHS) has been a concern for RANs and health organisations for some time (Lenthall et al., 2019). Prior to the 2016 murder of RANs Gayle Woodford in South Australia, it was common practice for RANs to attend after-hours call-outs alone. Woodford's death exposed critical safety failures in remote healthcare, prompting the introduction of 'Gayle's Law' in South Australia, which mandates the presence of a second responder during after-hours call-outs in South Australia (*Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act 2017*, 2017).

Despite this reform, similar risks remain nationwide. A study by Wright et al. (2024)found inconsistent WHS practices across services. While some organisations had strong safety policies and leadership, others offered only superficial compliance, leaving RANs exposed to risk. Key safety enablers include strong communication, local knowledge—often from Aboriginal Health Workers or Practitioners and community collaboration. Barriers included high staff turnover, poor orientation, and under-resourcing. Limited staffing and outdated infrastructure also made implementing safety measures, such as 'never alone' policies, difficult (Wright et al., 2024). The GNPE is designed to address identified barriers and promote a safe and supportive workplace.

4.13 Stress and self-care

Stress is a recurring challenge for NGNs during their transition to practice, impacting job satisfaction, well-being, and patient care (Hussein et al., 2019; Lea & Cruickshank, 2015a; Mellor et al., 2017; Murray-Parahi et al., 2016; Parker et al., 2018). While structured programs enhance clinical preparedness, they often lack sufficient social and emotional support, creating gaps in the transition experience (Mellor et al., 2017).

Effective stress management and self-care are critical to preventing burnout. Strategies such as resilience training and access to mental health resources help mitigate the emotional toll of transition (Mellor et al., 2017; Wise et al., 2023). Supporting self-care involves developing reflective skills, emotional regulation, social intelligence, and moral courage, while also addressing workplace incivility and fostering belonging (Mellor et al., 2017). Integrating these strategies into NG nursing programs enhances retention, job satisfaction, and long-term well-being in the nursing profession.

It is recommended that the CRANA*plus* Mental Health and Wellbeing services be incorporated into the GNPE by including initial self-care and developing resilience sessions in the orientation program, followed by monthly phone conferences with CRANA*plus* psychologists.

4.14 Socialisation

Socialisation is essential for NGNs' integration into the team and workplace culture, enabling them to develop key skills, with preceptors serving as key mentors (Adams & Gillman, 2016; Lea & Cruickshank, 2015a). NGNs need time to adjust to both the workplace and community, with nurse leaders playing a pivotal role in facilitating this transition (Fowler et al., 2018; Ohr et al., 2020).

Structured socialisation and team-based activities help build professional identity, reduce stress, and enhance belonging, particularly in inclusive and collaborative environments (Henderson et al., 2019; Parker et al., 2018). Encouraging community engagement, including involvement from community members and Aboriginal Health Practitioners, may further strengthen NGNs' connection to their workplace and surroundings. Additionally, supporting NGNs to attend CRANA*plus* and Compass conferences could enhance their professional identity as Remote Area Nurses and reinforce their commitment to rural and remote practice.

4.15 Cultural adaptation

Many RANs, particularly those who work in Remote Aboriginal communities, may experience a process of cultural adaptation. Living and working in another culture can be a positive learning and growth experience. However, many first go through a negative stage—commonly referred to as 'culture shock', "the anxiety that results from losing all our familiar signs and symbols of social intercourse" (Adler, 1975, p. 13).

Cultural adaptation typically unfolds in five stages:

1. The Honeymoon Stage: In which the individual experiences excitement and fascination with the new environment (Oberg, 1960 in Muecke et al., 2011).
2. The Rejection or Disenchantment Stage: Misunderstandings of cultural cues and language barriers often lead to frustration. During this stage, individuals may withdraw, avoid cross-cultural interaction, and develop negative attitudes that can resemble racism. Some individuals may return home with enduring negative views of the host culture (Muecke et al., 2011).
3. The Adjustment Stage: The individual begins to gain a more open-minded and balanced understanding of the new culture, often forming positive relationships with community members.
4. The Effective Functioning Stage: The individual accepts the local culture as valid and feels confident, viewing the opportunity to live and work cross-culturally as a privilege.
5. The Reverse Culture Shock: Upon returning to their original culture, individuals may experience unexpected distress, sometimes more intense than the initial adjustment. This reaction can be particularly unsettling due to its unexpected nature (Muecke et al., 2011).

There are several strategies that can support nurses in navigating the cultural adaptation process. Recognising that cultural adjustment is a normal experience is an important first step. Nurses are encouraged to remain open-minded and curious, seek out cultural allies, and actively pursue positive interactions within the local culture. Utilising observational skills and asking respectful questions can aid understanding. It is also helpful to allow room for mistakes, both personal and interactional, as part of the learning journey. Maintaining physical health, accessing peer support, and being mindful to avoid behaviours that may appear discriminatory are crucial. Patience is essential, as the benefits of reaching the effective functioning stage in a new cultural context are highly rewarding (Muecke et al., 2011).

4.16 Cultural safety and responsiveness

As the NGNs will be working with ACCHS' in remote Aboriginal communities, cultural safety has been identified by all ACCHS' as a priority. Cultural safety involves self-reflection by health professionals on how their own culture and biases affect care delivery, with safety defined by the patient, not the provider (Williams et al., 2021). Unlike cultural competence, cultural safety addresses power imbalances and emphasises emotionally, socially, and spiritual safe care (Durey et al., 2021). The *National Rural and Remote Nursing Generalist Framework 2023–2027* recognises cultural safety as a core capability for nurses in remote settings, where cross-cultural care is essential (Office of the National Rural Health Commissioner, 2023). Evidence has shown that culturally safe practices improve patient trust, engagement, and outcomes (Durey et al., 2021). Organisations such as the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives continue to stress that cultural safety is just as vital as clinical safety (CATSINaM, 2021). Culturally safe practice requires ongoing reflection on how an individuals' own cultural position influences their relationships with clients. In

order to encourage self-reflection, it is recommended that NGNs complete the *Cultural Safety Self-Assessment* at various stages of their professional development. See Appendix F.

Several ACCHS' suggested that NGNs undertake appropriate language classes, learning the local language rather than expecting clients to speak English. This would differ from community to community.

Achieving cultural safety requires action at individual, organisational, and systemic levels. The *Cultural Responsiveness in Action Framework* developed by Indigenous Allied Health Australia (2019) was designed to support this process by embedding culturally safe and responsive practices grounded in Aboriginal and Torres Strait Islander ways of knowing, being, and doing.

The IAHA Framework identifies six interconnected capabilities:

1. Respect for the centrality of cultures: Recognising culture as central to health and wellbeing.
2. Self-awareness – Continuously reflecting on personal values, biases, and their influence on care.
3. Proactivity: Anticipating issues and initiating culturally informed change.
4. Inclusive engagement: Reducing barriers and fostering meaningful participation.
5. Leadership: Inspiring and influencing culturally safe transformation.
6. Responsibility and accountability: Owning one's role in addressing health inequities.

The IAHA Framework offers a lifelong guide for individuals and organisations to engage in this reflective, transformative journey (IAHA, 2019). The journey to cultural safety for NGNs is designed to be incremental, introduced in the first two-week orientation, then continued through short online courses, attendance at the Framing Indigenous Health workshop, and the IAHA cultural responsiveness training, and will be supported by multisource supervision and mentoring by community members and Aboriginal Health Practitioners.

4.17 Retention strategies

To improve NGN retention in the GNPE, it is recommended that NGNs be given regular opportunities to leave the community, including four two-week study blocks each year to undertake education, paid flights to a home base twice a year, and the offer of a A$10,000 completion bonus.

4.18 Conclusion

The success of the GNPE depends on strong organisational commitment, structured support, and targeted recruitment strategies by which to attract and retain NGNs, particularly in rural and remote settings. Clear role expectations, effective mentorship, and structured transition programs are critical in fostering clinical confidence, resilience, and long-term retention.

Marketing and selection strategies should align with NT Health intake cycles, prioritising First Nations nurses and ensuring candidates are well-prepared for the unique challenges of remote healthcare environments. An

incremental program structure, with a balance between clinical skill development and critical thinking, will provide NGNs with a progressive and supportive transition into professional practice.

Comprehensive orientation, mentorship, peer support, and continuing education initiatives will further enhance NGN confidence and competence, while structured feedback mechanisms and preceptor training will strengthen workplace integration. Addressing workplace challenges such as incivility, stress, and burnout through zero-tolerance policies, resilience training, and self-care strategies will contribute to a healthier and more inclusive workplace culture.

In order to support retention and workforce sustainability, key strategies include structured socialisation, financial incentives, and regular professional development opportunities. By fostering a positive, supportive, and well-resourced work environment, the GNPE will enhance recruitment, retention, and the long-term sustainability of the rural and remote nursing workforce.

5. GNPE Curriculum

The GNPE curriculum has been mapped and aligned with the *National Rural and Remote Nursing Generalist Framework (2023–2027)*, which defines the unique skills required for nursing in remote settings (Office of the National Rural Health Commissioner, 2023). The program emphasises culturally safe practice, evidence-based decision-making, multidisciplinary collaboration, and professional accountability. These core domains address the unique challenges faced by Remote Area Nurses, particularly in underserved Aboriginal and Torres Strait Islander communities.

The curriculum is divided into two major content areas:

1. The Foundations of Remote Nursing include cultural safety, PHC principles, and the social determinants of health, consistent with the World Health Organization's (WHO) emphasis on equity and accessibility in healthcare (WHO, 2018).
2. The Advanced Clinical Practice component equips participants with skills in clinical reasoning, emergency management, chronic disease care, and trauma-informed practices, as tailored to the needs of remote populations (Aitken et al., 2023).

Remote populations face unique challenges in accessing quality education and support. The GNPE will to adopt a flexible delivery model tailored to these needs (Aitken et al., 2023). Commencing with a two-week workshop that introduces foundational concepts, and sets the stage for more in-depth learning, the program will continue in weekly online tutorials that will cover critical topics, such as chronic disease management and cultural competence (Lenthall et al., 2024). Four intensive two-week study blocks will be scheduled annually, providing focused learning opportunities through short courses in immunisation and pharmacotherapeutics. This comprehensive structure will ensure that participants will be able to balance ongoing education with the demands of remote practice.

Integrated themes throughout the curriculum include cultural safety, reflective practice, and strength-based approaches to Indigenous health. These themes emphasise the resilience of Aboriginal and Torres Strait Islander communities and aligns with global standards for culturally safe healthcare (NMBA, 2024; Schultz & Cairney, 2017; Verbunt et al., 2021). Evidence-based decision-making and teamwork are also prioritised, reflecting the multidisciplinary nature of remote health services (Carey et al., 2018).

Clinical skills development has been included as part of the program, with participants trained in health checks, immunisations, point-of-care testing, and chronic disease management. These skills will be applied using the *Revised Remote Area Nurse Model of Consultation*, which focuses on holistic and culturally safe care (Lenthall et al., 2024). In the second year, scholarship opportunities will allow participants to pursue a Graduate Certificate, further enhancing their clinical expertise and leadership abilities.

The GNPE curriculum is grounded in the key principles of responsiveness, workforce capacity building, and practical application (Webster et al., 2025). Developed in partnership with ACCHS', the program addresses local needs and priorities. By training culturally competent and skilled nurses, the GNPE aims to reduce workforce shortages and improve health outcomes in remote and Indigenous communities (Zhao et al., 2019). For the full curriculum, see Appendix G.

5.1 GNPE Timeline

The GNPE project proposes the establishment of an 18-month incremental program with NGNs commencing at the N2 level in the first year and progressing to N3 in the second year. First developed at CAAC, this approach has proved to be attractive to nursing graduates.

5.1.1 Year 1

Commencing employment would require an initial two-week workshop on Aboriginal Community Control, cultural safety, and the social and cultural determinants of health, as well as clinical skills, such as eye and ear examinations and well person checks. A 4WD course would also be included.

Participants will then have a supernumerary period of six weeks with the remote ACCHS. All ACCHS' emphasised the importance of NGNs developing an understanding and commitment to PHC early in the program. During this supernumerary period, participants will have one-week of supervised practice with a Remote Clinical Educator in order to increase participant retention and allow for a robust educational program, participants will have two-weeks, four times a year, outside the community as study blocks. They will also attend a half-day tutorial each week.

In the first year of the program, the NGNs will undertake a variety of online courses including a nationally accredited immunisation course. They will also attend face-to-face short courses including the Flinders University 'Framing Indigenous Health' course in the first six months. Later in the first year, during study blocks, NGNs will attend the Flinders University's 'Advanced Remote Nursing Practice' course. Feedback from Flinders University lecturers emphasised that NGNs struggled with the second course when it was undertaken too early in their program. It is also suggested that NGNs undertake the CRANA*plus* Remote Emergency Care (REC) and the Maternity Emergency Care (MEC) courses.

5.1.2 12–18 Months

In order to improve retention rates, support, and scholarship, participants will be given the opportunity to complete an appropriate Graduate Certificate after 6–12 months. NGNs would have two-week study blocks outside the community. It is recommended that each NGN receive a A$10,000 incentive payment at the end of the 18-month program.

6. Implementation Plan

6.1 Governance

The GNPE project recommends the establishment of a Governance Committee with representatives from Northern Territory-wide organisations and participating health services, including the following.

- NT PHN,
- AMSANT,
- CDU,
- Big Rivers Region ACCHS',
- Mala'la Health,
- Red Lily Health,
- Miwattj Health,
- NT Health, and
- CAAC.

Several other ACCHS' indicated they would like to be involved, but because of staff changes have not yet finalised their commitment, including Marthakal Homelands and Anyinginyi Health. They may be invited to participate at a later date.

This project also recommends that a subcommittee be established by which to oversee the implementation of the GNPE program in the Big Rivers Region, with representatives from: 1) Sunrise Health, 2) KWHB and 3) Wurli-Wurlinjang Health.

6.2 Funding

Most ACCHS rely on limited core funding, supplemented by program-specific funding, thus employing NGNs would require ACCHS to reallocate resources from an existing program area. In order to ensure the sustainability of the GNPE, the primary funding need identified by the health services is for an overall Program Coordinator and Remote Clinical Educator.

Three main funding opportunities have been identified: 1) a funding proposal to the Australian Government DHAC, 2) a proposal for a new University Department of Rural Health, and 3) a submission for a NHMRC Partnership Project.

Medical Research Future Fund – Rapid Applied Research Translation Initiative, and an explore consortium approach, led by ACCHS and supplemented by other funding sources for staffing and implementation.

6.2.1 Funding proposal to the Australian Government Department of Health and Aged Care

Preliminary feedback suggests that a funding proposal to the Australian Government DHAC for a remote GNPE aligns well with the department's priorities and has a strong chance of approval. Thus, a funding proposal should be developed with input from ACCHS' and supporting organisations in order to progress this opportunity. Letters of endorsement from participating health services will strengthen the application.

6.2.2 Proposal for a new University Department of Rural Health

A partnership between CDU and ACCHS' could establish a University Department of Rural Health (UDRH) in the NT, supporting rural and remote workforce training and research. While promising, this initiative requires sector advocacy, formal partnerships, and a detailed business case. Further discussions within the sector should be prioritised in the next six months to determine feasibility. For more details, refer to Appendix H.

6.2.3 The National Health and Medical Research Council Partnership Projects

The NHMRC Partnership Projects scheme is designed to foster collaborative research that directly informs health policy and practice in Australia. It supports projects that address real-world problems by encouraging strong partnerships between researchers and those working in health services, policy, and program delivery. The goal is to bridge the gap between research and implementation, ensuring that evidence informs health service improvement and delivery at both systemic and community levels.

Each Partnership Project can receive up to $A1.5 million over five years, with a total funding pool of approximately $A31.6 million in 2025. Importantly, these projects must be co-funded by partner organisations, such as health departments, ACCHS', non-governmental organisations, or industry bodies that contribute resources (cash or in-kind) equal to or greater than the NHMRC funding request. This co-investment model ensures the shared ownership, relevance, and sustainability of the research outcomes.

The scheme uses a rolling application process, with three peer review cycles (PRC) each year. In 2025, PRC1 closed in April, and PRC2 and PRC3 close in August and November. Applicants must lodge a *minimum data set* by a specified date before the final application deadline in each cycle, and successful applications are typically announced around four months after submission. We are considering applying for the November submission.

Only NHMRC-approved administering institutions—typically universities and research organisations—are eligible to submit applications. Partner organisations must play a significant role in shaping the research and using its findings, and an NHMRC-approved institution may only be listed as a partner with a formal waiver

request. The emphasis is on research supports the translation, implementation, and scaling of evidence-based solutions, especially where the impact will improve health service quality, equity, access, or efficiency.

The Partnership Projects scheme is ideal for researchers working in applied health settings—especially those focused on Aboriginal and Torres Strait Islander health, rural and remote service delivery, health workforce innovation, and system-level reform.

7. Implementation

7.1 Project implementation

7.1.1 Establishment – Governance and initial staffing

The establishment stage focuses on creating the governance and coordination structures necessary to support the successful rollout of the GNPE. A key priority, as mentioned in Section 6.1, is the formation of an overarching Governance Committee. This committee would provide strategic oversight, ensure alignment with cultural guide culturally responsive implementation, support evaluation, and ensure that the program aligns with community priorities and health workforce objectives.

Initial funding proposals will be sought as a submission to the Australian Government DHAC and to the NHMRC under its Partnership Projects scheme. it is recommended that a GNPE Program Coordinator be employed through a NT wide organisation (such as NT PHN, AMSANT, or CDU). Upon funding approval, the Program Coordinator will lead preparations for rollout. This position will play a critical role in coordinating activities across services, maintaining program momentum, facilitating communication among stakeholders, and supporting the development of program materials and implementation resources.

7.1.2 Stage 1 – Initial Rollout

The first implementation stage will involve the three ACCHS in the Big Rivers Region:

1. Sunrise Aboriginal Health Service;
2. Katherine West Health Board;
3. Wurli-Wurlinjang Health.

A Remote Clinical Educator will be recruited to support the first implementation region (Big Rivers), with Sunrise Health tentatively identified to host and coordinate this role across three participating services. This stage will also involve early engagement with ACCHS to confirm site readiness, define local implementation roles, and prepare for recruitment of NGNs.

Each service will recruit two NGNs, contingent on the employment of a shared regional Remote Clinical Educator. The educator, based at Sunrise Health, will support on-the-ground supervision, clinical education, and professional development across the three sites. A regional governance subcommittee will be formed with representatives from each service to provide local oversight and coordinate the delivery of Stage 1.

The NG nursing recruitment will include interviews and selection processes led by each service in collaboration with the GNPE Program Coordinator. Orientation will begin with a two-week centralised program in Katherine,

followed by a one-week on-site induction at each clinic. Once deployed, NGNs will be supported through structured supervision, mentoring, and continuing education.

A formative evaluation will be conducted during this stage to assess early implementation progress, identify strengths and challenges, and refine program processes. This will inform adjustments in preparation for Stage 2.

7.1.3 Stage 2 – Expanding the GNPE to three additional ACCHS'

In Stage 2, it is proposed to expand the program to three other ACCHs':

1. Mala'la Health
2. Red Lily Health
3. Miwatj Health

Each service will employ its own Remote Clinical Educator, responsible for providing localised, culturally responsive supervision and clinical education to support the successful transition of NGNs into remote practice. These educators will ensure consistent, high-quality support that reflects the specific context and needs of each community.

The expansion will build on the structures and lessons established during Stage 1, benefiting from the governance, coordination, and evaluation processes already in place. This phased approach allows for careful refinement, stronger regional collaboration, and sustainable integration of the GNPE across a broader footprint of remote health services.

8. GNPE Feasibility and Sustainability Analysis

8.1 Financial implications of agency nursing

Agency nursing companies have become a primary source of staffing for many ACCHS'. This shift from long-term employment contracts to short-term agency placements began after the Northern Territory Emergency Response in 2007 (Zhao et al., 2019) and has since been accelerated by ongoing nursing shortages and evolving expectations about work-life balance and job flexibility.

This reliance on agency staffing has created two significant challenges for ACCHS':

1. Escalating operational costs due to the high fees charged by private agency companies.
2. Disruptions to continuity of care, stemming from short-term placements and high staff turnover (NT PHN, 2023b).

Since the COVID-19 pandemic, the rates charged by private nursing agencies have surged, with some ACCHS' reporting that rates have doubled or tripled. Despite these increased costs, the level of clinical experience provided by agency nurses often does not reflect the premium being paid—more a reflection of high market demand than of workforce capability. For example, some ACCHS' have had to hire agency nurses who lack key remote qualifications, such as the CRANA*plus* REC and MEC, and Flinders University's Pharmacotherapeutics for RANs (NT PHN, personal communication, 2024).

Health services are often caught between competing priorities – ensuring a registered nurse is present to maintain minimum staffing levels or operating with workforce shortages. This decision frequently places additional pressure on existing permanent staff and may compromise quality of care. Previously, many services relied on the Remote Area Health Corps (RAHC) to fill vacancies; however, RAHC has shifted away from short-term placements, prompting increased reliance on more expensive private agencies (NT PHN, 2023b).

Even with these stopgap measures, many services struggle to meet their minimum staffing requirements. In the Top End, several ACCHS' have reported that 50% – 80% of their workforce currently consists of agency staff (NT PHN, 2023b).

The financial implications of this staffing model are considerable. One health service estimated that an agency nurse on a 4–6-week contract costs an additional A$8,000 beyond standard wages and travel. In another case, a health service reported paying an hourly rate of A$128 for an agency nurse (NT PHN, 2023b).

In order to quantify the impact, Table 8.1 and Table 8.2 present cost estimates derived from stakeholder consultations outlined Section 3.3. The model assumes a full-time agency nurse, working 40 hours per week for 52 weeks, with 10 agency contracts annually. Each contract attracts an A$8,000 agency fee and a A$4,000 travel cost. The estimated cost per day for an agency nurse is A$1,485. These figures do not include overtime

– often a routine component of remote service delivery – due to variability in how overtime is calculated across services. However, in many cases, overtime costs are substantial and would significantly increase the overall expenditure.

Table 8.1 outlines the total annual cost of employing one full-time agency nurse, while Table 8.2 presents the corresponding service rates (hourly, daily, annual) and scaled cost estimates for a workforce of six and 12 agency nurses.

Table 8.1. Annual cost estimates for one agency nurse

Item	Unit Cost (A$)	Cost per Year (A$)*
Agency fees *per contract*	8,000	80,000
Salary *per hour*	128	266,240
Travel cost *per contract*	4,000	40,000
Total Annual Cost (1 Nurse)		**386,240**

* 52 weeks, 40 hours per week.

Table 8.2. Scaled cost estimates and service rates

Item	Cost (A$)
Hourly cost per nurse to service (including agency fees and travel costs)	186
Cost per day (8-hour day)	1,486
Cost per year (52 weeks, 8-hour day)	386,235
Cost per year for 6 agency nurses	**2,317,411**
Cost per year for 12 agency nurses	**4,634,822**

Table 8.1 and Table 8.2 underscore the substantial financial burden agency staffing places on remote health services. An annual cost of A$386,235 for a single agency nurse represents a significant proportion of a service's workforce budget – especially when multiplied across multiple roles. For a small remote clinic requiring 6–12 agency nurses to maintain core service delivery, annual expenditure may range between A$2.3 million and A$4.6 million.

Importantly, this expenditure does not contribute to long-term workforce sustainability, local capacity building, or continuity of care. High turnover associated with short-term agency contracts often necessitates repeated onboarding and orientation, further compounding indirect costs. From a workforce planning perspective, this model represents a reactive and high-cost approach to addressing persistent staffing shortages, with limited return on investment in terms of workforce retention, cultural competence, or clinical continuity.

These challenges highlight the urgent need for alternative solutions that are both cost-effective for alternative, cost-effective models that align with long-term workforce development objectives and support the delivery of culturally safe, continuous care.

8.2 Estimated costs of the GNPE

In contrast to the high cost of agency staffing, the GNPE offers a structured, long-term workforce strategy focused on sustainability, local capacity building, and continuity of care. The GNPE model supports NGNs through a formalised 18-month program, combining employment at sustainable salary levels with structured education and wraparound support.

The GNPE includes supervision by a Remote Clinical Educator, support from a Program Coordinator, and participation in short courses to develop clinical and cultural capabilities required for remote practice. NGNs will be employed at N2 for the first 12 months and transition to N3 for the final 6 months.

The estimates presented in Table 8.3 cover all anticipated costs for the implementation of the GNPE, including salaries and on-costs for NGNs, Remote Clinical Educators, and Program Coordinators, as well as marketing, recruitment, relocation, travel, accommodation, short courses, and professional development. Accommodation costs include the two-week orientation and four study blocks (three in Year 1 and one during the final six months), while travel costs cover relocation, home-base return travel, per the conditions of employment, and short course attendance.

Table 8.3. Estimated Graduate Nurse Program Expansion costs by category and cohort size (18-month program) for new graduate nurses (NGN).

	Year 1 (N2)			12-18 Months		
Cost Category	***Cost per NGN (A$)***	***Cost x 6 NGNs (A$)***	***Cost x 12 NGNs (A$)***	***Cost per NGN (A$)***	***Cost x 6 NGNs (A$)***	***Cost x 12 NGNs (A$)***
Marketing and recruitment	4,000	24,000	48,000	0	0	0
Salaries (NGNs, oncosts, Program Coordinator, Remote Clinical Educators)	145,044	870,263	1,590,525	92,460	554,760	1,034,520
Accommodation (orientation and study block travel)	5,280	31,680	63,360	1,200	7,200	14,400
Travel (relocation, return home, and short course travel)	16,000	96,000	192,000	6,000	36,000	72,000
Professional development (short courses and cultural training, graduate certificate scholarship)	6,119	36,714	73,428	4,400	26,400	52,800
Retention bonus	0	0	0	10,000	60,000	120,000
Total	**176,443**	**1,058,657**	**1,967,313**	**114,060**	**684,360**	**1,293,720**
Total *if Program Coordinator and Remote Clinical Educators were externally funded*	**126,443**	**758,657**	**1,517,313**	**89,060**	**534,360**	**1,068,720**

8.2.1 Scaling assumptions

The following cost estimates are based on specific scaling assumptions, including the nurse-to-Remote Clinical Educator ratio and Program Coordinator-to-nurse ratio. For these calculations, the model assumes the following:

- The Remote Clinical Educator-to-NGN ratio is 1:6, meaning one educator supports six NGNs.
- The Program Coordinator-to-nurse ratio is 1:6 for cohorts of up to six NGNs and scales to 1:12 for cohorts of 12 NGNs, reflecting a more efficient distribution of coordination responsibilities as cohort size increases.

Accommodation costs are calculated for a two-week orientation and four study blocks (three in Year 1 and one in the final six months). Travel costs cover relocation to placement sites, return travel to home bases (twice during the 18 months), and short course attendance.

In order to improve clarity for decision-makers, GNPE costs have been summarised into five key categories: marketing and recruitment, salaries, accommodation, travel, and professional development. Costs are outlined for individual NGNs, as well as for cohorts of 6 and 12 participants.

A detailed breakdown of individual cost items – including course-by-course allocations, daily accommodation costs, and travel assumptions – is provided in Appendix I, Table I1, such as to support the financial modelling.

Table 8.5 presents the estimated cost of the GNPE for cohorts of six and 12 NGNs over the 18-month program period. Costs are shown with and without funding for the Program Coordinator and Remote Clinical Educators, providing flexibility depending on whether these roles are externally supported.

In order to complement the detailed breakdown in Table 8.3, Table 8.4 presents the total estimated cost per NGN over the full 18-month period. This summary includes scenarios both with and without funding for the Program Coordinator and Remote Clinical Educators, allowing for flexible planning depending on available external supports.

Table 8.4. Estimated per-nurse cost of Graduate Nurse Program Expansion over 18 months (with and without funded support roles)

Cost Per New Graduate Nurse	Including Program Coordinator and Remote Clinical Educators (A$)	Excluding Program Coordinator and Remote Clinical Educators (A$)
Year 1	176,443	126,443
12–18 months	114,060	89,060
Total over 18 months	**290,503**	**215,503**

Table 8.4 illustrates that while the GNPE requires upfront investment, the total cost per nurse remains significantly lower than the equivalent cost of agency staffing. In particular, the model offers greater value when scaled to support larger cohorts.

Notably, the salary costs for the Program Coordinator and Remote Clinical Educators were distributed proportionally across each NGN in the Table 8.6. For example, the cost of one full-time Remote Clinical Educator or Program Coordinator is estimated at A$150,000 annually, regardless of whether they are supporting one or six graduates. To calculate per-NGN costs, this total was divided evenly among the six NGNs, resulting in a per-person cost of A$25,000. While this approach provides a consistent estimate for comparison, it is important to note that economies of scale apply: the per-NGN cost of coordination and supervision decreases as cohort size increases. In practice, this means that employing fewer than six NGNs under the GNPE model would result in higher per-nurse costs unless coordination and education roles are shared across services or externally funded.

8.3 GNPE versus agency nursing: Cost, productivity, and value comparison

In order to support a balanced comparison between agency staffing and the GNPE, it is essential to consider not only financial investment but also actual workforce productivity and clinical capability.

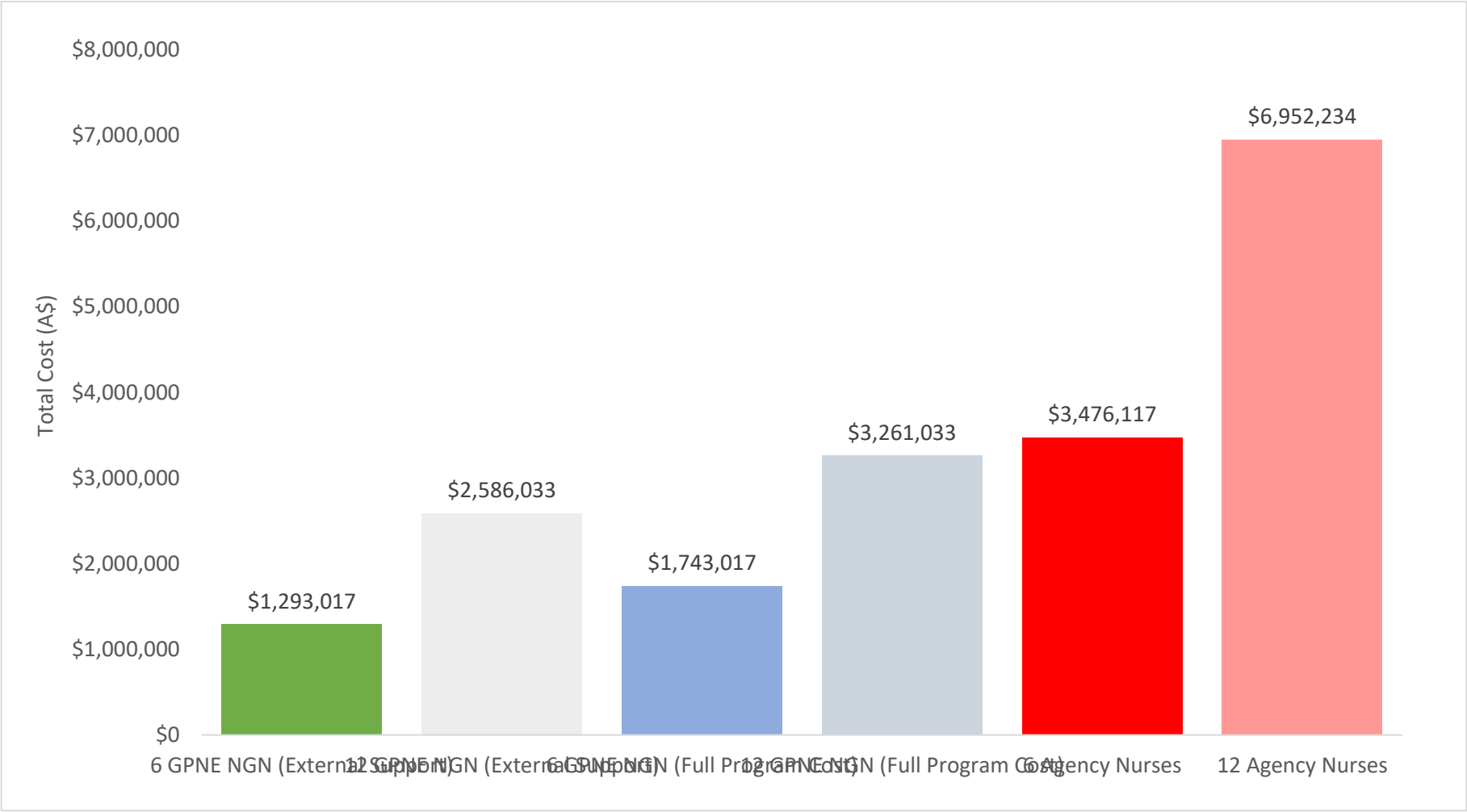
Figure 8.1 presents a side-by-side comparison of the total cost over 18 months to engage 6 or 12 GNPE participants vs agency nurses, including options where support roles are externally funded.

While GNPE participants require structured supervision and education, the model results in a significant reduction in overall expenditure compared to agency staffing. For instance, employing 12 GNPE participants over 18 months with externally funded supports costs approximately A$2.6 million—less than half the A$6.95 million required for 12 agency nurses. However, financial modelling must also account for the number of clinical days worked.

GNPE participants are not rostered to work every day due to structured study blocks, return-to-home leave, and professional development. As a result, the actual cost per clinical day worked is lower than that of an agency nurse. in order to provide a clear demonstration of this cost analysis in relation to days worked, Table 8.5 offers a detailed breakdown of the total days worked by an NGN.

Table 8.5 estimates the number of days worked by an NGN over an 18-month period, accounting for 6 weeks of annual leave, study blocks, supernumerary time post-orientation, and weekly tutorials.

Figure 8.1. Total cost comparison over 18 months – Graduate Nurse Program Expansion new graduate nurses (NGN) vs agency nurses.



GNPE: Graduate Nurse Program Expansion; NGN: New Graduate Nurses.

Table 8.5. Estimated total days worked by a New Graduate Nurse.

Item	Duration	Year 1 (12 months)	12–18 Months (6 months)
Total workdays available		260	130
Annual leave	6 weeks × 5 days	-30	-15
Study leave	8 days × 5 hours	-40	-10
Supernumerary	6 weeks × 5 days	-30	-0
Weekly tutorials	32 weeks x 0.5 days	-16	-8
Estimated days worked		**144**	**97**

The total estimated days worked by an NGN in the GNPE program is 241 days over 18 months. Despite this reduced number of working days, the day rate for GNPE participants remains significantly lower than that of an agency nurse.

Table 8.6 and Figure 8.2 compares the cost per day for a single NGN across three funding scenarios: Scenario A, which includes all associated costs; Scenario B, where the Program Coordinator and Remote Clinical Educator are externally funded; and Scenario C, which covers only core costs such as salary, on-costs, recruitment, marketing, and relocation. This comparison highlights the cost-efficiency of the GNPE model when calculated on a cost-per-day-worked basis.

Table 8.6. Estimated cost per day comparison across different funding scenarios for Graduate Nurse Program Expansion (GNPE) new graduate nurses (NGN) vs. agency staffing.

Funding Scenario	Year 1 (per NGN) (A$)	12–18 Months (per NGN) (A$)	Agency Staff (comparison) (A$)
A. GNPE including all costs (salary, coordination, educator, short courses, etc.)	1,225	1,176	1,486
B. GNPE excluding Program Coordinator and Remote Clinical Educator (externally funded)	878	918	1,486
C. GNPE core costs only (salary, oncosts, recruitment, marketing, relocation)	716	695	1,486

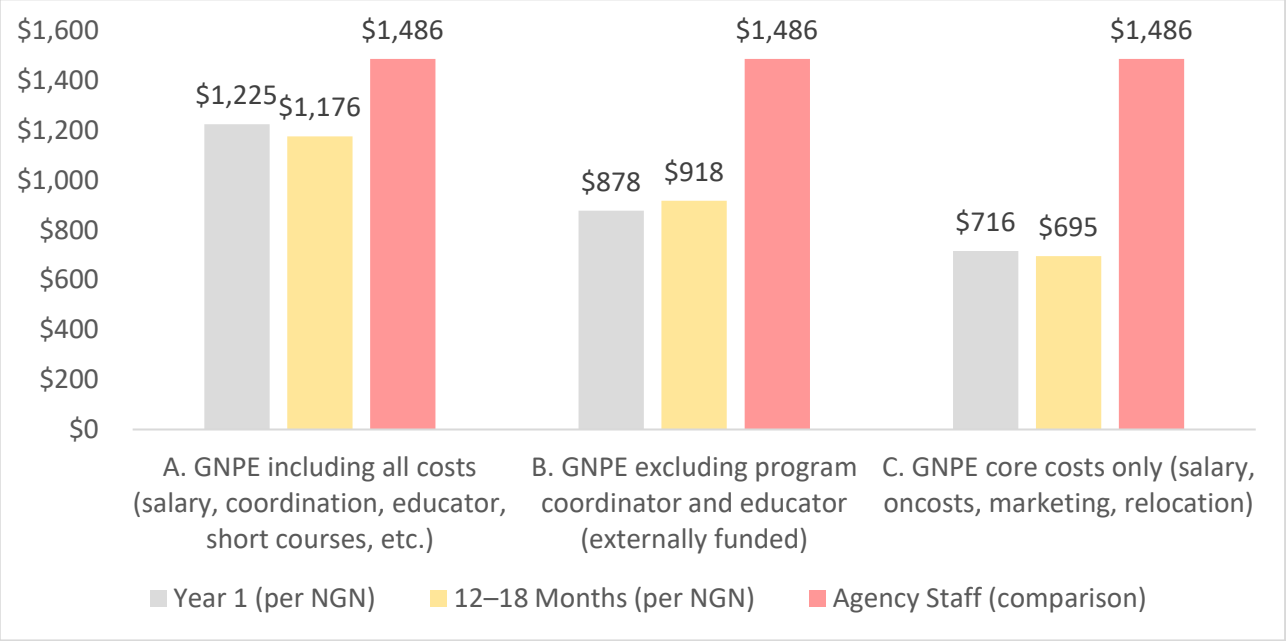
NGN: New Graduate Nurse.

The number of days worked by a GNPE participant over 18 months is reduced due to scheduled annual leave, study blocks, supernumerary time, and protected tutorial sessions. While this means GNPE participants deliver fewer billable days than agency nurses – who are typically expected to work full-time with limited leave – the model still offers strong cost advantages. When calculated on a cost-per-day-worked basis, GNPE remains significantly more affordable than agency staffing.

While these figures demonstrate the economic efficiency of the GNPE, it is equally important to recognise the difference in clinical experience and autonomy between GNPE participants and agency nurses. Agency staff

are often expected to operate independently and provide immediate coverage. As outlined earlier in this report, however, the capability of agency nurses can vary significantly – particularly in remote contexts where specialised clinical skills and cultural safety are essential. While many agency nurses meet these requirements, others arrive with limited remote experience or without critical qualifications such as REC, MEC, or pharmacotherapeutics training.

Figure 8.2. Estimated cost per day comparison across different funding scenarios for Graduate Nurse Program Expansion (GNPE) new graduate nurses (NGN) vs. agency staffing.



NGN: New Graduate Nurse.

In contrast, GNPE participants are early-career clinicians who are still developing their confidence and competence. The program is intentionally designed to accelerate this development through a highly supported and structured model. With access to Remote Clinical Educators, supernumerary time, protected study leave, and embedded cultural responsiveness training, graduates build their capability in a safe environment while contributing meaningfully to service delivery.

8.3.1 Total Investment to Scale GNPE

To illustrate the total investment required to deliver the GNPE at scale, Table 8.7 presents the full program costs for two implementation stages:

- **Stage 1** – an initial cohort of six NGNs over 18 months in the Big Rivers Region
- **Stage 2** – a second intake of 12 NGNs over 18 months, including a second intake of six NGNs in the Big Rivers Region and two NGNs each ACCHS' as the program extents to Red Lily Health, Miwatj Health, and Mala'la Health. This stage does include a lower number of NGNs per Remote Clinical

Educator for Red Lily Health, Miwatj Health, and Mala'la Health. These health services have highlighted the need for an additional educator and the unsuitability of sharing Remote Clinical Educators across such a vast region.

The costings include all program components – salaries, onboarding, travel, accommodation, short courses, evaluation, and a completion bonus – providing a comprehensive view of what is required to successfully implement and support the model for remote Aboriginal health services.

These costings demonstrate the scalability of the GNPE model. With fixed costs, such as program coordination and remote clinical education, distributed across each cohort, the cost per nurse will decrease as the program expands. As additional intakes are implemented and more graduates transition into the workforce, the GNPE will offer a repeatable, cost-efficient approach to building internal capability. This positions remote health services to move away from reliance on high-cost agency staffing and toward a more sustainable, scalable workforce model.

Table 8.7. Full cost of a Graduate Nurse Program Expansion in the Northern Territory.

		Stage 1 – 18 Month Program for 6 NGNs (A$)	Stage 2 – 18 Month program second intake 12 NGNs (A$)
Marketing and Recruitment		24,000	48,000
Relocation costs		30,000	60,000
Salaries	Program Coordinator	150,000	150,000
	New Graduate Nurse (NGN) salaries	456,210	912,104
	Remote Clinical Educator salary including oncosts	225,000	900,000
Accommodation	NGN orientation 2 weeks – 14 days: A$120 per night	20,160	40,320
	NGN study blocks: A$120 per night	57,600	115,200
Travel	Relocation	24,000	48,000
	Travel allowance A$3,000 twice a year to home base	72,000	144,000
	Travel to short courses	36,000	72,000
Short Courses	4WD Course, 2 days	5,280	10,560
	Immunisation course	4,620	9,240
	Framing Indigenous Health	12,444	24,888
	Advanced Remote Nursing Practice	12,444	24,888
	Pharmacotherapeutics for remote area nurses	7,800	15,600
	Remote Emergency Care	10,800	10,800
	Maternity Emergency Care	10,800	21,600
	IAHA Cultural Responsiveness: Stage 1 to 3	9,240	18,480
Graduate Certificate Scholarship		26,400	52,800
Bonus A$10,000		60,000	120,000
Evaluation Costs		25,000	50,000
Total		**1,279,798**	**2,848,480**

8.3.2 GNPE as a cost-effective workforce solution

The Graduate Nurse Program Expansion (GNPE) presents a cost-effective and scalable alternative to ongoing reliance on agency nursing. As detailed in the preceding analysis, the full cost of supporting a GNPE participant – including salaries, supervision, training, and leave – is significantly lower than the cost of engaging an agency nurse over the same 18-month period. When scaled to cohorts of six or 12 NGNs, this difference becomes even more pronounced, particularly when the Program Coordinator and Remote Clinical Educator roles are externally funded.

Beyond headline costs, the GNPE delivers value through increased flexibility and efficiency. Although participants work fewer days than agency nurses due to scheduled leave, study blocks, and supernumerary time, the per-day cost to services remains substantially lower. This ensures services receive a more affordable workforce even when accounting for reduced direct productivity during the transition phase.

The model's design allows for cost sharing across cohorts and regions, with fixed costs – such as program coordination and remote clinical education – distributed among multiple participants. As such, the GNPE becomes more cost-effective as it scales, enabling services to plan for growth and transition away from high-cost, reactive staffing.

While agency nurses will continue to fill urgent short-term gaps, they represent a high-cost solution with limited long-term return. In contrast, the GNPE fosters internal workforce capacities by supporting early-career clinicians to develop competence, confidence, and cultural responsiveness. Graduates are more likely to remain (Lea & Cruickshank, 2015b; Veginadu et al., 2024) in remote settings, reducing turnover and contributing to continuity of care.

The GNPE enables health services to redirect expenditure from temporary, high-cost staffing to a long-term, capability-building strategy. This strategic shift supports greater return on investment over time, thereby reducing onboarding costs, increasing retention, and fostering more resilient, community-embedded teams.

9. Monitoring and Evaluation

9.1 Purpose of monitoring and evaluation

Implementation of a remote graduate nurse program across the NT should be accompanied by a robust monitoring and evaluation plan, building from project findings, by which to assess delivery effectiveness. Robust and independent evaluation is critical to assessing design, planning, and the implementation of policies and programs in order to ensure that they meet their objectives. The *Productivity Commission's Indigenous Evaluation Strategy (2020),* provides a framework for government agencies when evaluating policies and programs affecting Aboriginal and Torres Strait Islander people. Evaluation should centre Aboriginal and Torres Strait Islander people, perspectives, priorities, and knowledges and be credible, useful, ethical, and transparent.

9.2 Future monitoring and evaluation of the GNPE

In addition to reflecting general evaluation principles, future monitoring and evaluation of the GNPE will draw from the literature on graduate nurse programs. It is recommended that the evaluation commence at the same time as the program in order to capture baseline data and to follow cohorts through the program. Some frameworks and approaches in the literature reflect evaluation of NG nursing roles and experiences. The most widely-used evaluation tool is the Casey-Fink Graduate Nurse Survey. See *Appendix J. New Graduate Nurse Experience Survey*.

Other frameworks include longitudinal studies of NG nursing experiences or focus on evaluation on implementation of NG nursing training programs and their impacts within the organisational setting and broader health workforce.

An evaluation of the NG nursing employment scheme through the Very Low-Cost Access (VLCA) initiative in New Zealand (Appleton Dyer et al., 2015) conducted process and impact (ie. outcome) evaluations in order to examine:

- The working relationships between the practices, Primary Health Organisations, and District Health Boards,
- Service delivery and patient care in general practice,
- The sustainability of VLCA practices,
- The workforce of the VLCA practices, and
- The NGNs professional development and career decisions.

The evaluation used mixed methods and a Realistic Evaluation design in order to understand the relationships between contexts, mechanisms, and outcomes.

Another in-depth evaluation of the New Graduate RN Transition Program in California used pre- and post-evaluation tools to assess participant confidence and competence, and Program Coordinators were tasked with tracking each participant's employment following completion. The evaluation tools reflected recommendations of a State-wide Program Advisory Committee comprised of nursing leaders and Program Coordinators.

Based on these frameworks and approaches, the key impact indicators likely to be useful in future monitoring and evaluation of the expanded GNPE in the NT reflect both process and outcome elements, including:

- Indicators relevant to the program itself, including enrolment numbers, the number of Remote Clinical Educators supported under the program, remote training locations, course satisfaction, and retention rates in the program;
- Indicators relevant to service and workforce impacts, including NGNs' confidence in their practice and job satisfaction, retention of NGNs in remote locations, contribution of NGNs to and role within remote multidisciplinary workforce teams, the cultural safety of the provided services, and NGNs working to their full scope of practice, with service efficiency; and
- Indicators relevant to patient health and community impacts, including patient satisfaction, quality of care, health care access, and health outcomes.

A program logic that links contexts, inputs, outputs, and desired short-, medium-, and long-term impacts will support the development and implementation of a detailed monitoring and evaluation plan. The initial program logic that will guide future monitoring and evaluation work is shown at Table 9.1. Future monitoring and evaluation of the GNPE will need to be appropriately resourced and conducted independently, drawing from the key principles in the Productivity Commission's Indigenous Evaluation Strategy. See Appendix K.

Table 9.1. Indicative program logic framework to inform future monitoring and evaluation of the Graduate Nurse Program Expansion (GNPE), with guiding principles from the *Productivity Commission's Indigenous Evaluation Strategy.*

Inputs	Outputs	Impact: Short-term	Impact: Medium-term	Impact: Long-term
• NG nursing scoping study report, including description of NGN model/s and remote NG nursing curriculum. • Evaluation planning workshop held with key stakeholders. • Robust and detailed monitoring and evaluation plan developed.	• Implementation of the GNPE across NT, including funding of NG nursing Remote Clinical Educators. • Feedback loops established to support continuous improvement of the program.	• Students are enrolled in the program. • Remote Clinical Educators are supported under the program. • Program supports training in remote locations. relevant to future practice • High participant satisfaction and retention in the program.	• High NGN competence, confidence, and job satisfaction. • NGNs are retained in remote locations. • NGNs enable and support remote multidisciplinary team-based care. • NGNs work to their full scope of practice. • Services are culturally safe. • Services are efficient and sustainable.	• Improved patient satisfaction and health care access, including quality of care. • Improved health outcomes.

NG: New Graduate; NGN: New Graduate Nurses; NT: Northern Territory.

Figure 9.1. Guiding principles of evaluation. Source: Lowitja Institute (2023).

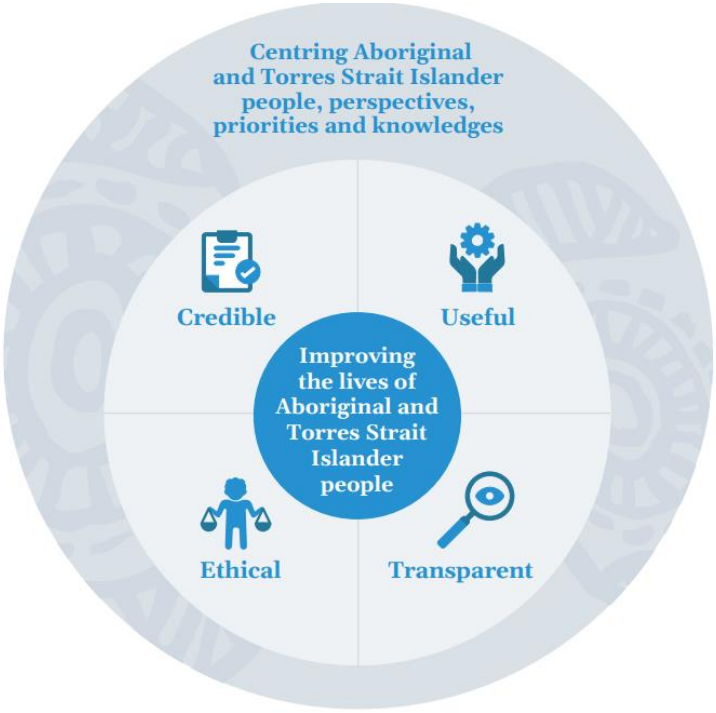


Figure 9.1, from the Lowitja Institute (2023) outlines the core principles that guide culturally safe, strengths-based evaluation in ATSI contexts. At the heart of the framework is a clear and singular aim: improving the lives of ATSI people. This goal serves as the central focus of all evaluation activity and is surrounded by four key principles, credible, useful, transparent, and ethical—that shape how evaluations should be designed, conducted, and applied.

To be credible, evaluations must be methodologically sound and rooted in both Indigenous and Western knowledge systems. This involves using trusted processes, engaging people with lived experience and cultural authority, and ensuring that findings are robust and meaningful. Credibility in this context also means that evaluations are grounded in community priorities and reflect the complex realities of Aboriginal and Torres Strait Islander peoples.

Evaluations must also be useful, producing outcomes that inform real-world decision-making. The knowledge generated should support improvements to programs, policies, and services in ways that are practical and directly beneficial to communities. Usefulness implies that evaluation is not a bureaucratic exercise, but a transformative tool that leads to tangible change.

Transparency is another foundational principle. Evaluations must involve open, honest communication about their goals, methods, and findings. This includes clarity about data ownership, reporting processes, and how results will be interpreted and shared. Transparent evaluation empowers communities to engage meaningfully and make informed decisions about their involvement.

Finally, evaluations must be ethical. This means respecting cultural protocols, upholding research ethics, and safeguarding Indigenous data sovereignty. Ethical evaluations require free, prior, and informed consent, and they prioritise respectful relationships, integrity, and accountability to community needs and expectations.

Encapsulating these principles is the broader commitment to centring Aboriginal and Torres Strait Islander people, perspectives, priorities, and knowledges. This ensures that Indigenous leadership, cultural values, and lived experiences are not peripheral but foundational to evaluation processes. It reflects a decolonising approach to research and evaluation—one that prioritises self-determination and the right to lead, control, and benefit from knowledge that affects one's health and wellbeing (Lowitja Institute, 2023).

Cultural safety is a key focus throughout the program. To encourage self-reflection, it is recommended that New Graduate Nurses complete the *Cultural Safety Self-Assessment Tool* (Appendix F) at various stages of their professional development.

10. Risk Register

The risk register (Table 10.1) was developed as a proactive tool to identify, assess, and address potential challenges associated with the implementation of the GNPE. Using a strengths-based approach, the register aims not only to mitigate risks but to embed culturally safe, sustainable, and context-specific solutions that support program success in remote ACCHS'.

Key risks were identified through stakeholder consultation, review of remote workforce literature, and reflection on lessons from existing graduate nurse programs. For each identified challenge, tailored mitigation strategies were developed that draw on the strengths of participating services, the governance framework, and external partners such as CRANA*plus*, IAHA, and the NT PHN. The risk register is intended to be a living document, reviewed regularly by the GNPE Governance Committee to support ongoing responsiveness and continuous improvement throughout program delivery.

Table 10.1. Risk register.

Challenges	Strength based approaches
Immediate funding uncertainty	
	• A proactive funding strategy that prioritises securing Australian Government funding as the primary investment source. • Exploration of additional external funding avenues such as philanthropic grants and university partnerships. • Stakeholder engagement to advocate for urgent financial support and ensure funding remains a strategic priority.
Long term financial sustainability	
	Diversified funding strategy to reduce reliance on a single funding source. • Formalisation of a reinvestment strategy for agency nursing fee savings in order to create a structured, predictable funding model. • Advocacy for recurrent funding from the Australian Government. • Cost-effectiveness analysis to demonstrate financial benefits and strengthen the case for continued investment.
Occupational stress	
	Psychological Support from CRANA*plus* Mental Health and Wellbeing team, including: • initial half day self-care workshop via videoconferencing during orientation program and monthly 30-minute virtual wellbeing reset workshops.
Unclear purpose and value proposition	
	• Clear program purpose and commitment by the health service to the program.
Marketing	
	A comprehensive marketing strategy led by the host organisations, with NT PHN providing support and promotional assistance through its networks.
Selection	
	NG nursing applicants to complete the Tyrell remote motivation questionnaire. • If possible, applicants to be interviewed in the community in which they will be attached.
Unrealistic expectations of NGNs by other staff	
	Orientation of managers and staff to the role and scope of NGNs included in team meetings.
Limited supervision and support:	

Challenges	Strength based approaches

Due to the high turnover of staff and the use of agency staff, supervision and support may be limited, particularly on-site in communities.	Funded positions
	Stage 1.
	• Employment of Program Coordinator
	• Employment of a Remote Clinical Educator for the Big Rivers Region
	Stage 2.
	• Three additional educators for
	  o Mala'la Health Service Aboriginal Corporation (Maningrida)
	  o Red Lily Health Board
	  o Miwatj Health Aboriginal Corporation
	• Remote Clinical Educators to:
	  o Complete clinical supervision education,
	  o Complete education on NGN transition theories,
	  o Complete education on the NG nursing curriculum, and
	  o Form a 'community of practice'.
	NGNs
	• Compulsory supernumerary experience for the first 6 weeks following orientation.
	• Local induction to the community and the ACCHS' operations.
	• Clinical supervision hybrid model (Hildebrand et al., 2023) for remote area nurses, including:
	• In person support from the Remote Clinical Educator for 1 week, periodically.
	  o Group supervision sessions involving the remote educator presenting a video consultation with a patient. The educator and NGNs take turns discussing the case, following with scripted prompt questions.
	  o On-demand distance support with the Remote Clinical Educator involving a debrief about a clinical case that has a reflective style.
	Case notes checks, wherein the remote clinical educator reviews five cases at random via Communicare (comprehensive electronic health records), and discusses potential improvements with the NGN.

On-call expectations	
	Gradual transition to on-call. • After orientation, NGNs accompany RAN one call-outs. • As confidence increases, the NGNs transition to the second-on-call position. • After completion of the REC course, the NGNs may transition to the first-on-call position. • Timing is dependent on an agreement between educator and the NGN as to when the NGNs' confidence and competence is appropriate to meet the requirements to act as first on call.
Lack of leadership and governance	
	• The establishment of an NT Governance Committee, with a Big Rivers Region subcommittee.
Isolation:	
Isolation can lead to feelings of loneliness and disconnection.	Create a cohort of NGNs, who will: • Attend a two-week orientation together. • Form a 'Community of Practice' with each other, encouraging peer support. • Attend weekly online forums with educator and peers. • Undertake two-week study blocks to allow NGNs to have regular time away from the remote location. • NGNs to have two trips a year to home base.
Workload	
NGNs may be asked to undertake a heavier workload than appropriate due to limited staffing and high patient demand.	• Ensure clear expectations of NGNs capabilities by and for all staff. • Place NGNs in an appropriate clinic. • Regular workload assessment and support provided by Remote Clinical Educator.

Challenges	Strength based approaches
Personal Safety – Remote Location	
• NGNs should always to be accompanied by a second person on call-outs. • NGNs to be accompanied by a second responder when doing outreach visits.	
Cultural Barriers and Safety	
• Cultural safety education to be included in the two-week orientation and threaded throughout the program. • A formal or informal community mentorship program. • Cultural responsiveness training through IAHA. • Language classes to be included, where possible.	

ACCHS: Aboriginal Community Controlled Health Service; CRANA*plus*: Council of Remote Area Nurses of Australia *plus*; IAHA: Indigenous Allied Health Australia; NGN: New Graduate Nurses; RAN: Remote Area Nurses.

11. Career Structure

A well-defined career pathway for newly graduated nurses will significantly enhance both job satisfaction and retention within the nursing profession. Engaging NGNs in discussions about their career goals early in their professional journey and revisiting these conversations throughout their program is crucial to fostering ongoing growth and commitment.

At the outset, NGNs should be informed of the various career advancement opportunities available within the nursing field. These pathways can include graduate diplomas and/or a Masters of Rural and Remote Health, or the pursuit of becoming a Nurse Practitioner. This advanced role requires a minimum of four years of clinical experience before an RN can apply to a nurse practitioner program. As NPs, nurses gain the autonomy to diagnose and treat patients, contributing to advanced patient care.

Other viable options for NGNs include specialising in public health, often achieved through a Master's in Public Health degree (Figure 11.2). This pathway allows nurses to focus on population health, preventative care, and health policy, addressing health challenges on a broader societal scale. Similarly, pursuing midwifery or specialising in child and family health equips nurses to provide specialised care to families, from prenatal to paediatric stages. Another emerging area is chronic disease management, a vital specialty given the increasing prevalence of long-term health conditions.

By outlining these career pathways and tailoring guidance to individual NG nursing interests, healthcare organisations can nurture a workforce that feels valued, motivated, and equipped for long-term success. These conversations not only empower NGNs but also align their professional development with the evolving needs of the healthcare system.

Figure 11.1. New graduate nurse (NGN) career progression.

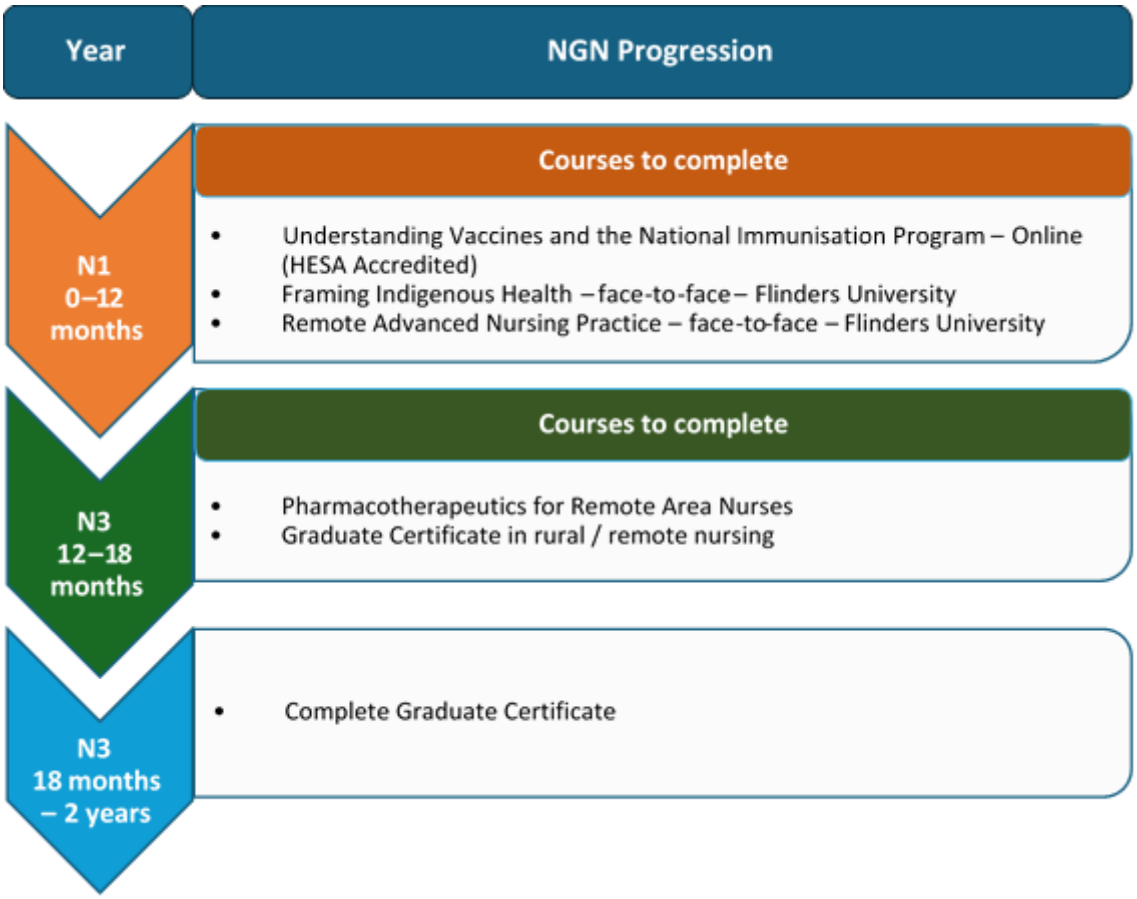
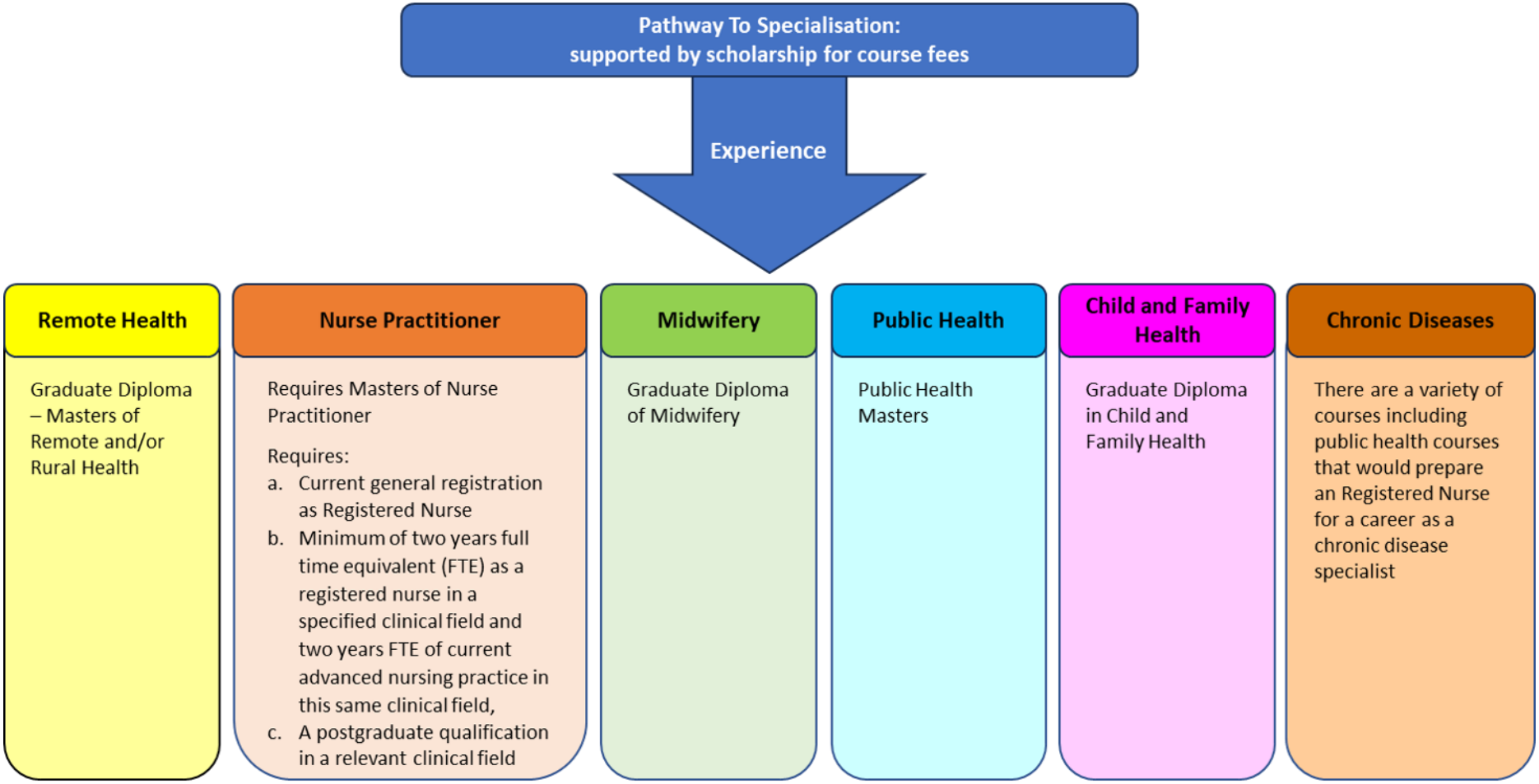


Figure 11.2. Pathway to specialisation.



12. Conclusion

The GNPE Scoping and Co-Design Project builds on the successful CAAC GNP and has support from ACCHS' and other stakeholders as a comprehensive and transformative response to the long-standing workforce challenges in remote ACCHS' across the NT. By integrating a robust evidence base with extensive stakeholder consultations and a participatory co-design process, the project has produced a framework that is not only innovative but also culturally safe and contextually responsive. This framework addresses critical issues such as high staff turnover, excessive reliance on costly agency nursing, and the complex transition challenges faced by NGNs moving into RA nursing roles (Aggar et al., 2017; CAAC, 2024).

A cornerstone of the GNPE framework is its incremental training model, which builds clinical competence, cultural responsiveness, and professional resilience over time. The program begins with an intensive orientation period that immerses NGNs in the core principles of Aboriginal Community Control, cultural safety, and primary healthcare fundamentals – an essential process due to the the documented disconnect between academic preparation and the clinical realities of remote practice (El Haddad et al., 2017; Fowler et al., 2018). Structured clinical placements, study blocks, and ongoing mentorship are designed to progressively increase responsibilities while providing continuous feedback and reflective opportunities, thereby facilitating the development of critical thinking and advanced clinical decision-making (Cusack et al., 2024; Murray et al., 2019).

In addition to improving clinical and cultural competencies, the GNPE offers substantial cost benefits compared to a reliance on agency nursing. Agency nurses, while sometimes necessary, impose a significant financial burden on health services through high fees, increased administrative overhead, and the disruption of continuity in care – factors that can compromise both patient outcomes and staff morale (Van Walraven et al., 2010). By investing in a structured, in-house program, the GNPE minimises these costs over the long term. The initiative promotes workforce stability through targeted recruitment, retention strategies, and financial incentives such as retention bonuses and scholarships. These measures are designed to not only reduce the recurring costs associated with agency nursing but also to enhance the overall quality and sustainability of the healthcare workforce (KPMG, 2023).

Furthermore, the GNPE framework integrates comprehensive support systems that extend beyond clinical training. Dedicated Remote Clinical Educator roles, strategic governance, and structured preceptorship, paired with robust mentorship and peer support networks help mitigate the logistical challenges of remote practice—such as limited infrastructure and professional isolation – and contribute to improved retention rates. These elements, underpinned by theories of transition shock and organisational socialisation (Gardiner & Sheen, 2017; Henderson et al., 2019), ensure that the program is dynamic, adaptive, and capable of continuous improvement through iterative evaluation and stakeholder feedback.

The success of the GNPE is predicated on the sustained commitment of multiple stakeholders, including governmental agencies, academic institutions, and the ACCHS'. The project's iterative evaluation framework – aligned with the Productivity Commission's Indigenous Evaluation Strategy (Productivity Commission, 2020), will ensure that key outcomes such as retention rates, clinical competence, and cost-effectiveness are regularly monitored and refined. This ongoing evaluation, coupled with adaptive governance and continuous stakeholder engagement, is essential for addressing emerging challenges and ensuring that the program remains responsive to the evolving needs of remote healthcare services.

Notwithstanding, the focus on immediate and long-term funding is the enabler by which to implement the program, a coordinated and collective approach to securing funding and commissioning the program is critical to the immediate focus of the vested stakeholders (ie. NT PHN, CDU, and the ACCHS).

In summary, the GNPE initiative represents a multifaceted strategy that not only addresses immediate staffing challenges but also lays the groundwork for long-term improvements in healthcare delivery for Australia's most underserved communities. By equipping NGNs with the skills, support, and cultural competencies necessary to excel in remote practice – and by significantly reducing the reliance on expensive agency nursing – the GNPE has the potential to enhance workforce stability, improve patient care outcomes, and serve as a replicable model for innovative, cost-effective, and context-specific workforce development. This comprehensive approach, supported by a wide range of empirical evidence and best practice frameworks, underscores a renewed commitment to achieving health equity and sustainable healthcare in remote Indigenous communities.

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Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix A.

Literature Review

Features of New Graduate Nurse Programs that Contribute to Building the Remote Area Nursing Workforce

Sue Lenthall PhD [1], Joanne Finn PhD [1], John Wakerman FAFPHM [2], Deborah Russell PhD [2], Alexandra Edelman PhD [2], Jo Seiler DBA [1], Alan Cass PhD [2].

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Introduction

The ‘graduate pipeline’ is a key approach used for recruiting, entry to practice, training, and retaining a skilled nursing and midwifery workforce (WHO, 2021). Despite the appeal of remote area (RA) nursing to new graduate nurses (NGN) due to its perceived challenges and rewards, barriers such as the need for several years of experience and specialised RA nursing education have hindered their pursuit of becoming remote area nurses (RAN). This has led many NGNs to explore alternative career paths, citing timing concerns and the anticipated increased difficulty of transitioning to RA nursing roles over time. In response, a proposed new graduate (NG) nursing program, an extension of the Central Australian Aboriginal Congress (CAAC) NG nursing program to other Aboriginal Community Controlled Health Services (ACCHS) in the Northern Territory (NT) aims to facilitate the training of RANs.

Search strategy

A systematic literature search was conducted in January and February 2025, to examine the transition experiences of NGNs in Australia. The following search terms were used: Graduate Nurse OR New Graduate Nurse AND Transition AND Australia. The databases searched are listed in Table A1.

Table A1. Summary of Search Results by Database

Database	Results
Scopus	41
Ovid Medline Full Text:	33
CINAHL Ultimate	18
JBI EPA	7
ProQuest	23
Full Library Search	293
Snowballing	14
Grey Literature	1
Total	418

Inclusion and exclusion criteria

The selection of studies was guided by specific inclusion and exclusion criteria in order to ensure relevance to the Australian NGN transition experience (Table A3).

Inclusion criteria

- Studies published between 2015 and January 2025.
- Research conducted within the Australian healthcare context.
- Studies that examined attributes of NGNs or NG nursing transition programs.

- Focus on new graduate Registered Nurses (RN) in general, remote or rural, or primary healthcare settings.
- Full-text articles available for review.

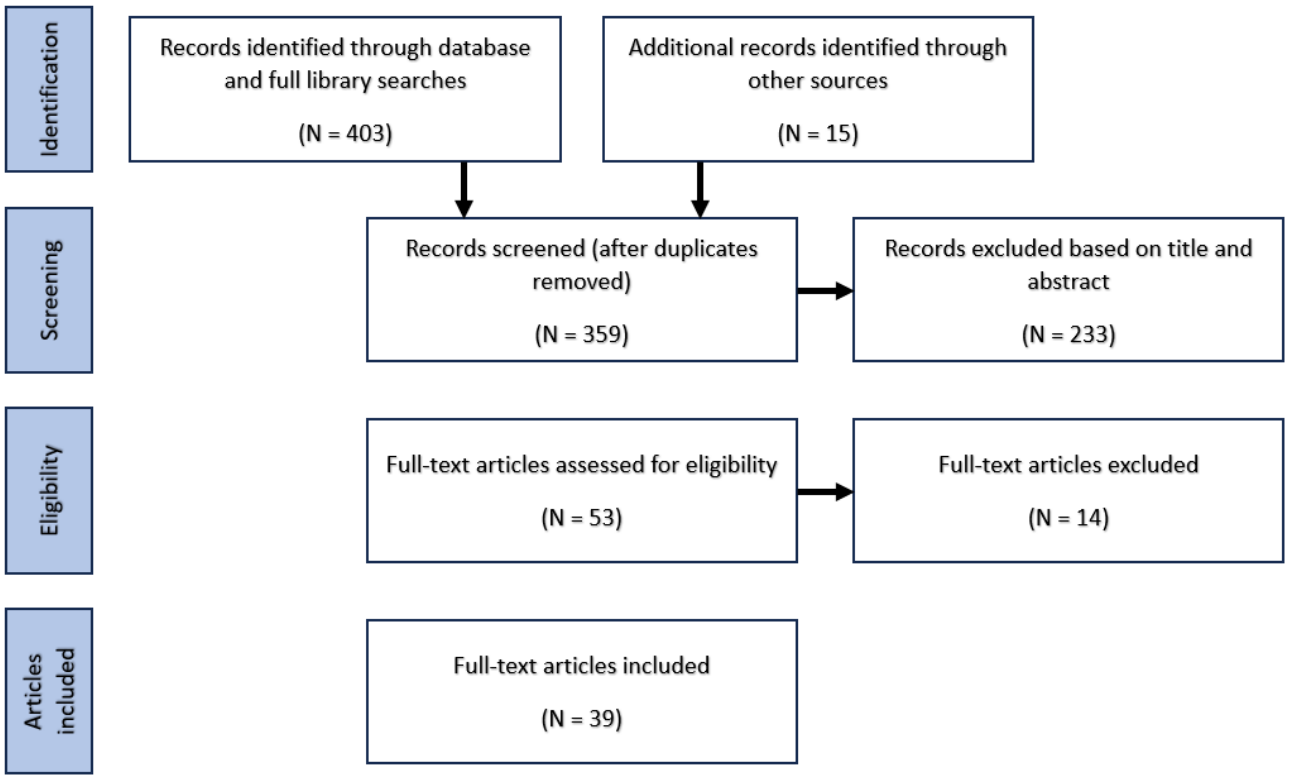
Exclusion criteria

- Studies published before 2015.
- Research conducted outside of Australia.
- Studies examining only a single strategy, such as simulation-based learning, wound care, or research skills.
- Research focused on Enrolled Nurses, Nursing Assistants, and Advanced Practice Nurses.

Nurse practitioners, or non-nursing professions

- NG nursing programs in specialised areas, such intensive care unit (ICU, mental health, neonatal, or paediatric nursing.
- Research protocol articles, bridging programs, and studies solely focused on NGNs' experiences during COVID-19 were excluded.

Figure A1. Summary of literature searching.



About new graduate nurses

Evidence pertaining to NG nursing programs was inductively analysed into four themes (Table A2):

1) Attributes of NGNs;

2) Transition theories;

3) Organisation considerations for offering NG nursing programs, with three sub-themes: organisational commitments or expectations, marketing, and selection; and

4) Program structure and key enabling factors, with nine sub-themes: incremental program, orientation or onboarding or induction program, support, preceptors or supervisors, reflection and critical thinking, incivility, bullying and horizontal violence, stress and self-care, socialisation and professional identity, and other challenges for rural and remote NGNs.

Attributes of NGNs

NGNs are increasingly expected to be 'practice-ready', a multifaceted concept influenced by education, clinical exposure, and workplace expectations (Aggar et al., 2017; El Haddad et al., 2017) However, studies have shown that NGNs do not transition easily into the role of RN and many express a willingness to leave the profession (El Haddad et al., 2017; Missen et al., 2016). There is a general dissatisfaction by many nurse managers and stakeholders with the level of preparation of nursing students, and complaints about a theory-practice gap. There is often a disconnect between health service manager expectations and those of NGNs, with managers expecting NGNs to be work-ready and to hit the ground running. This is usually an unrealistic expectation and at odds with most NGNs who expect to be supported to transition into their new role (Aggar et al., 2017; El Haddad et al., 2017; Masso et al., 2022; Murray et al., 2020), suggested shifting the focus from questioning graduates' readiness to assessing whether workplaces are prepared to support them.

NGNs often grapple with stress, feelings of anxiety, insecurity, inadequacy, abandonment, and intense feelings of frustration (Ankers et al., 2018; Fowler et al., 2018; Gardiner & Sheen, 2017; Lea & Cruickshank, 2015a). Compared to their more seasoned counterparts, NGNs may lack the critical thinking and clinical judgment that come with experience (Graf et al., 2020; Masso et al., 2022), as well as experience difficulties in time management and communication (Masso et al., 2022; McPhee et al., 2017; Murray-Parahi et al., 2016). The challenges faced by NGNs encompass adapting to the demands of clinical practice, including the development of clinical skills and judgment, fostering a positive self-concept, high workloads, limited feedback, and difficulties in adapting to professional responsibilities, understanding the organisation as a system, building relationships with colleagues, and navigating workplace culture (Dushscher ... in Graf et al., 2020). In addition,

there tends to be an increase in the incidence of medical errors during NGNs' transition to registered nursing practice (Murray et al., 2020).

The difficult transition period results in significant numbers of graduates being dissatisfied, and considering leaving or exiting the profession (Phillips et al., 2015). The turnover of NGNs in remote areas is anticipated to be a significant challenge for a remote Australian NG nursing program. Low satisfaction levels were linked with a lack of preparation, insufficient structured professional and personal support, lack of regular feedback, and skill development, (Henderson et al., 2015; Phillips et al., 2015). Studies have highlighted that offering consistent structured support (Adams & Gillman, 2016; Ankers et al., 2018; Gardiner & Sheen, 2017; Henderson et al., 2015) reduced anxiety and increased confidence among NGNs. Successful transition programs for graduate nurses not only enhance job satisfaction, but also contribute to increased retention in the profession, competence in practice, and serve as effective strategies to address the ongoing challenges of recruitment and retention (Cusack et al., 2024).

Transition theories

Various theories attempt to explain and understand the challenges and experiences encountered during the transition from student to NGN. Kramer (1974) in El Haddad et al. (2017) explained the conflict between NGNs' expectations and the realities of clinical practice, describing four phases: Honeymoon, Shock, Recovery, and Resolution. NGNs may begin with enthusiasm (Honeymoon), only to experience disillusionment as challenges emerge (Shock). With support, they enter the Recovery phase, where they develop coping mechanisms and adjust to their professional roles, eventually reaching Resolution (El Haddad et al., 2017).

Bridges (1991) in Graf et al. (2020) proposed a three-stage transition theory: letting go of the familiar to accept changes, followed by a neutral stage characterised by emotions and significant changes, and thirdly, a new beginning, which sees individuals accepting the new environment and forming new identities with an understanding of their roles (Graf et al., 2020).

Benner's novice-to-expert theory has five stages: novice, advanced beginner, competent, proficient, and expert (Benner, 1984, in Cusack et al., 2024), is widely used in nursing education. NGNs typically operate at the Novice or Advanced Beginner stages, relying heavily on guidelines and structured learning. Over time, through experience and reflection, they progress to higher levels of competence, developing holistic understanding and intuitive decision-making (Ankers et al., 2018). This framework helps educators design progressive training programs and enables NGNs to assess their own development.

Duchscher's theory (Duchscher, 2008, in Graf et al., 2020), describes the journey NGNs undergo in their first year of practice, categorising it into three stages: Doing (months 1–3), Being (months 4–9), and Knowing (months 10–12). In the Doing phase, NGNs face high levels of anxiety and rely on structured support to manage

the overwhelming transition into their roles. During the Being phase, they develop confidence and a professional identity but continue to experience challenges. The final phase, Knowing, marks the establishment of stability and competence in their roles. This model emphasises the importance of stage-specific support throughout the first year to facilitate a smooth transition into the workforce.

Transition shock, described as feelings of anxiety, instability, and insufficiency, is a key element in Duchscher's model (Duchscher, 2008, in Graf et al., 2020). There are four main elements of transition shock: emotional, physical, socio-cultural, and intellectual. Emotional challenges include feeling overwhelmed, anxious, and full of self-doubt, while physical exhaustion may arise from excitement and overstimulation. Socio-cultural aspects relate to the time it takes for nurses to feel part of the team and to establish a work-life balance, while intellectual challenges pertain to recalling theory in clinical situations (Duchscher, 2008, in Graf et al., 2020). While these models suggest a linear process, a study in Western Australia among rural NGNs indicated that the honeymoon stage and transition shock can coexist, emphasising the need for focused support during the initial nine months (Graf et al., 2021).

Table A2 combines the honeymoon period, first described by Kramer (1974) in Graf et al. (2021) on the experiences of Western Australian rural nursing graduates, the three transition stages as described by Duchscher's transition theory (Dushscher (2006) in Graf et al., 2020), and the corresponding stages of competence (novice to expert) by Benner, as described in Graf et al. (2021) and Murray et al. (2019).

Table A2. Transition theories relevant to the transition from student to new graduate (NG) nursing. Sources: Graf et al. (2020), Graf et al. (2021), Murray et al. (2019).

Period	Stage	…
First days to a week	**Honeymoon Stage** Also known as the fascination, elation, or exploration stage. This is where the individual feels a sense of euphoria, excitement, and enthusiasm. This may occur simultaneously with transition shock.	
0–3 to 4 months	**Transition Shock—Doing Stage** New graduate nurses (NGN) often have idealistic expectations of themselves and of the health service. They tend to be focused on tasks, not able to see the broader picture and experience difficulty with clinical reasoning and problem solving.	**Benner's Novice Stage** NGNs can demonstrate basic skills due to prior exposure, however, they require prompting and support from guidelines or mentors. They have no aspect recognition. Their knowledge evolves and is dependent on exposure to certain situations or prior experience.
3 to 4–9 months	**Transition Crisis—Being Stage** NGNs able to look beyond their own abilities or inabilities to see the patient. Increase in knowledge level, skill competency and critical thinking.	**Advanced Beginner** The NGN has enough exposure to real-world situations that any recurrent component is easily identified when it is related to rules and guidelines.
9 months plus	**Knowing Stage** Development of personal and professional socialisation and changes to what influences their stress levels. Frustrations move from their own insecurities and abilities to frustrations with the system and being at the bottom of the health hierarchy.	

Organisational Socialisation Theory focuses on how NGNs acclimate to workplace cultures. Structured onboarding and orientation programs aligned with this theory have been shown to improve socialisation, reduce stress, and promote professional identity (Ohr et al., 2020; Phillips et al., 2015). These theoretical approaches collectively highlight the complex and multifaceted nature of NGNs' transition experiences and provide a foundation for designing effective support programs.

Organisational considerations for offering NG nursing programs.

Successful NG nursing programs are dependent on organisational or health service commitment to the program, realistic expectations of NGNs, comprehensive marketing, and careful selection of participants.

Organisational commitments or expectations

The key enablers of effectiveness of an NG nursing program identified by KPMG (2023), included articulation of a clear program purpose and value proposition, with clear and effective organisational and management support, including executive sponsorship. Conversely, a lack of organisational commitment to NG nursing

programs has been identified as being detrimental to the well-being of NGNs and patient safety (Henderson et al., 2019). Studies emphasised the need for investment in resources such as preceptor training, professional development opportunities, and workload management (Murray et al., 2020; Wise et al., 2023). Organisations with strong leadership and inclusive workplace cultures foster better outcomes for NGNs by promoting collaboration and reducing professional isolation (Lea & Cruickshank, 2017; Wardrop et al., 2019).

In order to ensure successful transition into practice, it is crucial to set clear expectations and define the role of the NGN. Providing a supportive environment is equally vital, allowing NGNs to experience success as they progress through their program. This approach recognises the need for realistic expectations and acknowledges the importance of support structures in facilitating the successful integration of NGNs into their professional roles, as they move along the continuum of their NG nursing program (Calleja et al., 2019; Ohr et al., 2020).

Marketing

The marketing strategy for the CAAC Graduate Nurse program initially relied on online social media platforms and websites to attract applicants. While this approach proved effective in the first year, a decline in applications was observed in the second year, highlighting the need for a more targeted and comprehensive recruitment strategy (KPMG, 2023). Research suggests that NG nursing programs that emphasise career advancement, community engagement, and exposure to diverse clinical scenarios are more attractive to prospective applicants (Fowler et al., 2018; Green et al., 2024). Additionally, promoting the unique professional opportunities available in rural settings, such as broader scopes of practice and greater autonomy, can further enhance recruitment efforts (Fowler et al., 2018).

One of the key factors influencing the effectiveness of recruitment strategies is timing. Aligning marketing initiatives with the application timelines of other graduate programs in the NT and nationally ensures that NGNs are aware of available opportunities when making career decisions (KPMG, 2023). Without this alignment, NGNs may commit to other program, reducing the potential applicant pool. NG nursing programs that highlight long-term career progression pathways, structured mentorship, and opportunities to work in culturally rich and diverse environments tend to be more successful in recruiting new graduates (Fowler et al., 2018; Green et al., 2024). Additionally, marketing efforts should highlight the personal and professional benefits of rural practice, such as greater clinical responsibility, interdisciplinary collaboration, and the ability to make a meaningful impact in Indigenous healthcare (Fowler et al., 2018).

While the initial online marketing efforts of the CAAC NG nursing program were successful, a refined recruitment strategy that integrates timing considerations, targeted messaging, and a focus on career development is necessary to maintain and expand the applicant pool for the CAAC NG nursing program (KPMG,

2023). By aligning marketing efforts with NG nursing priorities and graduate program cycles, organisations can attract, support, and retain early-career nurses in rural and remote communities (KPMG, 2023).

Selection

Selection processes that focus on adaptability, resilience, and strong interpersonal skills help identify candidates who are more likely to succeed in demanding healthcare environments (Phillips et al., 2015). Key selection criteria often include academic performance, clinical placement experience, and demonstrated competencies in essential nursing skills (Aggar et al., 2017). Implementing a rigorous selection process ensures that candidates best suited for specific healthcare environments, such as primary care or rural settings, are identified and supported (Calleja et al., 2019).

Organisational priorities and workforce demands also shape selection processes, with healthcare institutions often tailoring recruitment to align with institutional culture and patient care requirements (Brunelli et al., 2022). In rural and remote healthcare settings, additional emphasis is placed on adaptability, resilience, and commitment to long-term service in underserved areas (Fowler et al., 2018; Green et al., 2024). In an NG nursing program for ACCHS', a strong interest in First Nations health would also be a key criterion, in alignment with culturally safe care.

Program structure and key factors.

The structure of the program, including incremental design, length of the program, and inclusion of a comprehensive orientation, onboarding and/or induction program are major considerations to the success of an NG nursing program. Comprehensive support, the vital role of preceptors or supervisors, the need for continuing education, the development of reflection and critical thinking, preventing, or addressing incivility, bullying, and horizontal violence, including strategies for self-care and the socialisation and increasing professional identity of the NGN are key factors for successful transition to practice for NGNs.

Incremental program

NGNs often lack the breadth and depth of critical thought and clinical judgment in their initial three months. Research has identified the first three to six months as particularly challenging for NGNs, marked by a lack of confidence (Cusack et al., 2024; Fowler et al., 2018; Graf et al., 2020). Studies also highlight the stress and nervousness arising from the perceived level of responsibility beyond the NGNs' competence, knowledge, and experience at the beginning of their nursing careers (Cusack et al., 2024; Fowler et al., 2018; Graf et al., 2020; Henderson et al., 2019).

NG nursing program structures are optimally incremental in design, with a focus on skills early in the program and the gradual introduction of critical thinking and more advanced practice skills as the NGN progresses in the program. An incremental approach recognises the challenges faced by NGNs in the early months of their professional journey and how these challenges change over time (Murray et al., 2019). Length of program may also be important, with one study (Brunelli et al., 2022) suggesting that programs that extend beyond 12 months, and incorporate continued mentorship and professional development opportunities, could be particularly relevant for NGNs in rural or remote areas, where extended adaptation to broader scopes of practice is required.

Orientation, onboarding and/or induction program

There is strong evidence that a structured induction or orientation program is associated with improved recruitment and retention (Graf et al., 2021; Lea & Cruickshank, 2017; Ohr et al., 2020). Onboarding processes for NGNs were found to be critically important, especially for health services that experience high vacancy rates (Ohr et al., 2020; Phillips et al., 2015). Thorough orientation programs and the gradual introduction of caseloads contributed to a positive transition experience (Walker et al., 2017). In contrast, a lack of comprehensive orientation when entering a new practice setting can have a detrimental impact on the confidence of NGNs (Ohr et al., 2020).

Support

Professional, clinical, intellectual, personal, emotional, and peer support are critical determinants for successfully navigating the transition continuum for NGNs, (Adams & Gillman, 2016; Ankers et al., 2018; Lea & Cruickshank, 2015b; Parker et al., 2018). Constructive and timely feedback, coupled with strong support systems and a positive workplace culture, emerged as key enablers for NGNs to develop clinical judgment and skills. These factors were associated with decreased anxiety and increased confidence in clinical roles (Parker et al., 2018). However, challenges included time constraints and variability in the quality of feedback provided by evaluators.

NGNs who are well-supported during the transition phase cope more effectively with the stressors they encounter, while those lacking adequate support face higher levels of burnout and attrition (Murray et al., 2020). The availability of structured mentorship and specific, constructive feedback was found to be particularly beneficial in addressing the challenges of professional practice. These support mechanisms not only mitigated anxiety, but also fostered professional growth and development (Aggar et al., 2017; Ankers et al., 2018; Cusack et al., 2024).

Peer support emerged as a critical factor in facilitating this transition by providing emotional, professional, and social reinforcement to graduate nurses (Gardiner & Sheen, 2017). The presence of peer networks enables

new nurses to share experiences, discuss challenges, and seek guidance from colleagues undergoing similar transitions, improving their confidence and resilience (Mellor et al., 2017).

One of the primary benefits of peer support is its ability to mitigate transition shock, which often occurs due to the discrepancy between academic preparation and clinical expectations (Graf et al., 2020). Programs incorporating structured peer support have been found to enhance new graduates' ability to cope with workplace demands, reducing burnout and increasing job satisfaction (Henderson et al., 2015). In rural and remote settings, where graduate nurses may experience additional professional isolation, peer support plays an even more vital role in fostering a sense of belonging and professional development (Calleja et al., 2019; Green et al., 2024).

Moreover, peer support has been identified as a crucial component in the broader framework of clinical facilitation and organisational socialisation (Brunelli et al., 2022; Parker et al., 2018). New graduate nurses who engage in peer mentorship or group discussions report increased confidence in clinical decision-making and enhanced communication skills (Hussein et al., 2019). Such structured peer support programs also facilitate knowledge exchange and reinforce a culture of collaboration within healthcare organisations (Murray et al., 2020).

Continuing education

Accessible continuing education were also emphasised as vital components of transition programs (Adams & Gillman, 2016; Aggar et al., 2017; Ankers et al., 2018). Continuing education is a fundamental component of nursing practice, enabling healthcare professionals to adapt to evolving healthcare environments, maintain clinical competencies, and enhance patient care outcomes (Adams & Gillman, 2016; Aggar et al., 2017; Brunelli et al., 2022). The integration of ongoing education into professional practice fosters a culture of lifelong learning, which is essential for maintaining high standards of care and supporting professional growth (Fowler et al., 2018; Phillips et al., 2015).

Continuing education is particularly crucial in rural and remote healthcare settings, where nurses may face challenges related to professional isolation and limited access to resources (Calleja et al., 2019; Green et al., 2024). Programs that provide structured educational opportunities, including workshops, online courses, and professional development initiatives help bridge knowledge gaps and improve clinical confidence among graduate nurses (Henderson et al., 2015).

Institutional support plays a critical role in facilitating continuing education for nurses. Organisations should invest in structured professional development programs, offer financial assistance, and provide mentorship opportunities to encourage ongoing learning (El Haddad et al., 2017). By prioritising continuing education,

healthcare institutions can enhance workforce competency, improve patient outcomes, and ensure that nurses remain well-prepared to meet the evolving demands of the profession (Murray et al., 2020).

Intellectual support is another critical aspect of graduate programs, as it helps NGNs bridge the gap between theoretical knowledge and practical application. This support can be evaluated through the review of orientation processes, the allocation of supernumerary days, and study day assignments. Programs that provide these resources effectively contribute to NGNs' confidence and readiness for professional practice (Fowler et al., 2018; Graf et al., 2020; Murray-Parahi et al., 2016).

Preceptors or supervisors

The allocation of a preceptor has been recognised as vital for the successful transition of NGNs. Effective preceptorship and mentorship, particularly within the critical first three months, delivered by experienced nurses, help guide NGNs from task-oriented responsibilities toward a more holistic approach to nursing care (Hussein et al., 2019). However, the selection and training of preceptors play a crucial role in ensuring a structured and supportive transition experience. Inadequate or inconsistent preceptor training has often resulted in an *ad hoc* approach to preceptorship, particularly in resource-limited settings such as rural and remote areas (Fowler et al., 2018).

Social learning processes, embedded within action research cycles, have been shown to enhance the capability of clinical facilitators, strengthening their ability to support NGNs effectively (Brunelli et al., 2022). Inquiry-based learning (IBL), which promotes active learning through questioning, critical thinking, and problem-solving, has been identified as an effective approach to addressing the challenges associated with transition shock (Donnelly et al., 2023). Key enablers of improved facilitation include collaborative discussions, reflective practices, and shared learning experiences, which enhance facilitators' confidence and ability to support graduate nurses (Brunelli et al., 2022).

Reflection and critical thinking

Reflection and critical thinking are essential for newly graduated nurses as they transition to professional practice, fostering clinical reasoning, confidence, and adaptability (Aggar et al., 2017; Ankers et al., 2018). Reflective practice helps NGNs bridge the gap between theory and application, enabling them to analyse experiences, identify areas for improvement, and build resilience (Brunelli et al., 2022; Cusack et al., 2024).

Critical thinking supports sound clinical decision-making, particularly in high-pressure environments. IBL encourages NGNs to engage deeply with clinical scenarios, enhancing problem-solving and analytical skills (Donnelly et al., 2023). Social learning processes and structured debriefing further strengthen NGNs' abilities

to assess patient conditions holistically and adapt to challenges, particularly in resource-limited settings (Calleja et al., 2019; Henderson et al., 2015).

Structured transition programs, mentorship, and facilitated reflection sessions play a crucial role in developing these skills, improving professional growth and patient care outcomes (Fowler et al., 2018; Hussein et al., 2019). By fostering a culture of critical inquiry and reflective practice, NGNs gain the confidence needed to navigate their evolving roles effectively (Donnelly et al., 2023; Graf et al., 2020).

Feedback

Effective feedback is a critical component of NGNs' transition to professional practice, providing guidance, reinforcing learning, and enhancing clinical confidence (Ankers et al., 2018; Gardiner & Sheen, 2017). Constructive, timely, and multisource feedback helps NGNs develop their clinical skills, adapt to workplace expectations, and improve decision-making (McPhee et al., 2017). However, variability in the quality and delivery of feedback remains a challenge, with some NGNs reporting difficulties in processing negative feedback, leading to stress and decreased job satisfaction (Fowler et al., 2018).

Multisource feedback, which includes input from supervisors, peers, and patients, has been found to enhance NGNs' professional development by providing a well-rounded assessment of their performance (McPhee et al., 2017). Programs incorporating structured feedback mechanisms, such as mentorship and guided reflection, have been shown to improve confidence, communication, and clinical judgment (Brunelli et al., 2022; Hussein et al., 2019).

In rural and remote settings, where professional support may be limited, structured feedback systems play an even greater role in helping NGNs feel supported and competent in their roles (Calleja et al., 2019). Ensuring that NGNs receive clear, constructive, and supportive feedback fosters resilience, enhances learning, and contributes to job satisfaction and retention (Cusack et al., 2024; Donnelly et al., 2023).

Ultimately, well-structured feedback systems improve NGNs' ability to reflect on their practice, make necessary adjustments, and grow as competent professionals. Encouraging a workplace culture that values constructive feedback and professional development is essential for a successful transition to practice (Graf et al., 2020; Murray et al., 2020).

Incivility, bullying, and horizontal violence

NGNs frequently experience workplace incivility, aggression, bullying, and horizontal violence (Mammen et al., 2018). Anderson and Pearson (1999) in Mammen et al. (2018), defined workplace incivility as

> Low-intensity deviant workplace behaviour, with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. These behaviours are characteristically rude, disrespectful, and discourteous, displaying a lack of regard to others.
>
> (p. 591)

Workplace incivility is a significant source of stress, isolation, alienation, and reduced teamwork and cooperation, often resulting in adverse patient care outcomes (Mammen et al., 2018). Hostile work environments undermine NGNs' confidence and job satisfaction (Masso et al., 2022).

One key factor contributing to workplace incivility is the temporary employment status associated with NG nursing programs, which can leave new nurses feeling vulnerable and unsupported (Mammen et al., 2018). However, implementing zero-tolerance policies and fostering supportive workplace cultures can help mitigate these challenges and create a more positive working environment for NGNs (Hussein et al., 2019; Murray-Parahi et al., 2016). Furthermore, respect, adequate support, and access to essential information are critical elements in ensuring a smooth transition for NGNs into the professional nursing workforce (Mammen et al., 2018).

Stress and self-care

Multiple studies have identified stress as a recurring challenge for NGNs during their transition to professional practice (Hussein et al., 2019; Lea & Cruickshank, 2015a; Mellor et al., 2017; Murray-Parahi et al., 2016; Parker et al., 2018). While structured transition programs may enhance NGNs' confidence in their clinical preparedness, they often fail to adequately address perceptions of social and emotional support, leaving a gap in the overall transition experience (Mellor et al., 2017). Effective stress management and self-care are critical to NGNs' success, as unmanaged stress can lead to burnout and negatively impact job satisfaction and patient care. Implementing resilience training and providing access to mental health resources have been found to help mitigate the emotional toll of transition, promoting well-being and preventing burnout (Mellor et al., 2017; Wise et al., 2023).

Supporting self-care among NGNs is essential for their long-term well-being and success in the nursing profession. Key strategies identified to assist NGNs in advocating for their own well-being include:

1) Developing interpretive skills, engaging in reflection, and utilising personal self-support strategies;
2) Enhancing social intelligence and fostering a sense of belonging;

3) Understanding the transitional process and its challenges;
4) Minimising horizontal violence within the workplace;
5) Recognising and regulating emotions effectively;
6) Managing moral distress while fostering moral courage;
7) Assessing personal progress and performance; and
8) Implementing self-care strategies to maintain overall well-being (Mellor et al., 2017).

By integrating these strategies into NG nursing transition programs, healthcare institutions can create a more supportive and sustainable environment for new nurses, improving retention and job satisfaction.

Socialisation and professional identity

Socialisation, described by Adams and Gillman (2016) as facilitating the integration of NGNs into the team and workplace culture NGNs, is crucial for them to acquire the necessary knowledge and skills for their roles within an organisation, with preceptors serving as key mentors (Adams & Gillman, 2016; Lea & Cruickshank, 2015a). NGNs need time to adjust to socialising within the workplace and within the community. Nurse leaders have an important role in ensuring NGNs are socialised appropriately (Fowler et al., 2018; Ohr et al., 2020). Team-based activities and structured socialisation processes foster professional identity and reduce stress. Inclusive workplace cultures that promote collaboration and respect are particularly effective in enhancing NGNs' sense of belonging (Henderson et al., 2019; Parker et al., 2018).

It was noted that some rural health services encourage NGNs on completion of their graduate program to gain experience in metropolitan areas, however, this can have a negative effect on NGNs' sense of belonging to the community (Fowler et al., 2018).

Other challenges for rural and remote NGNs

NGNs preparing for remote area nursing face numerous challenges beyond those experienced by their urban counterparts. Challenges faced by NGNs when transitioning to RA nursing practice are exacerbated in most rural and remote settings due to resourcing, lack of structured support programs, and lack of training for support staff who might mentor and give feedback, which then impacts recruitment and retention (Calleja et al., 2019). Structured, well supported transition programs that provide flexible support are urgently required in these settings. Peer support networks and accessible continuing education were highlighted as crucial (Calleja et al., 2019). Programs that integrate community engagement, financial incentives (such as relocation packages and loan forgiveness), and career development opportunities are pivotal in retaining NGNs (Calleja et al., 2019).

One of the primary difficulties is adapting to a new organisational structure, which often differs significantly from the hospital environments where they completed most of their training. Relocating to a remote area also presents logistical difficulties, such as limited accommodation options, as well as the need to integrate into small, often tight-knit communities (KPMG, 2023). Furthermore, NGNs working in remote settings must develop cultural competence in order to provide safe and effective healthcare to Aboriginal and Torres Strait Islander communities, where trust, cultural sensitivity, and an understanding of Indigenous health practices are paramount to delivering quality care (KPMG, 2023).

Increased responsibility and professional isolation

NGNs working in rural and remote areas experience greater autonomy and higher levels of responsibility due to the limited availability of senior nursing staff and specialised healthcare professionals (Calleja et al., 2019; Lea & Cruickshank, 2015a). Unlike their urban counterparts, who often work in multidisciplinary teams with accessible senior support, rural NGNs are frequently required to make critical clinical decisions independently, often with minimal supervision or specialist support. This heightened level of responsibility in primary care can be overwhelming, especially when coupled with large patient workloads, professional isolation, and the need to manage complex health conditions with limited resources (Aggar et al., 2017; Lea & Cruickshank, 2015a). These factors contribute to high levels of stress, burnout, and concerns regarding well-being, which, in turn, impact NGN retention in rural healthcare settings (Fowler et al., 2018).

Transition shock and inconsistent support

The transition shock experienced by NGNs in rural and remote settings is often more intense than in urban environments due to feelings of isolation, frustration, and unpreparedness (Calleja et al., 2019; Fowler et al., 2018; Lea & Cruickshank, 2015a). The support available through NG nursing programs in these settings has been found to be inconsistent, with significant variability in the availability and quality of preceptorship and mentoring. Senior staff members who serve as preceptors often lack formal training in providing structured guidance, leaving NGNs without the mentorship necessary to develop confidence and competence in their roles (Fowler et al., 2018; Lea & Cruickshank, 2015a).

Additionally, rural nurse managers are often unavailable to provide direct supervision and support to NGNs, further exacerbating feelings of professional isolation. Poor resourcing, limited access to continuing education, and the absence of structured transition programs further increase NGNs' vulnerability to burnout (Lea & Cruickshank, 2015b). Without effective support structures, many NGNs leave rural positions prematurely, contributing to ongoing workforce shortages in rural and remote communities (Fowler et al., 2018).

Retention strategies and workforce sustainability

In order to improve NG nursing retention in rural and remote settings, tailored support programs must be implemented. Research highlights the effectiveness of structured mentorship, community integration, and professional development opportunities in strengthening workforce retention in these settings (Aggar et al., 2017; Fowler et al., 2018). Formal mentorship programs that provide ongoing guidance and structured feedback can help mitigate feelings of professional isolation and increase NGNs' confidence in their clinical decision-making. Additionally, ensuring that senior nurses and preceptors receive adequate training will improve the overall quality of the support provided to NGNs (Hussein et al., 2019).

By addressing these challenges through structured transition programs, effective mentorship, and targeted support strategies, healthcare organisations can create an environment where NGNs feel valued, supported, and prepared to thrive in rural and remote nursing roles (Murray-Parahi et al., 2016; Wardrop et al., 2019).

Conclusion

This literature review has identified a broad range of factors influencing successes and challenges associated with the establishment of NG nursing programs. Four key themes have emerged from the literature. These were: 1) the attributes of NGNs; 2) transition theories; 3) organisational considerations for offering NG nursing programs; and 4) the program structure and key enabling factors.

New graduate nurses enter the workforce with strong theoretical knowledge, adaptability, and a foundational understanding of clinical practice. However, they often face significant challenges, including transition shock, skill gaps, professional isolation, and increased responsibility, particularly in rural and remote settings. These factors can impact their confidence, job satisfaction, and overall retention, necessitating the structured support mechanisms by which to facilitate a successful transition into professional practice (Brunelli et al., 2022; Phillips et al., 2017).

The complexity of the NG nursing transition process is well-documented in theoretical models. Duchscher's Transition Shock Model (Graf et al., 2021) describes the emotional, intellectual, and sociocultural challenges NGNs face as they shift from student to professional roles, often resulting in stress and disillusionment. Additionally, Benner's Novice to Expert Framework (Graf et al., 2021) emphasises that NGNs begin their careers as novices and require structured learning, mentorship, and clinical exposure in order to progress toward proficiency and expertise. Understanding these frameworks is critical for designing programs that effectively support NGNs and mitigate transition-related challenges.

Healthcare organisations play a crucial role in ensuring the successful transition of NGNs. Investing in structured transition programs is essential to improving retention, clinical competence, and overall workforce

sustainability. Specific considerations include addressing the unique challenges of rural and remote practice, such as professional isolation and resource limitations, and providing tailored support mechanisms. This includes ensuring the availability of well-trained preceptors, mental health resources, and workplace cultures that promote learning and well-being (Fowler et al., 2018; Lea & Cruickshank, 2015a).

Effective transition programs incorporate structured learning, mentorship, and reflective practice to enhance NGNs' clinical competence and confidence. Programs that gradually increase responsibility, foster social integration, and provide opportunities for critical reflection significantly improve retention and job satisfaction (Henderson et al., 2019; Walker et al., 2017). Key enablers included collaborative discussions, reflective practices, and shared learning experiences, which enhanced facilitators' confidence and ability to support graduate nurses (Brunelli et al., 2022). In rural and remote settings, tailored programs addressing isolation and professional development gaps are particularly crucial (Lea & Cruickshank, 2015a).

By adopting a theory-driven approach and implementing evidence-based strategies, healthcare organisations can create environments that support NGNs' transition, improve retention rates, and enhance the overall quality of nursing practice in both urban and rural settings. While NG nursing programs established in any setting are characterised by complexity, NG nursing programs specifically for RANs face additional and unique challenges. The challenges include the advanced clinical skills needed to work as a remote area nurse, geographical isolation, extraordinarily high staff turnover rates, reliance on short-term agency staff leading to a shortage of experienced preceptors, and limited resources such as accommodation in many remote communities. However, despite these challenges, innovative models can be developed through thorough consultation and strategic planning.

The transition to professional practice is a critical and complex phase for NGNs, particularly in rural and remote settings. While NGNs bring strong theoretical knowledge and adaptability, they often encounter challenges such as transition shock, skill gaps, and professional isolation, which can impact their confidence, job satisfaction, and retention. However, structured transition programs that integrate mentorship, reflective practices, and gradual responsibility increases have demonstrated positive outcomes, including improved retention rates, enhanced skill acquisition, and greater professional confidence (Brunelli et al., 2022; Phillips et al., 2017). Programs that emphasise social integration and structured learning further support NGNs in developing a strong professional identity and resilience (Henderson et al., 2019; Walker et al., 2017).

In order to address the ongoing challenges faced by NGNs, tailored strategies must be implemented. Remote specific programs that account for the unique demands of remote practice, including professional isolation and resource constraints, are essential. Organisational investment in structured support mechanisms, including preceptor training and access to mental health resources, will further strengthen NG nursing outcomes.

Additionally, integrating mentorship and reflective learning opportunities into all transition programs will foster critical thinking, emotional resilience, and professional growth.

By adopting these evidence-based recommendations, healthcare organisations can create environments that support NGNs' transition, improve retention rates, and enhance the overall quality of nursing practice in both urban and rural settings.

Table A3a. Selected studies, as determined by the Inclusion and exclusion criteria.

	Source	Study Aim	Design
1.	Adams, J. E., & Gillman, L. (2016). Developing an evidence-based transition program for graduate nurses. *Contemporary Nurse, 52*(5), 511–521. https://doi.org/10.1080/10376178.2016.1238287	To develop an evidence-based transition program for graduate nurses to support their integration into professional practice. The focus was on identifying key components that facilitate a smooth transition from student to professional nurse.	The research was based on a literature review approach, analysing existing studies and best practices related to graduate nurse transition programs. The authors synthesised relevant evidence to design a structured program that could be implemented in healthcare settings.
2.	Aggar, C., Bloomfield, J., Thomas, T. H., & Gordon, C. J. (2017). Australia's first transition to professional practice in primary care program for graduate registered nurses: a pilot study. *BMC Nursing*, *16*(1), 14. https://doi.org/10.1186/s12912-017-0207-5	To evaluate Australia's first 'Transition to Professional Practice in Primary Care' and assess the feasibility and outcomes of this pilot program.	This was a pilot study using a mixed-methods approach. Quantitative data were collected through surveys to assess the program's impact on participants' confidence, competence, and readiness for primary care roles. Qualitative feedback from participants and stakeholders provided insights into their experiences and perceptions of the program.
3	Ankers, M. D., Barton, C. A., & Parry, Y. K. (2018). A phenomenological exploration of graduate nurse transition to professional practice within a transition to practice program. *Collegian (Royal College of Nursing, Australia)*, *25*(3), 319–325. https://doi.org/10.1016/j.colegn.2017.09.002	To explore the experiences of graduate nurses transitioning to professional practice within a structured transition-to-practice (TTP) program. It sought to understand the challenges, enablers, and overall perceptions of the transition process to inform improvements in TTP programs.	A phenomenological qualitative approach, focusing on the lived experiences of graduate nurses. Data were collected through semi-structured interviews, providing in-depth insights into the personal and professional challenges faced by participants during their transition
4	Brunelli, V. N., Jeffrey, C. A., Tyler, S., & Henderson, A. (2022). Advancing clinical facilitator capability to support graduate nurses: Outputs from social learning processes embedded in action research cycles. *Nurse Education in Practice*, *58*, 103271. https://doi.org/10.1016/j.nepr.2021.103271	To enhance the capabilities of clinical facilitators to better support graduate nurses in their transition to professional practice. It focused on exploring the impact of social learning processes embedded in action research cycles as a method for advancing facilitator skills and improving graduate nurse experiences	An action research design involving iterative cycles of planning, action, observation, and reflection. The methodology allowed participants to engage collaboratively in identifying challenges and implementing strategies for improvement. Data were collected qualitatively through observations and feedback from participants.

	Source	Study Aim	Design
5.	Calleja, P., Adonteng-Kissi, B., & Romero, B. (2019). Transition support for new graduate nurses to rural and remote practice: A scoping review. Nurse Education Today, 76, 8–20. https://doi.org/10.1016/j.nedt.2019.01.022	To explore and map the transition support available for new graduate nurses in rural and remote practice settings.	A scoping review using a systematic search strategy across databases, including CINAHL, Medline, Proquest, Embase, Informit, PubMed, and more.
6	Cusack, L., Madsen, L., Duchscher, J. B., Cleveland, J., & You, W. (2024). Does transition theory matter?: A descriptive study of a transition program in Australia based on Duchscher's stages of transition theory and transition shock model. *Australian Journal of Advanced Nursing*, *41*(2), 33–41. https://doi.org/10.37464/2024.412.1050	To evaluate a transition program for new graduate nurses in Australia based on Duchscher's Stages of Transition Theory and Transition Shock Model.	A descriptive study design was used to assess the program's outcomes. The research employed a combination of quantitative and qualitative methods to gather data on participants' experiences, focusing on their perceptions of support, confidence, and professional development during the transition period.
7	Donnelly, F., Feltrin, C., & Munt, R. (2023). An Example of Inquiry-Based Learning in a Transition to Nursing Practice Curriculum. *The Journal of Continuing Education in Nursing*, *54*(6), 268–274. https://doi.org/10.3928/00220124-20230511-07	To evaluate the use of inquiry-based learning (IBL) in a Transition to Nursing Practice curriculum. It sought to explore how this educational approach enhances critical thinking, problem-solving, and clinical decision-making skills, among others.	A qualitative descriptive design, collecting feedback from participants engaged in the IBL-based curriculum
8	El Haddad, M., Moxham, L., & Broadbent, M. (2017). Graduate nurse practice readiness: A conceptual understanding of an age-old debate. *Collegian (Royal College of Nursing, Australia)*, *24*(4), 391–396. https://doi.org/10.1016/j.colegn.2016.08.004	To explore the concept of graduate nurse practice readiness, examining its definition, influencing factors, and implications for nursing education and practice.	A conceptual analysis study that synthesised existing literature and theoretical perspectives in order to develop a comprehensive understanding of graduate nurse practice readiness. The approach focused on identifying key themes and factors contributing to the perceived readiness of graduate nurses.
9	Fowler, A. C., Twigg, D., Jacob, E., & Nattabi, B. (2018). An integrative review of rural and remote nursing graduate programmes and experiences of nursing graduates. In Journal of Clinical Nursing (Vol. 27, Issues 5–6, pp. e753–e766). Blackwell	To conduct an integrative review of rural and remote nursing graduate programs and examined the experiences of nursing graduates in these settings.	An integrative review of existing literature on graduate nursing programs and the experiences of new graduate nurses in rural and remote healthcare settings

	Source	Study Aim	Design
	Publishing Ltd. https://doi.org/10.1111/jocn.14211		
10	Gardiner, I., & Sheen, J. (2017). Graduate nurses' experience of feedback, support, and anxiety: A pilot study. *Australian Journal of Advanced Nursing*, *35*(1), 6–15. https://doi.org/10.37464/2017.351.1471	To explore graduate nurses' experiences of feedback, workplace support, and anxiety during their transition to professional practice. It sought to identify the relationship between these factors and their impact on graduate nurses' confidence and performance in clinical settings.	This was a pilot study that used a mixed-methods approach. Quantitative data were collected through surveys assessing feedback, support, and anxiety levels, while qualitative data from open-ended responses provided deeper insights into participants' experiences.
11	Graf, A. C., Jacob, E., Twigg, D., & Nattabi, B. (2020). Contemporary nursing graduates' transition to practice: A critical review of transition models	To critically review contemporary transition theories to determine how they apply to the newly qualified graduate registered nurse programmes.	A narrative critical literature review.
12	Graf, A. C., Nattabi, B., Jacob, E., & Twigg, D. (2021). Experiences of Western Australian rural nursing graduates: A mixed method analysis	To explore the experiences of rural nursing graduates in Western Australia, focusing on challenges, supports, and adaptations during their transition to practice.	A mixed-method study combining quantitative surveys and qualitative interviews to provide a comprehensive analysis of graduates' experiences.
13	Green, E., Seaman, C. E., Barry, R., Lawrence, J., Skipworth, A., & Sinclair, M. (2024). Early career nurses' self-reported influences and drawbacks for undertaking a rural graduate nursing program. *Australian Journal of Advanced Nursing*, *41*(1), 1–9. https://doi.org/10.37464/2024.411.1125	To explore the self-reported influences and drawbacks experienced by early career nurses who undertook a rural graduate nursing program.	A qualitative descriptive design, using semi-structured interviews to gather detailed insights from participants.
14	Henderson, A., Ossenberg, C., & Tyler, S. (2015). 'What matters to graduates': An evaluation of a structured clinical support program for newly graduated nurses. *Nurse Education in Practice*, *15*(3), 225–231. https://doi.org/10.1016/j.nepr.2015.01.009	To evaluate the effectiveness of a structured clinical support program in addressing the needs and priorities of newly graduated nurses.	A mixed-methods design was employed, combining quantitative surveys with qualitative interviews and focus groups.

	Source	Study Aim	Design
15	Henderson, A., Rowe, J., Watson, K., & Hitchen-Holmes, D. (2019). Graduating nurses' expectations and experiences of graduate programs in Australia. *Nurse Education in Practice*, 35, 83–88.	To explore the expectations and experiences of new graduate nurses (NGN) participating in graduate programs in Australia. Specifically, it sought to understand how well these programs meet graduates' needs during their transition to professional practice.	A qualitative study using a mixed-methods approach. Data were collected through surveys and interviews with NGNs. The study focused on their expectations before starting the program and their experiences after completing it.
16	Hussein, R., Salamonson, Y., Everett, B., Hu, W., & Ramjan, L. M. (2019). Good clinical support transforms the experience of new graduates and promotes quality care: A qualitative study. *Journal of Nursing Management, 27*(8), 1809–1817. https://doi.org/10.1111/jonm.12880	To explore the role of clinical support in shaping the experiences of NGNs.	A qualitative descriptive study. Data were collected through semi-structured interviews with NGNs in order to gain in-depth insights into their experiences of clinical support during the transition period.
17	Kenny, P., Reeve, R., & Hall, J. (2016). Satisfaction with nursing education, job satisfaction, and work intentions of new graduate nurses. *Nurse Education Today*, *36*, 230–235. https://doi.org/10.1016/j.nedt.2015.10.023	To examine the relationships between NGNs' satisfaction with their nursing education, their subsequent job satisfaction, and their intentions regarding job retention or turnover.	This study employed a survey-based cohort design, collecting data from nursing students at two Australian universities and following them into their early careers. Structural Equation Modelling (SEM) was used to analyse the influence of satisfaction with nursing education on job satisfaction and to determine how job satisfaction affected nurses' intentions to stay in or leave their current positions.
18	KPMG. Insights Report - Central Australian Aboriginal Congress Graduate Nursing Program. Alice Springs; 2023.	To evaluate the Central Australian Aboriginal Congress (CAAC) Graduate Nursing Program that seeks to increase recruitment, upskill nurses, and improve retention in remote health settings.	A qualitative study commissioned by the Northern Territory Primary Health Network (NT PHN). Data was collected through onsite and phone interviews with graduate nurses, program staff, and an executive member, but excluded key stakeholders such as the Alice Springs Hospital and CAAC clinic staff.
19	Lea, J., & Cruickshank, M. (2015a). The support needs of new graduate nurses making the transition to rural nursing practice in	To explore the support needs of NGNs, transitioning into rural nursing practice in Australia.	A qualitative descriptive study using semi-structured interviews to gather data from NGNs about their experiences and support needs.

	Source	Study Aim	Design
	Australia. *Journal of Clinical Nursing*, *24*(7–8), 948–960. https://doi.org/10.1111/jocn.12720		
20	Lea, J., & Cruickshank, M. (2015b). Supporting new graduate nurses making the transition to rural nursing practice: views from experienced rural nurses. *Journal of Clinical Nursing*, *24*(19–20), 2826–2834. https://doi.org/10.1111/jocn.12890	To explore the perspectives of experienced rural nurses regarding the support needs of NGNs transitioning into rural nursing practice.	A qualitative descriptive study that used semi-structured interviews to collect data from experienced rural nurses.
21	Lea, J., & Cruickshank, M. (2017). The role of rural nurse managers in supporting new graduate nurses in rural practice. *Journal of Nursing Management, 25*(3), 176–183. https://doi.org/10.1111/jonm.12453	To explore the role of rural nurse managers in supporting NGNs.	A qualitative descriptive study using semi-structured interviews to gather data from rural nurse managers.
22	Mammen, B., Hills, D. J., & Lam, L. (2018). Newly qualified graduate nurses' experiences of workplace incivility in Australian hospital settings. *Collegian (Royal College of Nursing, Australia)*, *25*(6), 591–599. https://doi.org/10.1016/j.colegn.2018.08.003	To explore the experiences of newly qualified graduate nurses regarding workplace incivility during their participation in graduate nurse programs in Australian hospitals.	This study employed a descriptive-qualitative methodology, utilising face-to-face, in-depth interviews to gather data.
23	Masso, M., Sim, J., Halcomb, E., & Thompson, C. (2022). Practice readiness of new graduate nurses and factors influencing practice readiness: A scoping review of reviews. *International Journal of Nursing Studies*, *129*, 104208–104208. https://doi.org/10.1016/j.ijnurstu.2022.104208	To identify what is known about the practice readiness of new graduate nurses upon commencement of employment and how practice readiness changes over their first year of employment, as well as to explore the factors which influence practice readiness	A scoping review of existing reviews guided by the framework developed by Arksey and O'Malley, with search results based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement.
24	McPhee, S., Phillips, N. M., Ockerby, C., & Hutchinson, A. M. (2017). Multisource feedback to graduate nurses: a multimethod study. *Journal of Clinical Nursing*, *26*(21–22), 3442–3456. https://doi.org/10.1111/jocn.13710	To evaluate the feasibility and impact of multisource feedback (MSF) as a tool to support NGNs' professional development. It investigated how MSF influenced the confidence, competence,	This study used a multimethod design, combining quantitative surveys and qualitative interviews. The quantitative data assessed the effectiveness and perceptions of MSF, while the qualitative data

	Source	Study Aim	Design
		and performance of graduate nurses during their transition to practice.	explored graduate nurses' and their evaluators' experiences with the feedback process.
25	Mellor, P., Gregoric, C., & Gillham, D. (2017). Strategies new graduate registered nurses require to care and advocate for themselves: A literature review	To explore strategies NGNs' need to care for themselves and advocate effectively in the workplace.	A literature review of existing studies focusing on self-care and advocacy strategies for NGNs.
26	Missen, K., McKenna, L., & Beauchamp, A. (2015). Work readiness of nursing graduates: current perspectives of graduate nurse program coordinators. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, *51*(1), 27–38. https://doi.org/10.1080/10376178.2015.1095054	To explore the perspectives of new graduate (NG) nursing program coordinators on the work readiness of newly graduated nurses. It sought to identify key areas of strength and gaps in readiness and to examine how graduate nurse programs address these gaps.	This was a qualitative descriptive study that used semi-structured interviews with graduate nurse program coordinators as the primary data collection method.
27	Missen, K., McKenna, L., & Beauchamp, A. (2016). Graduate Nurse Program Coordinators' perspectives on graduate nurse programs in Victoria, Australia: A descriptive qualitative approach. *Collegian (Royal College of Nursing, Australia)*, *23*(2), 201–208. https://doi.org/10.1016/j.colegn.2015.03.004	To explore the perspectives of NG nursing program coordinators regarding the design, implementation, and effectiveness of NG nursing programs. It sought to identify key strengths and challenges of these programs.	A descriptive qualitative approach was employed, using semi-structured interviews with NG nursing program coordinators to gather detailed insights.
28	Missen, K., McKenna, L., Beauchamp, A., & Larkins, J.-A. (2016). Qualified nurses' rate new nursing graduates as lacking skills in key clinical areas. *Journal of Clinical Nursing*, *25*(15–16), 2134–2143. https://doi.org/10.1111/jocn.13316	To assess the perceptions of qualified nurses regarding their clinical skills.	A quantitative cross-sectional design, using a survey to collect data from qualified nurses
29	Murray, M., Sundin, D., & Cope, V. (2019). Benner's model and Duchscher's theory: Providing the framework for understanding new graduate nurses' transition to practice. *Nurse Education in Practice*, *34*, 199–203. https://doi.org/10.1016/j.nepr.2018.12.003	To explore how Benner's Novice to Expert Model and Duchscher's Stages of Transition Theory and Transition Shock Model provide a theoretical framework for understanding the transition experience of NGNs. It focused on how these models can guide mentoring, education, and	This study used a fixed mixed-methods approach to examine new graduate nurses' perceptions of patient safety, medical errors, and quality of care. A convergent design was used, where both qualitative and quantitative data were collected, analysed separately, and then combined to gain a

	Source	Study Aim	Design
		support strategies in enhancing patient safety, job satisfaction, and nurse retention. The paper sought to identify the barriers and enablers in this transition process.	comprehensive understanding of how new graduate registered nurses (NGRN) transition into practice.
30	Murray, M., Sundin, D., & Cope, V. (2020). Supporting new graduate registered nurse transition for safety: A literature review update	To update the literature on strategies that support the transition of NGRNs to ensure safety in practice/	A literature review analysing studies on transition support for NGRNs, with a focus on promoting safety and reducing errors during the transition period.
31	Murray-Parahi, P., DiGiacomo, M., Jackson, D., & Davidson, P. M. (2016). New graduate registered nurse transition into primary health care roles: an integrative literature review. *Journal of Clinical Nursing*, *25*(21–22), 3084–3101. https://doi.org/10.1111/jocn.13297	To explore the transition of NGRNs into primary health care (PHC) roles. Specifically, it sought to identify the challenges and facilitators associated with this transition and provide insights into how it could be supported effectively.	An integrative literature review that involved synthesising existing evidence from diverse sources, including qualitative and quantitative studies in order to create a comprehensive understanding of the topic. A systematic search and thematic analysis were conducted to extract and analyse data.
32	Ohr, S. O., Holm, D., & Giles, M. (2020). The organisational socialisation of new graduate nurses and midwives within three months of their entrance into the health workforce	To explore the organisational socialisation experiences of new graduate nurses and midwives within their first three months in the health workforce.	A qualitative study using semi-structured interviews to understand the socialisation process of new graduates during the early transition phase.
33	Parker, V., Giles, M., & Higgins, I. (2018). Transition programs for new graduate nurses: Integrative literature review.	To conduct an integrative review of literature on transition programs for new graduate nurses. Its primary goal was to identify key components, effectiveness, and challenges associated with these programs in supporting novice nurses' transition to professional practice	An integrative literature review that synthesised findings from existing studies. The researchers reviewed qualitative, quantitative, and mixed-methods studies in order to provide a comprehensive understanding of transition programs for NGNs.
34	Phillips, C., Esterman, A., & Kenny, A. (2015). The theory of organisational socialisation and its potential for improving transition experiences for new graduate nurses. *Nurse Education Today*, *35*(1), 118–124. https://doi.org/10.1016/j.nedt.2014.07.011	To explore the application of the theory of organisational socialisation to improve NG nursing transition experiences.	This study employed a theoretical analysis and literature review approach

	Source	Study Aim	Design
35	Phillips, C., Kenny, A., & Esterman, A. (2017). Supporting graduate nurse transition to practice through a quality assurance feedback loop. *Nurse Education in Practice*, *27*, 121–127. https://doi.org/10.1016/j.nepr.2017.09.003	To explore how a quality assurance feedback loop could support the transition of NGNs to professional practice.	A mixed-methods design was employed, incorporating both quantitative and qualitative approaches. Surveys were used to collect quantitative data on the experiences and outcomes of graduate nurses participating in the feedback loop, while interviews provided qualitative insights into their perceptions and the program's impact.
36	Thomas, T. H. T., Bloomfield, J. G., Gordon, C. J., & Aggar, C. (2018). Australia's first Transition to Professional Practice in Primary Care Program: Qualitative findings from a mixed-method evaluation. *Collegian (Royal College of Nursing, Australia)*, *25*(2), 201–208. https://doi.org/10.1016/j.colegn.2017.03.009	To evaluate Australia's first Transition to Professional Practice in Primary Care (TPPPC) Program	The study was part of a mixed-methods evaluation, with the qualitative component involving semi-structured interviews to explore participants' perceptions and experiences of the TPPPC program. The qualitative data provided detailed insights into how the program supported graduates' transition to primary care practice.
37	Walker, A., Costa, B. M., Foster, A. M., & de Bruin, R. L. (2017). Transition and integration experiences of Australian graduate nurses	To systematically review and synthesise qualitative research on the transition and integration experiences of Australian graduate nurses into professional practice.	A qualitative systematic review of studies focusing on the transition experiences of graduate nurses in Australia
38	Wardrop, R., Coyne, E., & Needham, J. (2019). Exploring the expectations of preceptors in graduate nurse transition; a qualitative interpretative study. *Nurse Education in Practice*, *34*, 97–103. https://doi.org/10.1016/j.nepr.2018.11.012	To explore the expectations of preceptors involved in the transition of graduate nurses to professional practice. It sought to understand the roles, challenges, and support needs of preceptors in facilitating the successful integration of graduate nurses into the clinical environment.	A qualitative interpretative study was conducted using semi-structured interviews.
39	Wise, M., Ossenberg, C., Spiller, K., & Henderson, A. (2023). Appraising differential capabilities of new graduate nurses: Development across the first nine months of employment. *Nurse Education Today*, *130*, 105943–105943. https://doi.org/10.1016/j.nedt.2023.105943	To appraise the differential capabilities of NGNs and examine how their competencies develop during the first nine months of employment	The study employed a longitudinal mixed-methods design, collecting data at multiple time points over nine months. Quantitative assessments measured skill development, while qualitative interviews provided insights into NGNs' experiences and perceptions of their growth and challenges.

Table A3b. Selected studies, as determined by the Inclusion and exclusion criteria.

	Source	Context	Limitations
1.	Adams, J. E., & Gillman, L. (2016). Developing an evidence-based transition program for graduate nurses. *Contemporary Nurse, 52*(5), 511–521. https://doi.org/10.1080/10376178.2016.1238287	The study was conducted in Perth, emphasising the challenges faced by newly graduated nurses as they enter the workforce.	The study relied solely on existing literature rather than empirical data from direct program implementation. The proposed transition program was not tested in practice, meaning its effectiveness remained theoretical at the time of publication.
2.	Aggar, C., Bloomfield, J., Thomas, T. H., & Gordon, C. J. (2017). Australia's first transition to professional practice in primary care program for graduate registered nurses: a pilot study. *BMC Nursing*, *16*(1), 14–14. https://doi.org/10.1186/s12912-017-0207-5	Conducted in New South Wales (NSW), within the broader shift in healthcare delivery from acute care to primary care, driven by the increasing focus on preventive and community-based health services.	As a pilot study, the number of participants was limited, reducing the generalisability of findings. The short implementation period limited the ability to assess long-term impacts on graduate registered nurse retention and performance. Without a comparison group, it was challenging to attribute outcomes solely to the transition to professional practice program program. Reliance on self-reported measures may have introduced bias in the results.
3	Ankers, M. D., Barton, C. A., & Parry, Y. K. (2018). A phenomenological exploration of graduate nurse transition to professional practice within a transition to practice program. *Collegian (Royal College of Nursing, Australia)*, *25*(3), 319–325. https://doi.org/10.1016/j.colegn.2017.09.002	Conducted in a metropolitan hospital in South Australia (SA).	The study included a limited number of participants, thus may not fully represent the diverse experiences of graduate nurses. The findings were based on one specific transition to practice program, limiting generalisability to other programs or settings. The qualitative nature of the study relied on participants' self-reported experiences, which may introduce personal biases
4	Brunelli, V. N., Jeffrey, C. A., Tyler, S., & Henderson, A. (2022). Advancing clinical facilitator capability to support graduate nurses: Outputs from social learning processes embedded in action research cycles. *Nurse*	The study was conducted in two acute care hospitals in Australia: A large adult facility with 780 beds and A medium-sized hospital with 448 beds.	The study focused on specific healthcare settings, which may limit the generalisability of its findings. A limited number of clinical facilitators participated, reducing the breadth of perspectives captured. The action research cycles were conducted over a

	Source	Context	Limitations
	Education in Practice, *58*, 103271–103271. https://doi.org/10.1016/j.nepr.2021.103271		relatively short period, which may not fully reflect long-term impacts on facilitator development or graduate nurse outcomes.
5.	Calleja, P., Adonteng-Kissi, B., & Romero, B. (2019). Transition support for new graduate nurses to rural and remote practice: A scoping review. Nurse Education Today, 76, 8–20. https://doi.org/10.1016/j.nedt.2019.01.022	The scoping review concentrated on rural and remote included Australian and International studies.	The study also included international literature that may not be applicable to Australia.
6	Cusack, L., Madsen, L., Duchscher, J. B., Cleveland, J., & You, W. (2024). Does transition theory matter?: A descriptive study of a transition program in Australia based on Duchscher's stages of transition theory and transition shock model. *Australian Journal of Advanced Nursing*, *41*(2), 33–41. https://doi.org/10.37464/2024.412.1050	The study was conducted across 12 hospitals within a major Australian national health service.	The study focused on a single health service in Australia, which may limit its generalisability. It concentrated on early transition stages, leaving the long-term impacts of the program unexplored.
7	Donnelly, F., Feltrin, C., & Munt, R. (2023). An Example of Inquiry-Based Learning in a Transition to Nursing Practice Curriculum. *The Journal of Continuing Education in Nursing*, *54*(6), 268–274. https://doi.org/10.3928/00220124-20230511-07	Conducted in a hospital-based transition program in Western Australia (WA).	Small sample size, which restricted generalisability, and reliance on participant self-reports, which could introduce bias.
8	El Haddad, M., Moxham, L., & Broadbent, M. (2017). Graduate nurse practice readiness: A conceptual understanding of an age-old debate. *Collegian (Royal College of Nursing, Australia)*, *24*(4), 391–396. https://doi.org/10.1016/j.colegn.2016.08.004	The study was conducted within the Australian healthcare context, but did draw on international literature.	The study did not include primary data collection, relying instead on existing literature, which limits its empirical validation and it did not capture the views of graduate nurses or stakeholders directly, limiting practical insights into lived experiences.
9	Fowler, A. C., Twigg, D., Jacob, E., & Nattabi, B. (2018). An integrative review of rural and remote nursing graduate programmes and experiences of	Rural and remote healthcare environments, focusing on the transition and support needs of nursing graduates in these areas.	Limited availability of high-quality research specific to rural and remote graduate programs. Variability

	Source	Context	Limitations
	nursing graduates. In Journal of Clinical Nursing (Vol. 27, Issues 5–6, pp. e753–e766). Blackwell Publishing Ltd. https://doi.org/10.1111/jocn.14211		in program design and evaluation metrics across studies
10	Gardiner, I., & Sheen, J. (2017). Graduate nurses' experience of feedback, support, and anxiety: A pilot study. *Australian Journal of Advanced Nursing*, *35*(1), 6–15. https://doi.org/10.37464/2017.351.1471	The study was conducted in NSW, and focused on graduate nurses in hospital settings during their transition year.	As a pilot study, the number of participants was limited, reducing the generalisability of the findings. It was conducted in a specific geographic and organisational context, which may not reflect broader experiences. Reliance on self-reported surveys may have introduced bias, as participants' perceptions could influence their responses.
11	Graf, A. C., Jacob, E., Twigg, D., & Nattabi, B. (2020). Contemporary nursing graduates' transition to practice: A critical review of transition models	Four main theories selected for the review were Kramer's reality shock theory, Benner's novice to expert theory, Bridges transition theory and Duchscher's stages of transition theory.	Limited focus on specific regions or healthcare systems. Lack of consistency in model evaluation metrics across studies.
12	Graf, A. C., Nattabi, B., Jacob, E., & Twigg, D. (2021). Experiences of Western Australian rural nursing graduates: A mixed method analysis	Rural healthcare settings in WA, with participants being new nursing graduates transitioning into professional roles in these environments.	Small sample size limits generalisability to other rural or remote settings. Potential bias from self-reported data.
13	Green, E., Seaman, C. E., Barry, R., Lawrence, J., Skipworth, A., & Sinclair, M. (2024). Early career nurses' self-reported influences and drawbacks for undertaking a rural graduate nursing program. *Australian Journal of Advanced Nursing*, *41*(1), 1–9. https://doi.org/10.37464/2024.411.1125	The research was conducted in rural and remote areas of WA, focusing on graduate nurses participating in a rural-specific transition program.	As a qualitative study, the findings were based on a limited number of participants, which may restrict the generalisability of the results. Reliance on participants' self-reports may have introduced bias, with responses reflecting personal perceptions rather than objective assessments
14	Henderson, A., Ossenberg, C., & Tyler, S. (2015). 'What matters to graduates': An evaluation of a structured clinical support program for newly graduated nurses. *Nurse Education in*	The study was conducted in Queensland (Qld), involving graduate nurses from a hospital-based structured clinical support program.	The study relied on participants' self-reports, which may introduce response bias and limit objectivity. It was conducted in one region and within a specific program, the findings may not be generalisable to other settings or programs.

	Source	Context	Limitations
	Practice, *15*(3), 225–231. https://doi.org/10.1016/j.nepr.2015.01.009		
15	Henderson, A., Rowe, J., Watson, K., & Hitchen-Holmes, D. (2019). Graduating nurses' expectations and experiences of graduate programs in Australia. *Nurse Education in Practice*, 35, 83–88.	The research was conducted in the Australian healthcare setting, focusing on graduate programs offered to newly registered nurses across various healthcare institutions. The programs included structured clinical rotations, mentorship opportunities, and additional professional development activities.	The study was limited by a relatively small and potentially homogenous sample, which might not represent the experiences of all new graduate nurses in Australia. The study captured experiences at specific points in time, potentially missing longer-term outcomes, or evolving perceptions of the participants.
16	Hussein, R., Salamonson, Y., Everett, B., Hu, W., & Ramjan, L. M. (2019). Good clinical support transforms the experience of new graduates and promotes quality care: A qualitative study. *Journal of Nursing Management, 27*(8), 1809–1817. https://doi.org/10.1111/jonm.12880	The study was conducted in NSW, within hospital settings where NGNs participated in graduate transition programs	It was conducted in one Australian state, limiting the generalisability of findings to other regions or countries. Reliance on participants' accounts may introduce bias, as their perceptions could be influenced by personal experiences.
17	Kenny, P., Reeve, R., & Hall, J. (2016). Satisfaction with nursing education, job satisfaction, and work intentions of new graduate nurses. *Nurse Education Today*, *36*, 230–235. https://doi.org/10.1016/j.nedt.2015.10.023	The study involved nursing students from two NSW universities who were followed into their early careers as graduate nurses.	The impact of education satisfaction on retention intentions was found to be small, meaning other factors play a significant role and while NG nursing programs significantly reduced turnover intentions, the study did not explore other factors influencing nurse retention in depth.
18	KPMG. Insights Report - Central Australian Aboriginal Congress Graduate Nursing Program. Alice Springs; 2023.	The program operates in remote Central Australia, facing staff shortages, recruitment difficulties, and training inconsistencies. It aimed to bridge the gap between hospital-based education and primary healthcare practice.	Include small sample size of interviewed graduates and staff. Exclusion of key stakeholders limits a broader perspective. Qualitative nature means findings are subjective and perception based.
19	Lea, J., & Cruickshank, M. (2015a). The support needs of new graduate nurses making the transition to rural nursing practice in	The study was conducted in NSW, across various rural healthcare settings.	The findings were based on a limited number of participants, which may reduce generalisability.

	Source	Context	Limitations
	Australia. *Journal of Clinical Nursing*, *24*(7–8), 948–960. https://doi.org/10.1111/jocn.12720		
20	Lea, J., & Cruickshank, M. (2015b). Supporting new graduate nurses making the transition to rural nursing practice: views from experienced rural nurses. *Journal of Clinical Nursing*, *24*(19–20), 2826–2834. https://doi.org/10.1111/jocn.12890	Conducted in NSW, across rural healthcare facilities.	The qualitative nature of the study and limited number of participants may affect the generalisability of the findings.
21	Lea, J., & Cruickshank, M. (2017). The role of rural nurse managers in supporting new graduate nurses in rural practice. *Journal of Nursing Management, 25*(3), 176–183. https://doi.org/10.1111/jonm.12453	Conducted in NSW, across various healthcare facilities.	The limited number of rural nurse managers, which may affect the generalisability of the findings.
22	Mammen, B., Hills, D. J., & Lam, L. (2018). Newly qualified graduate nurses' experiences of workplace incivility in Australian hospital settings. *Collegian (Royal College of Nursing, Australia)*, *25*(6), 591–599. https://doi.org/10.1016/j.colegn.2018.08.003	Focused on Australian hospital settings, specifically targeting newly qualified graduate nurses enrolled in graduate nurse programs.	As it is qualitative, findings may not apply to all settings.
23	Masso, M., Sim, J., Halcomb, E., & Thompson, C. (2022). Practice readiness of new graduate nurses and factors influencing practice readiness: A scoping review of reviews. *International Journal of Nursing Studies*, *129*, 104208–104208. https://doi.org/10.1016/j.ijnurstu.2022.104208	Study conducted in NSW; concerning whether new graduate nurses were adequately prepared for the workplace have been long-standing, often framed in terms of practice readiness and the ability to manage the 'reality shock' of transitioning from student to clinician	The study found no consistent, strong evidence of major deficiencies in the practice readiness of new graduates. However, some areas, such as confidence levels in the first months, were commonly highlighted as concerns. The literature included in the review used twenty different tools to measure competency, making it difficult to compare studies and draw firm conclusions about readiness levels.
24	McPhee, S., Phillips, N. M., Ockerby, C., & Hutchinson, A. M. (2017). Multisource feedback	Conducted in Victoria (Vic.), within hospital settings.	The study was limited to Victorian hospitals, reducing the generalisability of findings

	Source	Context	Limitations
	to graduate nurses: a multimethod study. *Journal of Clinical Nursing*, *26*(21–22), 3442–3456. https://doi.org/10.1111/jocn.13710		
25	Mellor, P., Gregoric, C., & Gillham, D. (2017). Strategies new graduate registered nurses require to care and advocate for themselves: A literature review	Transition of new graduate nurses into professional practice, with a focus on personal well-being and professional advocacy.	Limited by the quality and scope of the reviewed literature. Lack of empirical validation for some identified strategies
26	Missen, K., McKenna, L., & Beauchamp, A. (2015). Work readiness of nursing graduates: current perspectives of graduate nurse program coordinators. *Contemporary Nurse : A Journal for the Australian Nursing Profession*, *51*(1), 27–38. https://doi.org/10.1080/10376178.2015.1095054	The study was conducted in Vic. hospitals offering NG nursing programs.	The study included a limited number of program coordinators, which may affect the generalisability of findings
27	Missen, K., McKenna, L., & Beauchamp, A. (2016). Graduate Nurse Program Coordinators' perspectives on graduate nurse programs in Victoria, Australia: A descriptive qualitative approach. *Collegian (Royal College of Nursing, Australia)*, *23*(2), 201–208. https://doi.org/10.1016/j.colegn.2015.03.004	The study was conducted in Vic., involving graduate nurse program (GNP) coordinators from various healthcare organisations	The study included a limited number of GNP coordinators, which may restrict the generalisability of findings.
28	Missen, K., McKenna, L., Beauchamp, A., & Larkins, J.-A. (2016). Qualified nurses' rate new nursing graduates as lacking skills in key clinical areas. *Journal of Clinical Nursing*, *25*(15–16), 2134–2143. https://doi.org/10.1111/jocn.13316	Conducted in Vic. Hospitals, where qualified nurses worked alongside NGNs.	The study relied on the perceptions of qualified nurses, which may not provide an objective assessment of new graduates' skills.
29	Murray, M., Sundin, D., & Cope, V. (2019). Benner's model and Duchscher's theory: Providing the framework for understanding new graduate nurses' transition to practice. *Nurse*	The study was conducted in WA. The study highlights the expectation in healthcare organisations that NGNs should be able to "hit the ground running", even though they often required additional support. This disconnect between	The transition from student to nurse is highly individual and influenced by different work environments, mentorship opportunities, and personal resilience, generalising difficult.

	Source	Context	Limitations
	Education in Practice, *34*, 199–203. https://doi.org/10.1016/j.nepr.2018.12.003	expectations and reality can contribute to workplace stress, dissatisfaction, and attrition.	
30	Murray, M., Sundin, D., & Cope, V. (2020). Supporting new graduate registered nurse transition for safety: A literature review update	Transition of NGRNs into professional practice across various healthcare settings, emphasising safe and effective care delivery.	Limited by variability in the quality and scope of reviewed studies. Lack of standardisation in transition programs makes comparisons difficult.
31	Murray-Parahi, P., DiGiacomo, M., Jackson, D., & Davidson, P. M. (2016). New graduate registered nurse transition into primary health care roles: an integrative literature review. *Journal of Clinical Nursing*, *25*(21–22), 3084–3101. https://doi.org/10.1111/jocn.13297	The transition of new graduate nurses has typically been studied in acute care settings. However, this study highlights the increasing demand for nurses in PHC settings due to changes in healthcare delivery, such as an aging population and a focus on preventive care. The paper contextualises its findings within the broader shift from hospital-based to community and primary care nursing.	There is a scarcity of studies directly examining the transition of NGRNs into PHC roles. The inclusion of studies with varied designs and quality made synthesis challenging. Findings may not be applicable across all healthcare systems or geographical regions due to differences in PHC models and nurse education.
32	Ohr, S. O., Holm, D., & Giles, M. (2020). The organisational socialisation of new graduate nurses and midwives within three months of their entrance into the health workforce	Healthcare settings in Australia, focusing on the initial three months of practice for new graduate nurses and midwives.	Small sample size limits generalisability. Findings may not fully capture long-term socialisation experiences beyond three months.
33	Parker, V., Giles, M., & Higgins, I. (2018). Transition programs for new graduate nurses: Integrative literature review.	The review focused on transition programs implemented in healthcare settings, particularly in Australia and comparable international contexts. These programs typically included clinical rotations, mentorship or preceptorship, and structured educational components designed to bridge the gap between theoretical knowledge and clinical practice	The heterogeneity of transition program designs across different settings made it challenging to generalise findings. Some studies included in the review had limited data on long-term outcomes, restricting insights into the sustained impact of transition programs.
34	Phillips, C., Esterman, A., & Kenny, A. (2015). The theory of organisational socialisation and its potential for improving transition experiences for new graduate nurses. *Nurse Education*	Conducted in the context of nursing practice in Australia.	The study did not include primary data collection, relying on existing literature, which limits empirical validation of its recommendations.

	Source	Context	Limitations
	Today, *35*(1), 118–124. https://doi.org/10.1016/j.nedt.2014.07.011		
35	Phillips, C., Kenny, A., & Esterman, A. (2017). Supporting graduate nurse transition to practice through a quality assurance feedback loop. *Nurse Education in Practice*, *27*, 121–127. https://doi.org/10.1016/j.nepr.2017.09.003	The study was conducted in SA, within hospital settings where NG nursing programs were in place.	The study was conducted in one region, which may limit the generalisability of findings to other settings or healthcare systems.
36	Thomas, T. H. T., Bloomfield, J. G., Gordon, C. J., & Aggar, C. (2018). Australia's first Transition to Professional Practice in Primary Care Program: Qualitative findings from a mixed-method evaluation. *Collegian (Royal College of Nursing, Australia)*, *25*(2), 201–208. https://doi.org/10.1016/j.colegn.2017.03.009	The research was conducted in NSW, focusing on graduate nurses who participated in the TPPPC program	Qualitative findings were based on a limited number of participants, which may reduce generalisability.
37	Walker, A., Costa, B. M., Foster, A. M., & de Bruin, R. L. (2017). Transition and integration experiences of Australian graduate nurses	Transition of graduate nurses into various Australian healthcare settings, with emphasis on their integration and adaptation to professional roles.	Variability in the quality and methodology of included studies.
38	Wardrop, R., Coyne, E., & Needham, J. (2019). Exploring the expectations of preceptors in graduate nurse transition; a qualitative interpretative study. *Nurse Education in Practice*, *34*, 97–103. https://doi.org/10.1016/j.nepr.2018.11.012	Conducted in Qld, focusing on preceptors working in hospital-based graduate nurse programs.	The study included a limited number of preceptors, which may reduce the generalisability of the findings.
39	Wise, M., Ossenberg, C., Spiller, K., & Henderson, A. (2023). Appraising differential capabilities of new graduate nurses: Development across the first nine months of employment. *Nurse Education Today*, *130*, 105943–105943. https://doi.org/10.1016/j.nedt.2023.105943	Conducted in hospitals in Qld	Some of the data relied on NGNs' self-assessments, which may introduce bias or subjectivity

Table A3c. Selected studies, as determined by the Inclusion and exclusion criteria.

	Source	Findings
1.	Adams, J. E., & Gillman, L. (2016). Developing an evidence-based transition program for graduate nurses. *Contemporary Nurse, 52*(5), 511–521. https://doi.org/10.1080/10376178.2016.1238287	The study identified three key concepts essential for supporting graduate nurses during their transition into professional practice: • Support: Providing structured assistance to help graduate nurses navigate the challenges of their new roles. • Socialisation: Facilitating the integration of graduate nurses into the workplace culture and team dynamics. • Facilitated Learning Opportunities: Offering targeted educational experiences to enhance clinical skills and professional development.
2.	Aggar, C., Bloomfield, J., Thomas, T. H., & Gordon, C. J. (2017). Australia's first transition to professional practice in primary care program for graduate registered nurses: a pilot study. *BMC Nursing*, *16*(1), 14–14. https://doi.org/10.1186/s12912-017-0207-5	Key enablers included structured mentorship, access to ongoing education, and exposure to the diverse scope of primary care practice. Challenges included adapting to the autonomous nature of primary care and a lack of familiarity with community health practices. Stakeholders highlighted the need for sustainable funding and expanded opportunities for graduate nurses in primary care.
3	Ankers, M. D., Barton, C. A., & Parry, Y. K. (2018). A phenomenological exploration of graduate nurse transition to professional practice within a transition to practice program. *Collegian (Royal College of Nursing, Australia)*, *25*(3), 319–325. https://doi.org/10.1016/j.colegn.2017.09.002	Participants highlighted several challenges during the transition, including feelings of anxiety, lack of confidence, and difficulty adapting to the demands of clinical practice. However, the structured support provided by the TTP program, including mentorship, peer support, and opportunities for skill development, was critical in easing their transition. Participants valued the gradual increase in responsibilities and the collaborative environment fostered by the program. The study emphasised the importance of effective mentorship and tailored support to build confidence and competence among graduate nurses. It also underscored the need for organisations to create environments that encourage learning and professional growth, ensuring a smoother transition to practice.
4	Brunelli, V. N., Jeffrey, C. A., Tyler, S., & Henderson, A. (2022). Advancing clinical facilitator capability to support graduate nurses: Outputs from social learning processes embedded in action research cycles. *Nurse*	The study found that social learning processes embedded within action research cycles significantly improved the capability of clinical facilitators. Key enablers included collaborative discussions, reflective practices, and shared learning experiences, which enhanced facilitators' confidence and ability to support graduate nurses. Facilitators reported improved skills in providing constructive feedback, fostering graduate nurse independence, and navigating complex clinical environments.

	Source	Findings
	Education in Practice, *58*, 103271–103271. https://doi.org/10.1016/j.nepr.2021.103271	Graduate nurses also benefited from the improved facilitation, reporting increased confidence, better role clarity, and enhanced support during their transition. The findings underscored the importance of equipping clinical facilitators with the tools and frameworks needed to foster a positive and supportive learning environment.
5.	Calleja, P., Adonteng-Kissi, B., & Romero, B. (2019). Transition support for new graduate nurses to rural and remote practice: A scoping review. Nurse Education Today, 76, 8–20. https://doi.org/10.1016/j.nedt.2019.01.022	Challenges faced by NGNs when transitioning to practice are exacerbated in most rural and remote settings due to resourcing, lack of structured support programs, and a lack of training for support staff to mentor and give feedback, which impacts on recruitment and retention. Structured, well supported transition programs that provide flexible support are urgently required in these settings. Peer support networks and accessible continuing education were highlighted as crucial. Programs that integrate community engagement, financial incentives (such as relocation packages and loan forgiveness), and career development opportunities are pivotal in retaining NGNs.
6	Cusack, L., Madsen, L., Duchscher, J. B., Cleveland, J., & You, W. (2024). Does transition theory matter?: A descriptive study of a transition program in Australia based on Duchscher's stages of transition theory and transition shock model. *Australian Journal of Advanced Nursing*, *41*(2), 33–41. https://doi.org/10.37464/2024.412.1050	The study found that incorporating Duchscher's Transition Theory and Transition Shock Model into the program provided a structured framework that significantly supported new graduate nurses. Participants reported improved confidence, better role clarity, and a stronger sense of professional identity. The program's staged approach helped nurses manage the emotional and professional challenges of transitioning into practice, mitigating transition shock and promoting gradual skill development. However, challenges were noted, such as inconsistent mentorship and varying levels of support across facilities. Participants also emphasised the importance of tailored support and ongoing professional development opportunities to sustain their growth and retention.
7	Donnelly, F., Feltrin, C., & Munt, R. (2023). An Example of Inquiry-Based Learning in a Transition to Nursing Practice Curriculum. *The Journal of Continuing Education in Nursing*, *54*(6), 268–274. https://doi.org/10.3928/00220124-20230511-07	IBL effectively promoted active learning, increased engagement, and improved participants' ability to integrate theoretical knowledge into practice. However, challenges such as time constraints and the need for skilled facilitators were noted. The study highlighted the potential of IBL to enhance transition programs but emphasised the importance of adequate support and resources for successful implementation.
8	El Haddad, M., Moxham, L., & Broadbent, M. (2017). Graduate nurse practice readiness: A conceptual understanding of an age-old debate. *Collegian (Royal College of Nursing, Australia)*, *24*(4), 391–396. https://doi.org/10.1016/j.colegn.2016.08.004	The study identified graduate nurse practice readiness as a multi-faceted concept influenced by education, clinical exposure, and workplace expectations. Key factors affecting readiness included the quality of clinical placements, the alignment of education with practice needs, and the availability of support during transition. It emphasised the importance of structured transition programs and ongoing professional development to address gaps in preparedness.

	Source	Findings
9	Fowler, A. C., Twigg, D., Jacob, E., & Nattabi, B. (2018). An integrative review of rural and remote nursing graduate programmes and experiences of nursing graduates. In Journal of Clinical Nursing (Vol. 27, Issues 5–6, pp. e753–e766). Blackwell Publishing Ltd. https://doi.org/10.1111/jocn.14211	NGNs often felt overwhelmed and abandoned with intense feelings of frustration. Many suffered transition shock and did not feel ready for the role. Most support offered in the new graduate programmes was ad hoc, and senior staff were inadequately supported in their roles as preceptors. However, there were additional issues, for example, the lack of resources for preceptorship and the heightened importance of socialisation in the rural and remote context.
10	Gardiner, I., & Sheen, J. (2017). Graduate nurses' experience of feedback, support, and anxiety: A pilot study. *Australian Journal of Advanced Nursing*, *35*(1), 6–15. https://doi.org/10.37464/2017.351.1471	NGNs highly valued constructive feedback and supportive interactions with colleagues and supervisors. Positive feedback and a strong support system were associated with reduced anxiety and increased confidence in their clinical roles. However, the absence of consistent feedback and perceived lack of support contributed to heightened anxiety and feelings of inadequacy. The qualitative findings emphasised the importance of timely, specific, and constructive feedback in helping graduate nurses navigate the challenges of transitioning to professional practice. Participants also highlighted the need for structured mentorship and a supportive workplace culture to mitigate anxiety and foster professional development.
11	Graf, A. C., Jacob, E., Twigg, D., & Nattabi, B. (2020). Contemporary nursing graduates' transition to practice: A critical review of transition models	Kramer's theory was developed in 1974 and provides a basic understanding of the transition process; however, the role of the new graduate has significantly changed. Benner's novice to expert and Bridges transition theory are concepts that also remain relevant although they are both limited by the changing level of graduating nurse, from advanced beginner to novice level. Duchscher's conceptual framework aligned the three valid theories with the challenges contemporary registered graduates' experience. Duchscher's main themes were transition shock, overwhelmed with change, abandonment, and fractured reality. Social support and a sense of belonging were important enablers.
12	Graf, A. C., Nattabi, B., Jacob, E., & Twigg, D. (2021). Experiences of Western Australian rural nursing graduates: A mixed method analysis	Rural nursing graduates face unique challenges, including professional isolation, heavy workloads, and limited access to resources. Support systems, such as mentorship and structured orientation programs, are crucial in easing the transition. Graduates highlighted the need for improved preparation for rural practice during education and more accessible ongoing professional development opportunities. The honeymoon stage of transition co-existed with transition shock at the commencement of graduate programmes, which may obscure the need for continuing adequate support. Inadequate and/or a lack of preceptorship was evident throughout Western Australian rural graduate programmes.

	Source	Findings
13	Green, E., Seaman, C. E., Barry, R., Lawrence, J., Skipworth, A., & Sinclair, M. (2024). Early career nurses' self-reported influences and drawbacks for undertaking a rural graduate nursing program. *Australian Journal of Advanced Nursing*, *41*(1), 1–9. https://doi.org/10.37464/2024.411.1125	Motivators to undertake a rural program included the opportunity to develop diverse clinical skills, experience greater autonomy, and contribute to underserved communities. Participants also valued the sense of community and close-knit working relationships in rural settings. However, significant drawbacks were reported, including feelings of isolation, limited access to mentorship, and challenges related to the broad scope of practice. Participants also highlighted difficulties in balancing professional responsibilities with personal well-being due to the demands of rural healthcare.
14	Henderson, A., Ossenberg, C., & Tyler, S. (2015). 'What matters to graduates': An evaluation of a structured clinical support program for newly graduated nurses. *Nurse Education in Practice*, *15*(3), 225–231. https://doi.org/10.1016/j.nepr.2015.01.009	The study found that graduate nurses highly valued structured support during their transition, with mentorship, regular feedback, and skill development identified as critical components. Participants emphasised the importance of a supportive workplace culture and constructive communication with senior staff in building their confidence and competence. Challenges highlighted included variability in the quality of mentorship and feedback, as well as high workloads that limited opportunities for reflective learning. Despite these challenges, participants reported increased confidence and job satisfaction, attributing this to the structured nature of the support program.
15	Henderson, A., Rowe, J., Watson, K., & Hitchen-Holmes, D. (2019). Graduating nurses' expectations and experiences of graduate programs in Australia. *Nurse Education in Practice*, 35, 83–88.	While many participants reported that the programs met their expectations in terms of support and skill development, some highlighted discrepancies between expectations and the reality of workload and autonomy. Participants emphasised the importance of mentorship in fostering confidence and competence, but the quality of mentorship varied across programs. Common challenges included high workloads, limited feedback, and difficulties in adapting to professional responsibilities. Graduate programs were associated with improved clinical competence, confidence, and job satisfaction among participants, despite challenges.
16	Hussein, R., Salamonson, Y., Everett, B., Hu, W., & Ramjan, L. M. (2019). Good clinical support transforms the experience of new graduates and promotes quality care: A qualitative study. *Journal of Nursing Management, 27*(8), 1809–1817. https://doi.org/10.1111/jonm.12880	Good clinical support significantly enhanced NGNs' experiences during their transition to practice. Supportive factors included approachable preceptors, effective mentorship, regular constructive feedback, and a collaborative workplace culture. These elements fostered confidence, skill development, and professional growth, enabling NGNs to deliver quality care and integrate more effectively into clinical teams. Conversely, a lack of clinical support contributed to feelings of stress, inadequacy, and isolation, negatively impacting NGNs' confidence and performance. Participants emphasised the

	Source	Findings
		importance of structured support systems to help navigate the challenges of transition and improve patient care outcome
17	Kenny, P., Reeve, R., & Hall, J. (2016). Satisfaction with nursing education, job satisfaction, and work intentions of new graduate nurses. *Nurse Education Today*, *36*, 230–235. https://doi.org/10.1016/j.nedt.2015.10.023	The study identified two key aspects of job satisfaction: work environment satisfaction and work hours and wages satisfaction. Satisfaction with work preparation during education was positively associated with both. However, only work environment satisfaction had a significant effect on nurses' likelihood of staying in their jobs. Satisfaction with work hours and wages did not show a significant effect on retention. The most influential factor in reducing turnover intentions was participation in a graduate transition program. The study suggests that policies aimed at improving the work environment, such as fostering supportive leadership and teamwork, may be more effective in retaining nurses than simply adjusting wages or working hours. Furthermore, investing in graduate transition programs could have the most significant impact on new nurse retention. These findings highlight the importance of workplace support and structured transition programs in addressing nursing workforce challenges.
18	KPMG. Insights Report - Central Australian Aboriginal Congress Graduate Nursing Program. Alice Springs; 2023.	Program Purpose Unclear – Stakeholders disagreed on its goal (e.g., general primary care vs. remote area nursing). Graduate Experiences Varied – Some received structured support, while others lacked mentorship and remote placements. Recruitment Decline – Applications dropped from 130 (2021) to 7 (2023) due to poor marketing, competition from other programs, and Alice Springs' safety concerns. Training Gaps – Staff shortages reduced supervision and training quality; onboarding was disorganised. Retention Issues – No clear transition plan after graduation, leading to high staff turnover. Recommendations: Clarify Program Purpose – Align stakeholders on a defined goal. Improve Organisational Support – Secure management buy-in and more educator resources. Enhance Training & Mentorship – Increase senior clinical support and protect graduates' learning time. Revise Recruitment Strategies – Engage universities, refine marketing, and align timing with other programs. Strengthen Feedback Mechanisms – Regularly gather and act on feedback from graduates and staff.
19	Lea, J., & Cruickshank, M. (2015a). The support needs of new graduate nurses making the transition to rural nursing practice in	The study found that NGNs in rural areas face unique challenges, including professional isolation, a broad scope of practice, and the need to develop clinical independence quickly. These factors often led to feelings of anxiety and stress. Effective support mechanisms, such as structured mentorship, access to

	Source	Findings
	Australia. *Journal of Clinical Nursing*, *24*(7–8), 948–960. https://doi.org/10.1111/jocn.12720	professional development opportunities, and collegial support, were identified as critical in easing the transition. Participants emphasised the importance of formal orientation programs and consistent guidance from experienced rural nurses. They also highlighted the value of building connections with the local community to foster personal and professional satisfaction. However, limited access to resources and training opportunities in rural areas were significant barriers to their development.
20	Lea, J., & Cruickshank, M. (2015b). Supporting new graduate nurses making the transition to rural nursing practice: views from experienced rural nurses. *Journal of Clinical Nursing*, *24*(19–20), 2826–2834. https://doi.org/10.1111/jocn.12890	The study found that experienced rural nurses play a pivotal role in supporting NGNs during their transition. Participants emphasised the importance of mentorship, which provides guidance, encouragement, and knowledge-sharing to help NGNs build confidence and adapt to the broad scope of rural nursing practice. Structured orientation programs, regular feedback, and opportunities for skill development were also highlighted as essential. However, challenges included high workloads and limited time for mentorship, which often restricted the ability of experienced nurses to provide consistent support. Participants stressed the need for organisational commitment to formalised support structures and additional resources to alleviate these barriers.
21	Lea, J., & Cruickshank, M. (2017). The role of rural nurse managers in supporting new graduate nurses in rural practice. *Journal of Nursing Management, 25*(3), 176–183. https://doi.org/10.1111/jonm.12453	The study found that rural nurse managers play a critical role in facilitating the transition of NGNs. Key strategies included providing mentorship, fostering a supportive workplace culture, and ensuring access to professional development opportunities. Nurse managers emphasised the importance of tailored support to help NGNs develop the skills and confidence required for the broad scope of rural nursing practice. Challenges included high workloads, limited resources, and the difficulty of balancing organisational responsibilities with providing hands-on support to NGNs. Nurse managers also identified the need for greater organisational investment in structured orientation programs and resources to better support NGNs.
22	Mammen, B., Hills, D. J., & Lam, L. (2018). Newly qualified graduate nurses' experiences of workplace incivility in Australian hospital settings. *Collegian (Royal College of Nursing, Australia)*, *25*(6), 591–599. https://doi.org/10.1016/j.colegn.2018.08.003	Four major themes emerged from the analysis: Realising Vulnerability: Graduate nurses felt vulnerable due to their temporary employment status and the challenges of adapting to new clinical environments. Sensing Self-actualisation: Despite challenges, some nurses experienced personal growth and increased confidence as they navigated workplace incivility. Changing Expectations: Initial expectations of a supportive work environment often shifted due to experiences of incivility.

	Source	Findings
		Yearning for Respect, Support, and Information: There was a strong desire among graduate nurses for respect from colleagues, adequate support systems, and access to information to help them manage workplace challenges.
23	Masso, M., Sim, J., Halcomb, E., & Thompson, C. (2022). Practice readiness of new graduate nurses and factors influencing practice readiness: A scoping review of reviews. *International Journal of Nursing Studies*, *129*, 104208–104208. https://doi.org/10.1016/j.ijnurstu.2022.104208	The study found no strong evidence of major deficiencies in new graduate nurses' practice readiness, though low confidence levels in the first few months were a common concern. Overall, graduates demonstrated adequate knowledge and skills, but areas like critical thinking, advanced clinical skills, and communication needed improvement. Confidence and competence typically increased within six months of employment. Three key factors influenced transition: intrapersonal, interpersonal, and organisational. Personal resilience helped graduates manage stress and workload pressures, though many felt overwhelmed at first. Interpersonal factors such as workplace relationships had a significant impact—supportive colleagues and mentors boosted confidence, while bullying and incivility were major stressors. Organisational factors, particularly structured transition programs, preceptorship, and supportive leadership, were crucial in improving readiness. However, hostile work environments and lack of structured support undermined confidence and job satisfaction. The study suggests shifting the focus from questioning graduates' readiness to assessing whether workplaces are prepared to support them. Strong transition programs, mentorship, and a positive work culture are key to enhancing competence, confidence, and retention.
24	McPhee, S., Phillips, N. M., Ockerby, C., & Hutchinson, A. M. (2017). Multisource feedback to graduate nurses: a multimethod study. *Journal of Clinical Nursing*, *26*(21–22), 3442–3456. https://doi.org/10.1111/jocn.13710	The study found that MSF was a valuable tool for promoting self-reflection, identifying areas for improvement, and enhancing graduate nurses' confidence and competence. Graduate nurses appreciated receiving feedback from multiple perspectives, as it provided a more comprehensive view of their performance. MSF also fostered communication and collaboration between graduate nurses and their colleagues. However, challenges included time constraints and variability in the quality of feedback provided by evaluators. Some graduate nurses found negative feedback difficult to process without adequate support. The study emphasised the need for training and guidelines to ensure consistency and effectiveness in delivering MSF.
25	Mellor, P., Gregoric, C., & Gillham, D. (2017). Strategies new graduate registered nurses require to care and advocate for themselves: A literature review	Eight strategies with potential to assist NGNs to care and advocate for themselves were identified. 1. Interpretive style, reflection, and personal self-support, 2. Social intelligence and fitting in, 3. Understanding the nature of transition,

	Source	Findings
		4. Minimise horizontal violence, 5. Recognising and regulating of emotions, 6. Manage moral distress and foster moral courage, 7. Assess progress and performance, and 8. Strategies of self-care.
26	Missen, K., McKenna, L., & Beauchamp, A. (2015). Work readiness of nursing graduates: current perspectives of graduate nurse program coordinators. *Contemporary Nurse : A Journal for the Australian Nursing Profession*, *51*(1), 27–38. https://doi.org/10.1080/10376178.2015.1095054	The study found that while nursing graduates demonstrated strong theoretical knowledge and a willingness to learn, they often lacked practical clinical skills, confidence, and the ability to manage workload and time effectively. Program coordinators emphasised the importance of NG nursing programs in addressing these gaps through structured support, mentorship, and skill development opportunities. Challenges included variability in NGNs' readiness levels, the high demands of clinical environments, and the need for programs to balance support with the expectation of independence. Coordinators highlighted the value of fostering resilience, critical thinking, and communication skills as essential components of work readiness.
27	Missen, K., McKenna, L., & Beauchamp, A. (2016). Graduate Nurse Program Coordinators' perspectives on graduate nurse programs in Victoria, Australia: A descriptive qualitative approach. *Collegian (Royal College of Nursing, Australia)*, *23*(2), 201–208. https://doi.org/10.1016/j.colegn.2015.03.004	The study revealed that GNP coordinators viewed these programs as essential for supporting new graduate nurses in bridging the gap between academic preparation and clinical practice. Effective mentorship, structured orientation, and ongoing feedback were identified as key components of successful programs. Coordinators emphasised the importance of tailoring programs to meet individual needs, particularly in diverse and high-pressure clinical environments. Challenges highlighted included resource constraints, varying levels of graduate readiness, and the balancing act between providing support and fostering independence. Coordinators also noted inconsistencies in program delivery across organisations, which could impact the experiences and outcomes for graduate nurses.
28	Missen, K., McKenna, L., Beauchamp, A., & Larkins, J.-A. (2016). Qualified nurses' rate new nursing graduates as lacking skills in key clinical areas. *Journal of Clinical Nursing*, *25*(15–16), 2134–2143. https://doi.org/10.1111/jocn.13316	The study found that qualified nurses perceived new graduates as lacking competence in several critical clinical areas, including medication administration, patient assessment, and time management. Despite this, graduates were recognised for their enthusiasm, willingness to learn, and ability to work collaboratively within teams. The findings highlighted a disconnect between nursing education and the expectations of clinical practice. Participants emphasised the need for graduate transition programs to focus on developing practical, hands-on skills, and improving confidence in high-stakes situations. The study also suggested

	Source	Findings
		that increased collaboration between academic institutions and healthcare providers could help align educational preparation with clinical realities.
29	Murray, M., Sundin, D., & Cope, V. (2019). Benner's model and Duchscher's theory: Providing the framework for understanding new graduate nurses' transition to practice. *Nurse Education in Practice*, *34*, 199–203. https://doi.org/10.1016/j.nepr.2018.12.003	The study found that the transition from student to registered nurse is a challenging and multi-phased process, often marked by stress, confidence issues, and a gap between theoretical knowledge and clinical practice. Duchscher's Stages of Transition Theory describes this transition in three phases: • *Doing* (0–3 months), where nurses experience transition shock and struggle with expectations; • *Being* (4–9 months), where they begin to develop critical thinking and autonomy but still feel caught between student and professional roles; and • *Knowing* (10–12 months), where they gain competence and confidence, shifting their focus to holistic patient care while becoming aware of workplace challenges. Benner's Novice to Expert Model aligns with these findings, showing that NGRNs begin as advanced beginners, capable of performing basic skills but struggling with prioritisation, critical thinking, and adapting to unexpected situations. They require structured mentorship and gradual responsibility increases to progress toward competency. Workplace support is crucial, as many NGRNs face high stress, poor communication, and unrealistic expectations, which can contribute to job dissatisfaction and attrition. Key barriers to a successful transition include lack of mentorship, workplace incivility, overwhelming workloads, and a disconnect between education and practice. Conversely, structured transition programs, strong mentoring relationships, and simulation-based training help build confidence and competence. The study emphasises that healthcare organisations must shift their focus from expecting NGRNs to be fully prepared on day one to creating supportive environments that facilitate gradual skill development and professional growth.
30	Murray, M., Sundin, D., & Cope, V. (2020). Supporting new graduate registered nurse transition for safety: A literature review update	Report suggests a higher incidence of medical errors occur during times of transition for new practitioners. The culture of the environment is influential in NGNs transition and the safety of their practice. Transition programs have proven to assist NG nursing transition through a supportive environment with ongoing opportunities to translate knowledge to practice and consolidate learned skills. Support is essential to alleviate workplace stressors and if both senior nurses and NGNs maintain realistic expectations, safety will be maintained.
31	Murray-Parahi, P., DiGiacomo, M., Jackson, D., & Davidson, P. M. (2016). New graduate registered	NGNs face significant challenges transitioning into PHC roles, including role confusion, stress, and difficulty adapting to the autonomy and broad scope of practice required. Limited mentorship,

	Source	Findings
	nurse transition into primary health care roles: an integrative literature review. *Journal of Clinical Nursing*, *25*(21–22), 3084–3101. https://doi.org/10.1111/jocn.13297	preceptorship, and structured support programs, along with a lack of familiarity with community health practices, exacerbate these challenges. Facilitators of a successful transition include tailored mentorship and preceptorship programs, structured graduate programs specific to PHC, and supportive organisational cultures. Access to continuing education also helps NGRNs build confidence and competence. These findings emphasise the need for healthcare organisations and educational institutions to collaborate on targeted transition programs to align training with PHC demands.
32	Ohr, S. O., Holm, D., & Giles, M. (2020). The organisational socialisation of new graduate nurses and midwives within three months of their entrance into the health workforce	New graduates experienced challenges in adjusting to workplace culture, including navigating expectations and building professional relationships. Supportive colleagues and effective orientation programs were key to successful socialisation. Barriers included limited formal mentorship, high workloads, and unclear role expectations. Recommendations included fostering inclusive workplace cultures, improving communication, and offering structured mentorship and support during the initial months
33	Parker, V., Giles, M., & Higgins, I. (2018). Transition programs for new graduate nurses: Integrative literature review.	Transition programs for new graduate nurses were most effective when they included structured clinical rotations, mentorship, and ongoing education tailored to graduates' needs. These elements helped bridge the gap between academic learning and professional practice, improving clinical competence, confidence, and retention rates by mitigating stress and burnout. However, program effectiveness varied due to factors like inconsistent mentorship quality, high workloads, and a lack of alignment between academic preparation and program demands. Addressing these challenges through standardised program design and evaluation is essential to ensure consistent support and positive outcomes for all new graduate nurses.
34	Phillips, C., Esterman, A., & Kenny, A. (2015). The theory of organisational socialisation and its potential for improving transition experiences for new graduate nurses. *Nurse Education Today*, *35*(1), 118–124. https://doi.org/10.1016/j.nedt.2014.07.011	The study identified key components of organisational socialisation that could enhance the NGNs' transition experiences, including clear communication of role expectations, structured onboarding programs, and mentorship. It emphasised the importance of fostering a supportive workplace culture that promotes collaboration and feedback. These strategies were found to help NGNs build confidence, adapt to their roles, and feel valued within their organisations. The study also highlighted challenges such as inconsistent implementation of socialisation processes and the lack of organisational support for transition programs. It called for greater emphasis on structured orientation and continuous professional development to align organisational practices with the needs of NGNs.

	Source	Findings
35	Phillips, C., Kenny, A., & Esterman, A. (2017). Supporting graduate nurse transition to practice through a quality assurance feedback loop. *Nurse Education in Practice*, *27*, 121–127. https://doi.org/10.1016/j.nepr.2017.09.003	The study found that the quality assurance feedback loop significantly supported graduate nurses during their transition to practice. Key benefits included increased confidence, improved clinical competence, and enhanced communication skills. Graduate nurses valued the structured feedback provided through the loop, which helped them identify strengths, address weaknesses, and set goals for improvement. Challenges included inconsistent implementation of feedback processes and varying levels of engagement from supervisors and mentors. Some participants reported that feedback lacked specificity or was delivered in a way that did not foster constructive learning. The study highlighted the importance of training mentors and supervisors to deliver effective feedback.
36	Thomas, T. H. T., Bloomfield, J. G., Gordon, C. J., & Aggar, C. (2018). Australia's first Transition to Professional Practice in Primary Care Program: Qualitative findings from a mixed-method evaluation. *Collegian (Royal College of Nursing, Australia)*, *25*(2), 201–208. https://doi.org/10.1016/j.colegn.2017.03.009	The study highlighted that the TPPPC program effectively supported graduate nurses in transitioning to primary care. Participants appreciated the structured support, including mentorship, education, and exposure to diverse clinical scenarios. They reported increased confidence, competence, and understanding of primary care roles, particularly in managing complex and chronic conditions. However, challenges included adjusting to the autonomy required in primary care, variability in workplace support, and limited opportunities for hands-on experience in some areas. Participants also emphasised the need for stronger integration between the program and workplace expectations to ensure consistent support.
37	Walker, A., Costa, B. M., Foster, A. M., & de Bruin, R. L. (2017). Transition and integration experiences of Australian graduate nurses	Graduate nurses faced challenges such as role ambiguity, workload pressures, and managing complex clinical environments. Supportive factors included effective preceptorship, mentorship, and structured orientation programs. Professional relationships and workplace culture significantly impacted their integration experiences. Recommendations included improving the consistency and structure of transition programs and fostering supportive workplace environments to enhance confidence and retention.
38	Wardrop, R., Coyne, E., & Needham, J. (2019). Exploring the expectations of preceptors in graduate nurse transition; a qualitative interpretative study. *Nurse Education in Practice*, *34*, 97–103. https://doi.org/10.1016/j.nepr.2018.11.012	Found that preceptors held high expectations for graduate nurses, particularly regarding professionalism, critical thinking, and the ability to adapt to clinical environments. They emphasised the importance of graduate nurses demonstrating initiative, a willingness to learn, and effective communication skills. Preceptors reported that their roles were demanding and required balancing teaching responsibilities with their clinical workloads. Challenges included time constraints, insufficient training or preparation for the preceptor role, and inconsistent support from organisations. Despite these challenges, preceptors expressed a strong commitment to fostering graduate nurses' development and ensuring their successful transition to professional practice.

	Source	Findings
39	Wise, M., Ossenberg, C., Spiller, K., & Henderson, A. (2023). Appraising differential capabilities of new graduate nurses: Development across the first nine months of employment. *Nurse Education Today*, *130*, 105943–105943. https://doi.org/10.1016/j.nedt.2023.105943	Found that NGNs demonstrated significant growth in clinical skills, confidence, and professional behaviours over the nine months, though development varied among individuals. Key factors influencing progression included mentorship quality, workplace culture, and exposure to diverse clinical scenarios. Supportive preceptorship and constructive feedback were pivotal in fostering skill acquisition and confidence. However, challenges such as workload pressures, inconsistent feedback, and variability in support across units hindered some NGNs' development. Participants highlighted the importance of structured graduate programs, tailored support, and opportunities for reflective practice in addressing these challenges.

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Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix B.

Survey Results

In order to obtain information on preferences for a graduate nurse program for remote Aboriginal Community Controlled Health Services (ACCHS) in the Northern Territory (NT), a Qualtrics survey was distributed to second- and third-year nursing students, and new graduate nurses and registered nurses who had completed a new graduate nurse program in the previous three years, to provide information. The return rate was relatively poor with only 52 responses.

Keys terms

Nurse:	A Registered Nurse.
Graduate nurse:	A nurse who is newly graduated as a Registered Nurse.
Nursing student:	A student studying a nursing degree to become a Registered Nurse.
Preceptor:	A teacher or instructor in the workplace setting.
Subsidised:	When some of the costs are paid for by your employer.

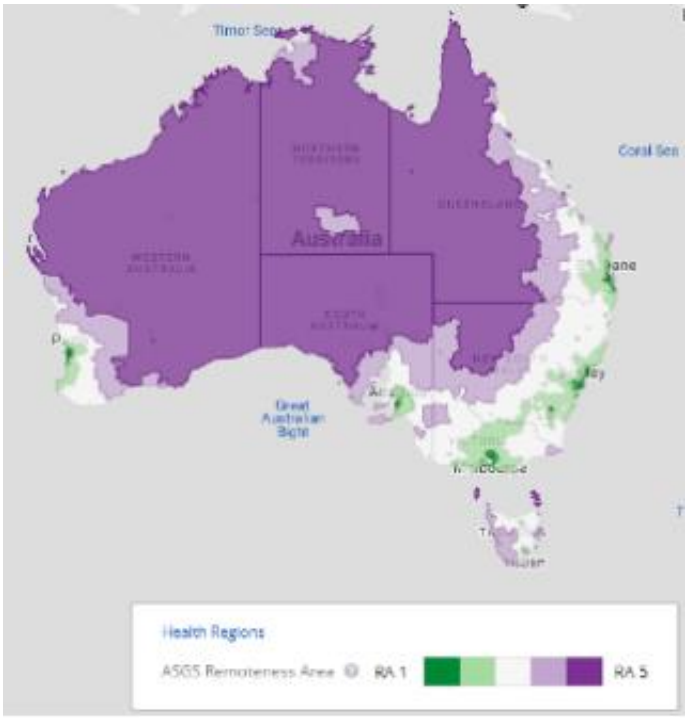
Survey Results

1. Student or New Graduate Nurse?

Nursing student 2nd year	37
Nursing student 3rd year	12
New Graduate Nurse	2
None of the above	1

2. Graduate nurses: In which geographical location did you complete (or are completing) your graduate year?

Remote area (RA 4-5 purple)	8
Outer regional area (RA 3 white)	4
Inner regional area (RA 2 light green)	4
Major city (RA 1 dark green)	9



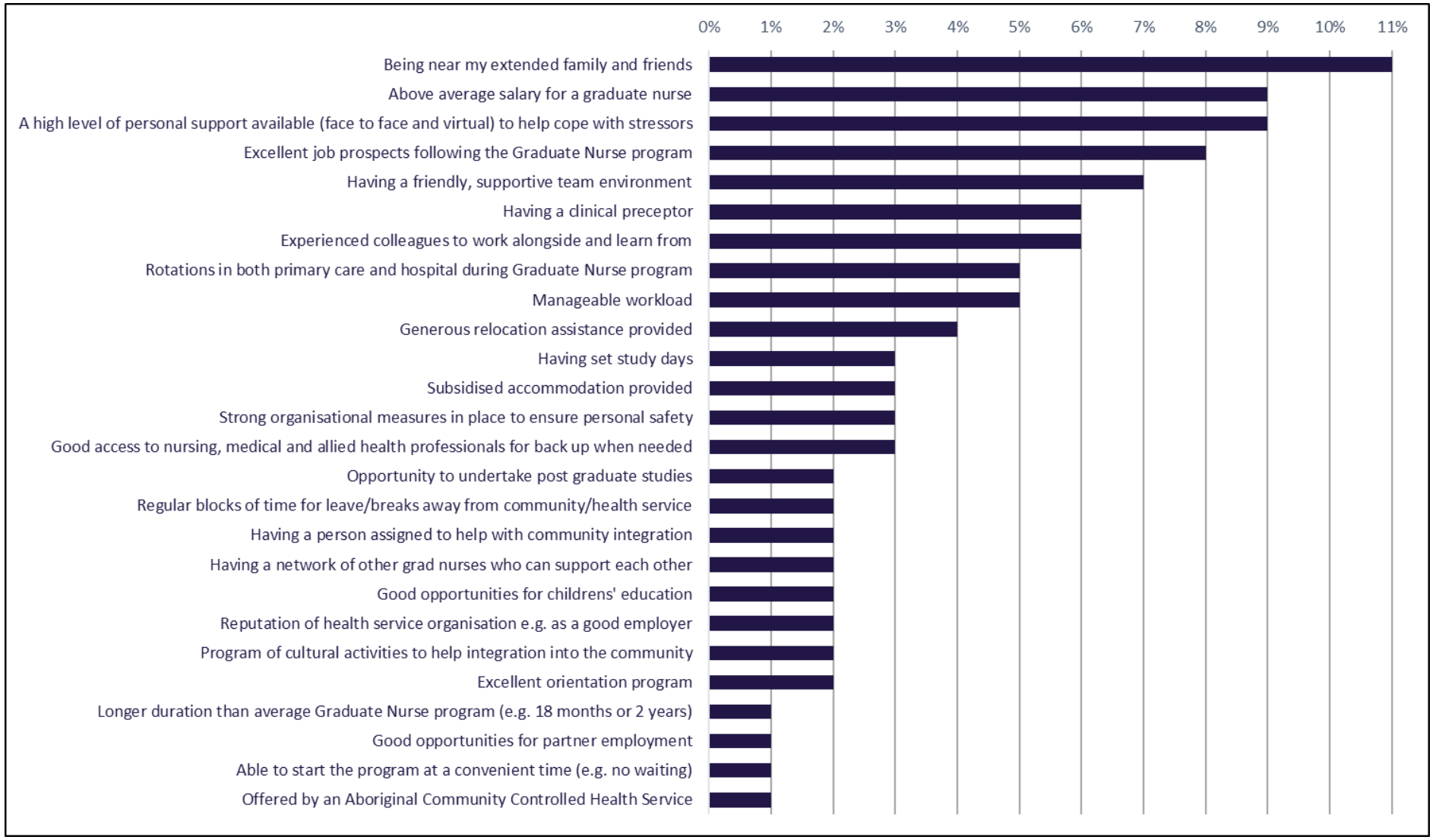
3. Please indicate what State or Territory you have the strongest connections with.

Northern Territory	12
New South Wales	7
Queensland	7
Australian Capital Territory	1
Victoria	14
Western Australia	5
South Australia	1

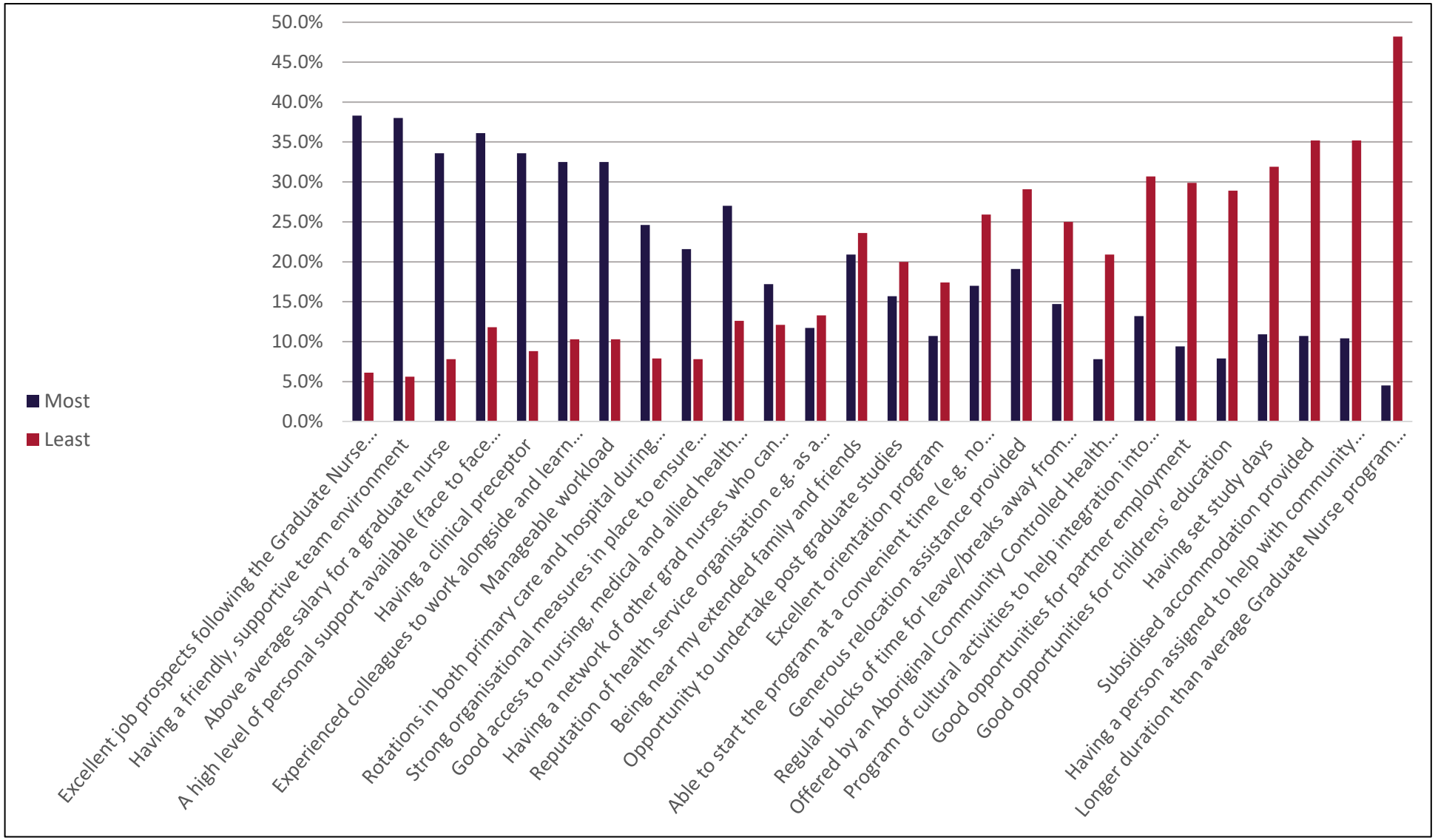
4. Could you please indicate if you are Aboriginal and/or Torres Strait Islander.

Aboriginal	4
Torres Strait Islander	2
Aboriginal and Torres Strait Islander	2
Non-Indigenous	39

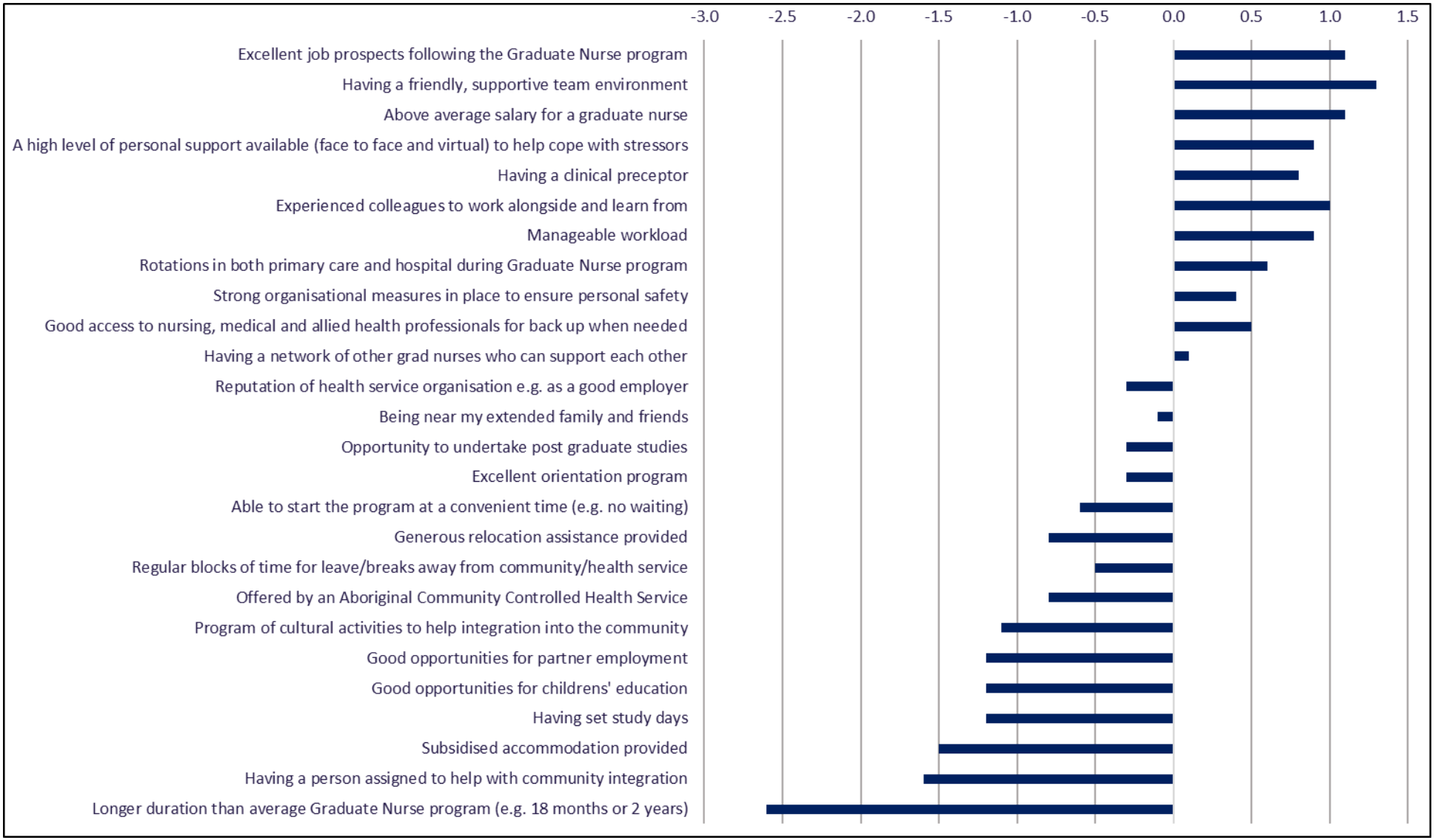
5. Attributes most valued in a new graduate nursing program.



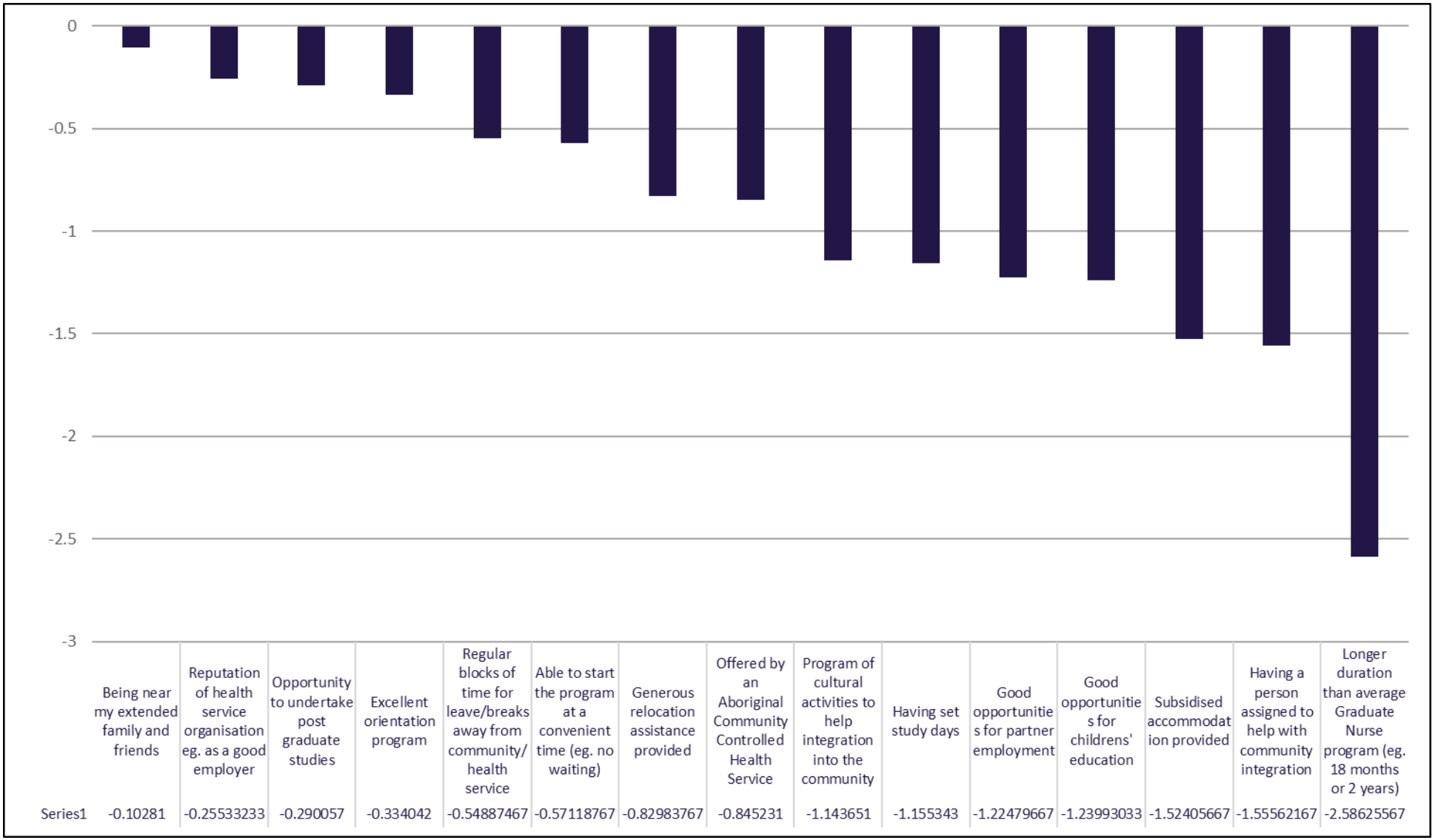
6. Attributes most valued in an new graduate nursing program—Feature counts.



7. Attributes most valued positive and least valued negative in an new graduate nursing program.



8. Attributes least valued in an new graduate nursing program.



	Being near my extended family and friends	Reputation of health service organisation eg. as a good employer	Opportunity to undertake post graduate studies	Excellent orientation program	Regular blocks of time for leave/breaks away from community/ health service	Able to start the program at a convenient time (eg. no waiting)	Generous relocation assistance provided	Offered by an Aboriginal Community Controlled Health Service	Program of cultural activities to help integration into the community	Having set study days	Good opportunities for partner employment	Good opportunities for childrens' education	Subsidised accommodation provided	Having a person assigned to help with community integration	Longer duration than average Graduate Nurse program (eg. 18 months or 2 years)
Series1	-0.10281	-0.25533233	-0.290057	-0.334042	-0.54887467	-0.57118767	-0.82983767	-0.845231	-1.143651	-1.155343	-1.22479667	-1.23993033	-1.52405667	-1.55562167	-2.58625567

9. Attributes of an new graduate nursing program in order of most valued.

1	Having a friendly supportive team environment	1.308134
2	Excellent job prospects following the Graduate Nurse program	1.143382
3	Above average salary for a graduate nurse	1.108628
4	Experienced colleagues to work alongside and learn from	0.977107
5	Manageable workload	0.932188
6	A high level of personal support available (face to face and virtual) to help cope with stressors	0.897999
7	Having a clinical preceptor	0.785689
8	Rotations in both primary care and hospital during Graduate Nurse program	0.639378
9	Good access to nursing, medical and allied health professionals for back up when needed	0.545874
10	Strong organisational measures in place to ensure personal safety	0.422145
11	Having a network of other grad nurses who can support each other	0.091558

10. Attributes least valued, in order of least valued.

1	Longer duration than average Graduate Nurse program (eg. 18 months or 2 years)	-2.58625567
2	Having a person assigned to help with community integration	-1.55562167
3	Subsidised accommodation provided	-1.52405667
4	Good opportunities for children's' education	-1.23993033
5	Good opportunities for partner employment	-1.22479667
6	Having set study days	-1.155343
7	Program of cultural activities to help integration into the community	-1.143651
8	Offered by an Aboriginal Community Controlled Health Service	-0.845231
9	Generous relocation assistance provided	-0.82983767
10	Able to start the program at a convenient time (eg. no waiting)	-0.57118767
11	Regular blocks of time for leave/breaks away from community/health service	-0.54887467
12	Excellent orientation program	-0.334042
13	Opportunity to undertake post graduate studies	-0.290057
14	Reputation of health service organisation eg. as a good employer	-0.25533233
15	Being near my extended family and friends	-0.10281

11. Please outline any other attributes that you think are important for a graduate nurse program.

- Structure of the time table between the organisation and the graduate nurse
- Support from Preceptors and other nurses
- Being accommodating to family breaks
- Accommodation and travel
- Free rent or at least half and can bring family
- Patience
- Support and assurance of safety
- Set study days and training opportunities with experienced clinical educators
- Self-care
- More income support
- Feeling supported and awarded appropriately
- Good pay, amazing support network, great team
- Teamwork, good communication and being professional
- Time with family

Analysis

Graduate nurse program preferences

Urban and remote preferences

- Graduate nurses favour either urban or remote locations, with less preference for regional zones. This may suggest polarising preferences between city and isolated areas.

State/Territory connections

- Victoria and Northern Territory dominate the state of residence.

Gender and age

- Respondents were predominantly female and clustered in the 25–34 age group, which aligns with early to mid-career professionals.

Indigenous representation

- A small proportion of respondents identified as Aboriginal, Torres Strait Islander, or both. There might be opportunities for targeted support or outreach to these groups.

Top valued attributes

- “Having a friendly supportive team environment” (1.308) and “Excellent job prospects” (1.143) were the most valued attributes.
- Practical aspects like having a manageable workload, personal support, and rotations were also ranked highly.

Least Valued Attributes

- Longer program duration (-2.586) and subsidised accommodation (-1.524) were the least valued attributes.
- Community integration support and opportunities for family and/or partner integration also ranked low in value.

Supportive work environment

- A friendly team environment and job prospects significantly outweighed logistical or community factors like accommodation or relocation assistance.

Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix C.

Aboriginal Community Controlled Health Services

Central Australian Aboriginal Congress Aboriginal Corporation

For almost 50 years, the Central Australian Aboriginal Congress (CAAC) has provided support and advocacy for Indigenous people in the struggle for justice and equity.

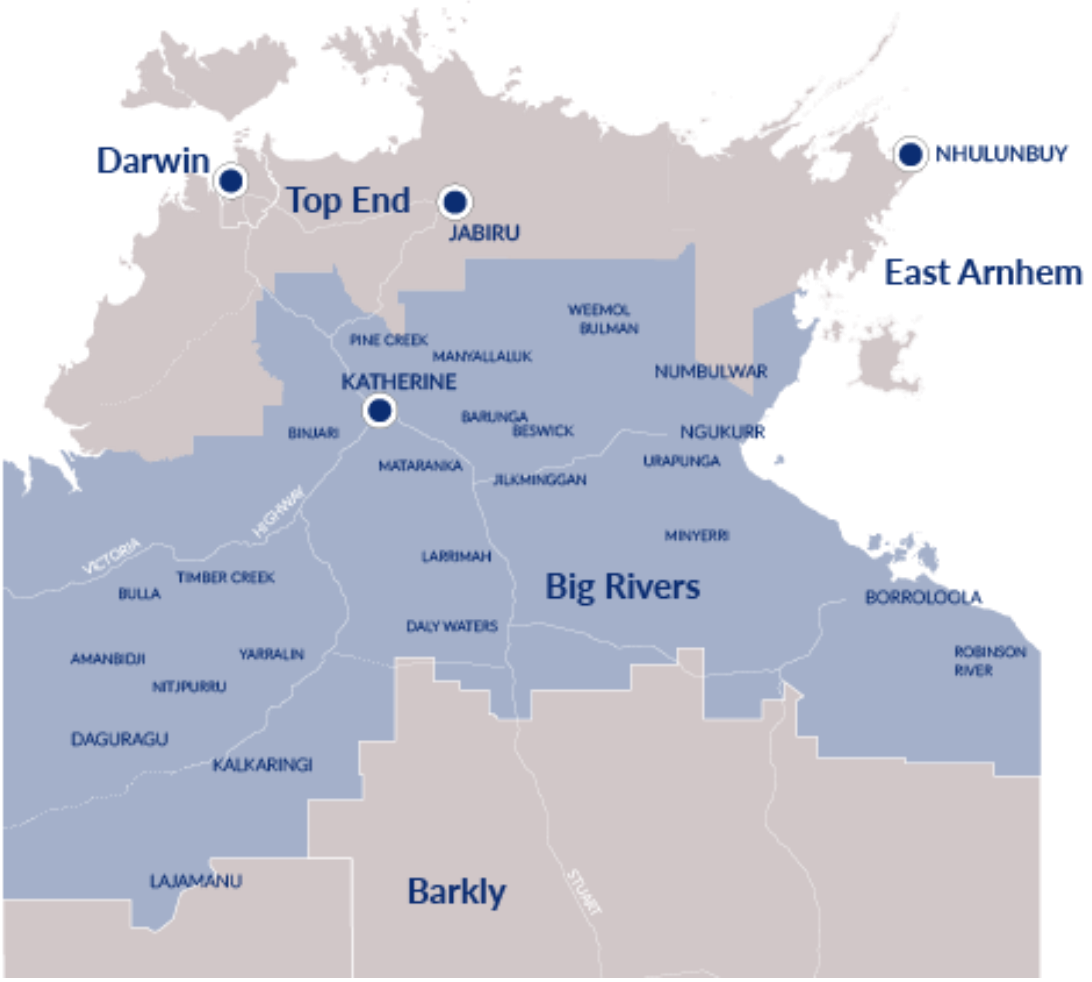
Since that time, CAAC has expanded to become the largest Indigenous community-controlled health organisation in the Northern Territory (NT), providing a comprehensive, holistic and culturally-appropriate primary health care service to Indigenous people living in and nearby Alice Springs, including eight remote communities: Amoonguna, Ntaria (and Wallace Rockhole), Ltyentye Apurte (Santa Teresa), Utju (Areyonga) Mutitjulu, Yulara, Imanpa, and Kaltukatjara (Dockers River). Today, CAAC is one of the most experienced Indigenous primary health care services in the country, a strong political advocate of closing the gap on Indigenous health disadvantage and a national leader in improving health outcomes for all Indigenous people (CAAC, 2024).

Big Rivers Region

Katherine West Health Board Aboriginal Corporation

The Katherine West Health Board Aboriginal Corporation (KWHB) operates eight health centres across 160,000 km^2. The four main health centres are in Kalkaringi, Lajamanu, Timber Creek, and Yarralin. Our smaller health centres are in Bulla, Nitjpurru (Pigeon Hole), Lingara, and Amanbidji (Kildurk) (KWHB, 2025a).

KWHB provide culturally appropriate, accessible and responsive health care including acute emergency care services. This includes after-hours treatment, wellbeing checks, health screening, early intervention, pain and injury treatment, and health management. They also offer services in maternal health, child health, sexual health, chronic diseases, social and emotional wellbeing, and allied and specialist health, as well as operate a mobile team that travels to the most remote regions of the NT and is staff by experienced remote area nurses (KWHB, 2025b).



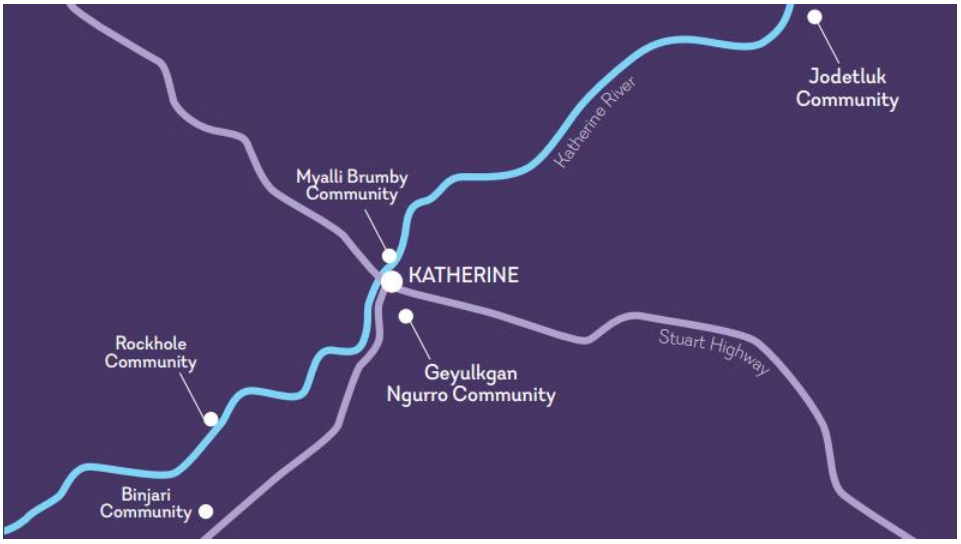
Sunrise Health Service Aboriginal Corporation

The Sunrise Health Service Aboriginal Corporation (Sunrise Health) provides culturally appropriate health services to a large area of the NT east of Katherine. The communities SHSAC services include Barunga, Mataranka, Wugularr (Beswick) Jilminggan, Manyallaluk (Eva Valley), Minuerre, Bulman, Ngukurr, Weemol, and Urapunga (Rittarangu), with the total population serviced reaching approximately 4,000. Sunrise Health provides a range of services including acute emergency care, including after-hours treatment, maternal health, child health, sexual health, chronic diseases, social and emotional wellbeing, allied, and specialist health (Sunrise Health, 2020).

Wurli-Wurlinjang Aboriginal Health Services

The Wurli-Wurlinjang Aboriginal Health Service (Wurli-Wurlinjang Health) is based in Katherine, with outreach to several small communities nearby, the largest being Myalli Brumby (also known as Kalano). Also serviced are Rockhole, Binjari, and the smaller communities of Jodetluk (Gorge Camp) and Geyulkgan Ngurro (Walpiri Camp). The three key Aboriginal groups in Katherine are the Dagoman, Jawoyn and Wardaman people (Miwatj Health, 2022).

Wurli-Wurlinjang Health offers general and primary health care (PHC) services, dental health, women's and children's health, men's health, and chronic conditions care, along with sexually transmitted infection (STI) services and health promotion. While they do offer an after-hours service, emergency care is provided by Katherine Hospital (Miwatj Health, 2022).



Mala'la Health Service Aboriginal Corporation

Mala'la Health Service Aboriginal Corporation (Mala'la Health) is an Aboriginal Community Controlled Health Service (ACCHS) at Maningrida, servicing its homelands. Maningrida is a remote Indigenous community in Arnhem Land, NT, located approximately 500 km east of Darwin and 300 km north-east of Jabiru. The Traditional Owners of the country are the Kunibidji people, whose language is Ndjebbana, however, there are a further 13 different languages spoken in Maningrida. Most people in the community can speak three or four languages, with Burarra (46%), Ndjébbana (12%), Eastern Kunwinjku, Na-Kara and Wurlaki also quite widely spoken. Maningrida has a population of approximately 2,600 people, including those who live on the 30 surrounding homeland outstations. Mala'la Health provides comprehensive and culturally appropriate PHC services, aged care, and community services, family and community wellness checks, and National Disability Insurance Scheme (NDIS) support services. It also has a partnership with Orange Sky to provide free mobile laundry facilities and the Murnun Men's shed (Miwatj Health, 2023).

Miwatj Health Aboriginal Corporation

Aboriginal people in the Miwatj region form three major cultural blocks:

- Anindilyakwa people (Groote Eylandt and Bickerton Island),
- Nunggubuyu people (the Numbulwar area), and
- Yolŋu (broadly, the area from Miliŋinbi/Raminginiŋ in the west to Yirrkala in the east).

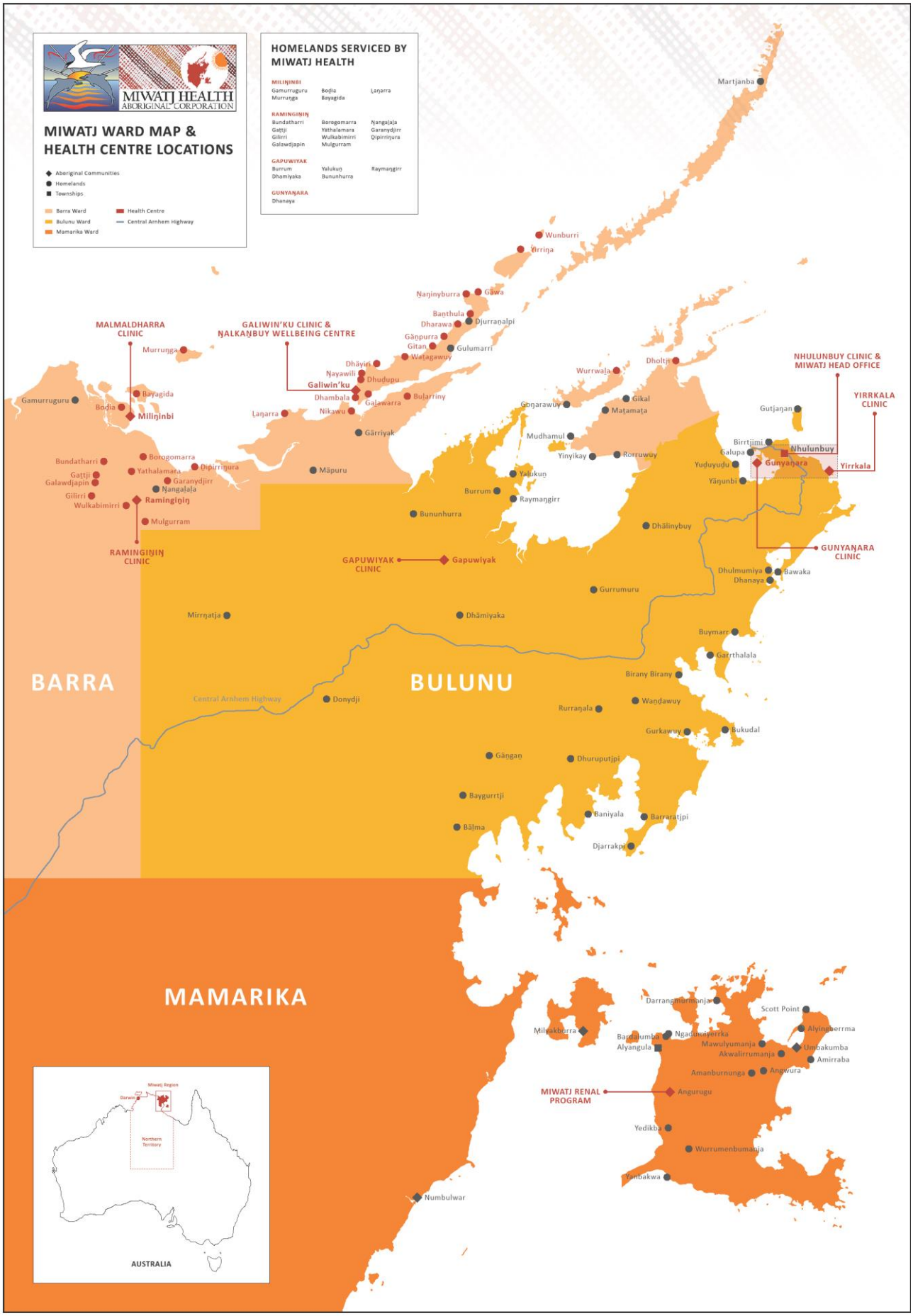
While the languages and clan names differ between the Yolŋu, Anindilyakwa, and Nunggubuyu peoples, underlying concepts and principles are similar across the region. Throughout East Arnhem Land, there are many dialects of the Yolŋu Matha language group, with English often being a third or fourth language for most of the Yolŋu people (Miwatj Health, 2024).

There are three wards in the region:

1. Bulunu Ward is situated in East Arnhem Land, with 3 of its 4 communities situated on the Arafura Sea coastline. This area, with its white sandy beaches, enjoys tropical weather and spectacular landscapes of rugged coastlines, waterfalls, and gorges. The Gapuwiyak community is nestled on the edge of Lake Evella, 120 km west of the major town of Nhulunbuy, where the Miwatj Health Aboriginal Corporation (Miwatj Health) head office is located. Other major communities include Gapuwiyak, Gunyaŋara, Yirrkala, and Nhulunbuy, and Miwatj Health provides comprehensive primary care services to these communities (Miwatj Health, 2021a).

2. Barra Ward include the communities of Raminginin, Yurrwi (Milingimbi), and Galiwin'ku. The primary care clinics are operated by NT Health, with Miwatj Health Aboriginal Corporation (MHAC) offering comprehensive PHC services and providing fly-in fly-out services to the surrounding homelands of Boḏiya, Laŋarra, Murruŋga Island, and Ḏipirri (Miwatj Health, 2021b).

3. Mamarika Ward includes the communities of Numbulwar, Milyakburra, Umbakumba, Angurugu, and Alyangula. The PHC Clinics in Mamarika Ward are currently operated by NT Health. MHAC has a permanent renal dialysis service in Angurugu, supporting haemodialysis clients to return to Country, while also coordinating the eye health program in this region (Miwatj Health, 2021c).


MIWATJ HEALTH
ABORIGINAL CORPORATION
MIWATJ WARD MAP &
HEALTH CENTRE LOCATIONS
Aboriginal Communities
Homelands
Townships
Barra Ward
Bulunu Ward
Mamarika Ward
Health Centre
Central Arnhem Highway
HOMELANDS SERVICED BY
MIWATJ HEALTH
MILIṈINBI
Gamurruguru
Murrunga
Boḍia
Bayagida
Laṇarra
RAMINGIṈIṈ
Bundatharri
Gattji
Gilirri
Galawdjapin
Borogomarra
Yathalamara
Wulkabimirri
Mulgurram
Ṇangaḷala
Garanydjirr
Ḍipirriṇjura
GAPUWIYAK
Burrum
Dhamiyaka
Yaḷukuṇ
Bununhurra
Raymaṇgirr
GUNYAṆARA
Dhanaya
MALMALDHARRA
CLINIC
GALIWIN'KU CLINIC &
ṆALKAṆBUY WELLBEING CENTRE
NHULUNBUY CLINIC &
MIWATJ HEAD OFFICE
YIRRKALA
CLINIC
RAMINGIṈIṈ
CLINIC
GAPUWIYAK
CLINIC
GUNYAṆARA
CLINIC
MIWATJ RENAL
PROGRAM
Martjanba
Wunburri
Yirriṇa
Naṇinyburra
Gawa
Baṇthula
Dharawa
Djurraṇalpi
Gäṇpurra
Gitan
Gulumarri
Watagawuy
Dhäyiri
Ṇayawili
Galiwin'ku
Dhuḍupu
Dhambala
Galawarra
Bularriny
Nikawu
Laṇarra
Gärriyak
Murrunga
Bayagida
Boḍia
Miliṇinbi
Gamurruguru
Bundatharri
Gattji
Galawdjapin
Gilirri
Wulkabimirri
Borogomarra
Yathalamara
Ḍipirriṇjura
Garanydjirr
Ṇangaḷala
Raminginiṇ
Mulgurram
Māpuru
Mirrṇatja
Dhāmiyaka
Donydji
Central Arnhem Highway
Wurrwala
Dholtji
Gonarawuy
Gikal
Maṭamaṭa
Mudhamul
Yinyikay
Rorruwuy
Yaḷukuṇ
Burrum
Raymaṇgirr
Bununhurra
Dhälinybuy
Gutjaṇan
Birrtjimi
Galupa
Nhulunbuy
Yuguyuḍu
Gunyaṇara
Yirrkala
Yäṇunbi
Dhulmumiya
Dhanaya
Bawaka
Gurrumuru
Buymarr
Garrthalala
Birany Birany
Waṇḍawuy
Rurraṇala
Gurkawuy
Bukudal
Gäṇgaṇ
Dhuruputjpi
Baygurrtji
Baniyala
Barraratjpi
Bälma
Djarrakpi
BARRA
BULUNU
MAMARIKA
Darranghurmanja
Scott Point
Milyakburra
Alyingberrma
Bardaumba
Ngadumayerrka
Alyangula
Mawulyumanja
Umbakumba
Akwalirrumanja
Amirraba
Amanburnunga
Angwura
Angurugu
Yedikba
Wurrumenbumanja
Yanbakwa
Numbulwar
Miwatj Region
Darwin
Northern Territory
AUSTRALIA

Red Lily Health Board Aboriginal Corporation



Red Lily Health Board Aboriginal Corporation (Red Lily Health) offers PHC services to the Bininj-Arrakpi people in the West Arnhem Land region. With a corporate office in Darwin, the main office is in Jabiru, located approximately 255 km from Darwin, with a population of approximately 900 people. Other communities in the serviced region include Warruwi (Goulburn Island; ~450 people, Minjilang (Crocker Island; ~300 people), and Gunbalanya (Oenpelli; ~1,350 people). Gunbalanya is currently managed by NT Health, but is in a transition process to community control by Red Lily Health. As of January 2025, Red Lily Health has 17 Full Time Equivalent (FTE) nursing positions and anticipate at least nine more following the Gunbalanya transition in July 2026 (Red Lily Health, 2023).

Anyinginyi Health Aboriginal Corporation

The Anyinginyi Health Aboriginal Corporation (Anyinginyi Health) is an ACCHS based in Tennant Creek, NT. Established in 1984 as the Anyinginyi Congress Aboriginal Corporation, it was renamed in 2003, coinciding with an expansion of services beyond Tennant Creek.

The organisation provides comprehensive PHC services to Indigenous people in Tennant Creek and the surrounding Barkly region, covering nearly 150,000 km^2. Their services extend to over 7,500 individuals across multiple communities, including Elliott, Mungkarta, and Ali Curung.

Anyinginyi Health operates through several key sections:

- **Parlpuru Ninji Kari (Health Services)**: Offering medical, dental, and allied health services to support clients' health and well-being at every life stage.
- **Kalpa Purru Wirranjarlki (Public Health)**: Implementing preventive and educational programs covering various health areas.
- **Piliyintinji-Ki (Stronger Families)**: Providing tailored social and emotional health services that respect and embrace diverse cultures for men, women, and families.
- **Nyangirru Piliyi-ngara Kurantta (Corporate Services)**: Encompassing vital administrative functions to ensure seamless operations.

Anyinginyi Health's vision is for the Barkly Indigenous communities to be healthy, thriving, and happy places to live. Their purpose centres on delivering high-quality, flexible PHC services within a culturally responsive framework to Indigenous people of the Barkly region. Their Board of Directors is elected by members of the organisation, ensuring that the services provided are aligned with the needs and aspirations of the local Indigenous communities (Anyinginyi Health, n.d.).

Marthakal Homelands and Resource Centre Aboriginal Corporation



The Marthakal Homelands and Resource Centre Aboriginal Corporation (Marthakal Homelands) is an Indigenous-owned organisation based in Galiwin'ku, Elcho Island, NT. Established in October 1986, it serves as the parent entity of the Marthakal Group, which is dedicated to delivering a variety of services to the Yolngu people and the residents of the Marthakal Homelands.

The Marthakal Homelands' mission centres on fostering strong connections to land and sea culture, enabling Yolngu to maintain their traditions and self-reliance. Marthakal Homelands provides a safe and healthy environment for children to grow and learn, contributing to the development of strong individuals within the community (Marthakal Homelands, n.d.).

Danila Dilba Health Service



Danila Dilba Health Service (DDHS) is an ACCHS established in 1991 to provide culturally appropriate, comprehensive PHC and community services to Biluru (Aboriginal and Torres Strait Islander) people in the Yilli Rreung (greater Darwin) region of the NT.

Operating a network of eight clinics, including a mobile outreach clinic, DDHS employs more than 240 multidisciplinary staff across the region. Their services encompass a range of specialist and allied health, social, and emotional wellbeing programs, as well as health promotion and education. Each year, more than 12,000 people, comprising around 5,000 families, utilise their services.

The organisation's vision is to achieve health, wellbeing, and quality of life outcomes for Biluru people, that are equal to or greater than those of non-Indigenous Australians. Their mission focuses on improving the physical, mental, spiritual, cultural, and social wellbeing of the Biluru community through innovative, culturally safe, and effective comprehensive PHC programs and services.

DDHS offers a wide array of medical and support services, including:

- Specialist health and clinical services;
- Youth services;
- School-based health checks;
- Dental services;
- Alcohol and other drugs support;
- Tackling Indigenous smoking program;
- Women's and men's clinics;
- A mobile clinic; and
- Social and emotional wellbeing (SEWB) services.

DDHS is governed by a board representing the diversity of the community, including a dedicated Larrakia Officer. Members elect the directors from Aboriginal and/or Torres Strait Islander residents of the Yilli Rreung region, and the board appoints two independent non-member directors (DDHS, 2024).

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Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix D.

Very Remote Practitioners' Work Motivation Scale

Source:

Tyrrell, M. S., Carey, T. A., & Wakerman, J. (2018). The work motivations of the health practitioner who stays for a substantial time in the very remote Indigenous community workplace. *Australian Journal of Psychology, 70*(4), 318–329. https://doi.org/10.1111/ajpy.12218

	Item	Very unlike me 0	Unlike me 1	Moderately unlike me 2	Moderating like me 3	Like me 4	Very like me 5
Living Location Preferences							
1	Usually, I prefer rural community living to city living.						
2	Usually, I am excited by the idea of living in wilderness country.						
3	Wherever I work, I feel the need to be within easy driving distance of major capital cities. (R)						
4	I would quit a job where the local climate makes life uncomfortable sometimes. (R)						
Clinical Self-containment							
5	Wherever I work, I feel the need to have frequent and easy access to good clinical supervision. (R)						
6	Wherever I work, I feel the need to be able to regularly access a mentor. (R)						
7	I would quit a job where I feel professionally isolated a lot of the time. (R)						
8	I would quit a job where I get very little positive feedback from management and patients/clients. (R)						
9	I am more inclined to stay in a job if I have ready access to expert clinical support. (R)						
10	I would quit a job where my employer does not show strong leadership in what is expected. (R)						
Intercultural Interests							
11	In considering a new job, I prefer one that introduces me to the stories and views of Aboriginal and Torres Strait Island people.						
12	In considering a new job, I prefer one that teaches me to communicate well with people from another culture.						
13	In considering a new job, I prefer one that raises my confidence in working with people of other cultures.						
14	In considering a new job, I prefer one that helps me to learn to speak an Aboriginal or Torres Strait Islands language.						

	Item	Very unlike me 0	Unlike me 1	Moderately unlike me 2	Moderating like me 3	Like me 4	Very like me 5
15	In considering a new job, I prefer one that involves me helping to close the gap between Indigenous and non-Indigenous health status.						
	Challenge Seeker						
16	Usually, I choose work that involves adventure.;						
17	Usually, I will take risks to gain new experience.						
18	Usually, I am considered by some as too high a risk taker.						
19	Usually, I love having to adapt to new situations at work.						
	Personal Demand Preferences						
20	I would quit a job where clients / patients regularly approach me out-of-hours about their needs. (R)						
21	I would quit a job where I quite often get called out by the job after hours. (R)						
22	I would quit a job where there is no backfill of my job when I take leave. (R)						
23	I would quit a job where most of my patients /clients have limited English. (R)						
24	I believe that mixing social and clinical relationships should be avoided. (R)						
	Clinical Competence						
25	I am more inclined to stay in a job if I am not presented with complex clinical challenges often. (R)						
26	Given the choice, I will choose a job that helps me build my skills to deal with complex presentations in my patients / clients.						
27	Usually, I enjoy taking on a large clinical workload.						
	Relationship Imperatives						
28	In choosing any job, my big priorities include the needs and wants of those special to me.						
29	I am committed to making joint decisions with those important to me about any career move.						
30	I am committed to having a job within no more than a few hours' drive of my family networks.						

	Item	Very unlike me 0	Unlike me 1	Moderately unlike me 2	Moderating like me 3	Like me 4	Very like me 5
	Lifestyle Preferences						
31	Wherever I work, I feel the need to establish a very comfortable work/leisure balance						
32	Wherever I work, I feel the need to be inspired by the surrounding environment I live in.						
33	I am committed to choosing a work situation that allows me an optimally healthy lifestyle. (R)						

(R) = reverse scoring.

Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix E.

Rural Health Student Clubs

02 8337 8100

Info@nrhsn.org.au

executivecommittee@nrhsn.org.au

Suite 1, 53 Cleary St Hamilton, NSW 2303 Australia

National Rural Health Clubs under the National Rural Health Student Network

University		**Rural Health Club**		
Degree	***Campus Locations***	***Website***	***Email / Contact Page / Links***	***Comments***
Australian Catholic University (ACU)		Towards Rural and Outback Health Professionals in Queensland (TROHPIQ)		
Bachelor of Nursing (BN)	Blacktown Brisbane Canberra North Sydney	https://www.nrhsn.org.au/all-clubs/trohpiq	https://www.trohpiq.org/ https://www.facebook.com/TROHPIQpage https://www.instagram.com/trohpiq/ https://www.linkedin.com/company/trohpiq	
Central Queensland University (CQU)		Rural Health in the Northern Outback (RHINO)		
BN	Cairns Emerald Mackay Rockhampton Townsville	https://www.nrhsn.org.au/all-clubs/rhino		
		Towards Rural and Outback Health Professionals in Queensland (TROHPIQ)		
		https://www.nrhsn.org.au/all-clubs/trohpiq	https://www.trohpiq.org/ https://www.facebook.com/TROHPIQpage https://www.instagram.com/trohpiq/ https://www.linkedin.com/company/trohpiq	
Charles Darwin University (CDU)		Students Association for Rural and Remote Health (STARRH)		
BN	Darwin	https://www.nrhsn.org.au/all-clubs/starrh	https://nrhsn.org.au/contact-us/	
	Alice Springs	Central Australian Remote Health Student Society (CARHSS)		
		https://nrhsn.org.au/club/carhss/	https://nrhsn.org.au/contact-us/	
Charles Sturt University (CSU)		Rural Health Positive (RH+)		
BN	Albury-Wodonga Bathurst Dubbo	https://www.nrhsn.org.au/all-clubs/rhpositive	ruralhealthpositive@gmail.com https://www.facebook.com/RuralHealthPositive	The Victorian Government provides scholarships for students studying nursing in Wodonga.

University		Rural Health Club		
Degree	***Campus Locations***	***Website***	***Email / Contact Page / Links***	***Comments***
	Orange Port Macquarie Wagga Wagga			
Curtin University (CU)		Western Australian Allied Health Interested in Bush Experience (WAALHIIBE)		
BN	Albany Perth Kalgoorlie	https://www.nrhsn.org.au/all-clubs/waalhiibe	waalhiibe@ruralhealthwest.com.au https://www.facebook.com/waalhiibe/ https://twitter.com/waalhiibe	
Deakin University		Nursing, Occupational Therapy, Medicine, Allied Health at Deakin (NOMAD)		
BN	Burwood Geelong Waterfront Warrnambool	https://www.nrhsn.org.au/all-clubs/nomad	secretary.nomad@gmail.com	
Edith Cowan University (ECU)		Students and Practitioners Interested in Rural Practice Health Education (SPINRPHEX)		
BN	Joondalup	https://www.nrhsn.org.au/all-clubs/spinrphex	https://www.facebook.com/Spinrphex/ https://twitter.com/spinrphex https://www.facebook.com/Spinrphex/	
		Western Australian Allied Health Interested in Bush Experience (WAALHIIBE)		
		https://www.nrhsn.org.au/all-clubs/waalhiibe	waalhiibe@ruralhealthwest.com.au https://www.facebook.com/waalhiibe/ https://twitter.com/waalhiibe	
Flinders University		Flinders University Rural Health Society (FURHS)		
BN	Adelaide Riverland	https://nrhsn.org.au/club/furhs/ https://www.nrhsn.org.au/all-clubs/furhs	https://www.facebook.com/FURHS https://www.instagram.com/furhs_/	

University		Rural Health Club		
Degree	***Campus Locations***	***Website***	***Email / Contact Page / Links***	***Comments***
Griffith University (GU)		HOPE4HEALTH (H4H)		
BN	Gold Coast Logan Brisbane South (Nathan)	https://www.nrhsn.org.au/all-clubs/hope4health	secretary@hope4health.org.au https://www.hope4health.org.au/contact/ https://www.facebook.com/hope4health/ https://twitter.com/hope_4_health https://www.facebook.com/hope4health/	
James Cook University (JCU)		Rural Health in the Northern Outback (RHINO)		
BN	Cairns Mackay Townsville	https://www.nrhsn.org.au/all-clubs/rhino		
La Trobe University (LTU)		La Trobe Rural Health Club (LARHC)		
BN	Albury-Wodonga Bendigo Melbourne (Bundoora) Mildura Shepparton	https://www.nrhsn.org.au/all-clubs/larhc	larhc@latrobe.edu.au https://www.facebook.com/LARHC/	The Victorian Government provides scholarships for students studying nursing in Wodonga.
Monash University		Wildfire Rural & Indigenous Health Club (WILDFIRE)		
BN	Clayton Peninsula	https://www.nrhsn.org.au/all-clubs/wildfire	wildfire@monashclubs.org http://www.facebook.com/WildfireRHC https://instagram.com/wildfirerhc	

University		Rural Health Club		
Degree	***Campus Locations***	***Website***	***Email / Contact Page / Links***	***Comments***
Murdoch University		Students and Practitioners Interested iN Rural Practice Health Education (SPINRPHEX)		
BN	Mandurah Murdoch	https://www.nrhsn.org.au/all-clubs/spinrphex	https://www.facebook.com/Spinrphex/ https://twitter.com/spinrphex https://www.facebook.com/Spinrphex/	
		Western Australian Allied Health Interested in Bush Experience (WAALHIIBE)		
		https://www.nrhsn.org.au/all-clubs/waalhiibe	waalhiibe@ruralhealthwest.com.au https://www.facebook.com/waalhiibe/ https://twitter.com/waalhiibe	
Queensland University of Technology (QUT)		Towards Rural and Outback Health Professionals in Queensland (TROHPIQ)		
BN	Kelvin Grove	https://www.nrhsn.org.au/all-clubs/trohpiq	https://www.trohpiq.org/ https://www.facebook.com/TROHPIQpage https://www.instagram.com/trohpiq/ https://www.linkedin.com/company/trohpiq	
The University of Adelaide		Adelaide University Rural Health Alliance (AURHA)		
BN	North Terrace	https://www.nrhsn.org.au/all-clubs/aurha	https://aurha.org/ https://www.facebook.com/aururalhealthalliance/ https://twitter.com/AURHA_	
University of Canberra (UC)		Canberra Rural Allied Health and Nursing Collective (CRANC)		
BN	Canberra	https://www.nrhsn.org.au/all-clubs/cranc	uccranc@gmail.com https://www.facebook.com/UCCRANC https://www.instagram.com/cranc_uc/	
University of Newcastle		Bringing Rural Experience and Awareness to Hunter Health Education (BREAATTHHE)		
BN	Callaghan Central Coast Newcastle City Sydney	https://www.nrhsn.org.au/all-clubs/breaathhe	https://www.facebook.com/BREAATHHE https://www.instagram.com/breaathhe/	

University		Rural Health Club		
Degree	***Campus Locations***	***Website***	***Email / Contact Page / Links***	***Comments***
University of New England		New England Rural Health Club for Health Alliance (NERCHA)		
BN	Armidale Sydney Tamworth Taree	https://www.nrhsn.org.au/all-clubs/nercha	https://www.facebook.com/NERCHA.UNE/ https://www.instagram.com/nercha.une/	
University of Notre Dame (UNDA)		Students and Practitioners Interested in Rural Practice Health Education (SPINRPHEX)		
BN	Fremantle Broome Sydney	https://www.nrhsn.org.au/all-clubs/spinrphex	https://www.facebook.com/Spinrphex/ https://twitter.com/spinrphex https://www.facebook.com/Spinrphex/	
		Western Australian Allied Health Interested in Bush Experience (WAALHIIBE)		
		https://www.nrhsn.org.au/all-clubs/waalhiibe	waalhiibe@ruralhealthwest.com.au https://www.facebook.com/waalhiibe/ https://twitter.com/waalhiibe	
University of Queensland (UQ)		Towards Rural and Outback Health Professionals in Queensland (TROHPIQ)		
BN	St Lucia Gatton Herston	https://www.nrhsn.org.au/all-clubs/trohpiq	https://www.trohpiq.org/ https://www.facebook.com/TROHPIQpage https://www.instagram.com/trohpiq/ https://www.linkedin.com/company/trohpiq	
University of South Australia (UniSA)		Rural Outlook for University Students Towards All Health (ROUSTAH)		
BN	City East	https://www.nrhsn.org.au/all-clubs/roustah	ROUSTAHAdmin@unisa.edu.au USASA-roustah@usasa.sa.edu.au	
University of Southern Queensland (USQ)		Towards Rural and Outback Health Professionals in Queensland (TROHPIQ)		
BN	Ipswich Toowoomba	https://www.nrhsn.org.au/all-clubs/trohpiq	https://www.trohpiq.org/ https://www.facebook.com/TROHPIQpage https://www.instagram.com/trohpiq/ https://www.linkedin.com/company/trohpiq	

University		Rural Health Club		
Degree	***Campus Locations***	***Website***	***Email / Contact Page / Links***	***Comments***
University of Sunshine Coast (USC)		Towards Rural and Outback Health Professionals in Queensland (TROHPIQ)		
University of Tasmania (UTAS)		Rustica: Rural Health Tasmania		
BN	Burnie Hobart Launceston	https://www.nrhsn.org.au/all-clubs/rustica	https://www.facebook.com/rustica.utas/	
University of Western Australia (UWA)		Students and Practitioners Interested in Rural Practice Health Education (SPINRPHEX)		
BN		https://www.nrhsn.org.au/all-clubs/spinrphex	https://www.facebook.com/Spinrphex/ https://twitter.com/spinrphex https://www.facebook.com/Spinrphex/	
		Western Australian Allied Health Interested in Bush Experience (WAALHIIBE)		
		https://www.nrhsn.org.au/all-clubs/waalhiibe	waalhiibe@ruralhealthwest.com.au https://www.facebook.com/waalhiibe/ https://twitter.com/waalhiibe	
Western Sydney University		Rural Health Union of Western Sydney (RHUWS)		
BN	Campbelltown	https://www.nrhsn.org.au/all-clubs/rhuws		

Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix F.

Cultural Safety Self-Evaluation Tool

Source:

Royal Children's Hospital. (2021). *Cultural safety self-assessment tool.* Centre for Diversity and Inclusion, The Royal Children's Hospital Melbourne. https://www.rch.org.au/uploadedFiles/Main/Pages/diversity-equity-and-inclusion/Cultural%20Safety%20-%20Self%20Assessment%20Tool%20(2021).pdf

Cultural Safety Self-Evaluation Tool



This self-evaluation questionnaire is a list of positive attitudinal and cognitive skills that contribute to building a culturally safe workplace and delivering culturally safe services. It is designed for you to evaluate your own culturally safe attitudes, awareness and knowledge. [1]

	This does not describe me at all				*This describes me perfectly*
Personal Cultural Self-Awareness					
I have a clear sense of my own ethnic, cultural and racial identity.	1	2	3	4	5
I am aware that, in order to learn more about others, I need to understand and be prepared to share my own culture.	1	2	3	4	5
I am aware of my discomfort when I encounter differences in race, colour, religion, sexual orientation language, and ethnicity.	1	2	3	4	5
I am aware of the assumptions that I hold about people of cultures different from my own.	1	2	3	4	5
I know my family's story of immigration and assimilation into Australia.	1	2	3	4	5
I am aware of how my cultural perspective influences my judgement about what are 'appropriate', 'normal', or 'superior' behaviours, values, and communication styles.	1	2	3	4	5
If I am a White person working with an Aboriginal person, I understand that I will likely be perceived as a person with power and racial privilege, and that I may not be seen as 'unbiased' or as an ally.	1	2	3	4	5
Cultural Sensitivity and Humility					
I know that differences in colour, culture, ethnicity, etc., are important parts of an individual's identity which they value.	1	2	3	4	5
I am knowledgeable about historical incidents in Australia's past that demonstrate racism and exclusion towards Aboriginal and Torres Strait Islander people. (E.g., the Protection Act, the White Australia policy, Stolen Generation, Self-Management, etc.).	1	2	3	4	5
I accept that in cross-cultural situations there can be uncertainty and that uncertainty can make me anxious. It can also mean that I do not respond quickly and take the time needed to get more information.	1	2	3	4	5
I recognise that cultures change over time and can vary from person to person; as does attachment to culture.	1	2	3	4	5
I recognise that achieving cultural competence involves a commitment to learning over a life-time.	1	2	3	4	5
I am conscious about areas where there are gaps my cultural knowledge.	1	2	3	4	5
I recognise that unconscious bias and stereotypes build up over a lifetime and impact on my judgments of people who belong to groups which are different from mine.	1	2	3	4	5

	This does not describe me at all				*This describes me perfectly*
Developing Personal Ability					
I am developing ways to interact respectfully and effectively with individuals and groups.	1	2	3	4	5
I am aware of my stereotypes as they arise and have developed personal strategies for reducing the harm they cause.	1	2	3	4	5
I can effectively intervene when I observe others behaving in racist and/or discriminatory manner.	1	2	3	4	5
I am able to adapt my communication style to interact effectively with people who communicate in ways that are different from my own.	1	2	3	4	5
I seek out people who challenge me to maintain and increase the cross-cultural skills I have.	1	2	3	4	5
I am actively involved in initiatives, small or big, that promote understanding among members of diverse groups.	1	2	3	4	5
I take any opportunity to put myself in places where I can learn about difference and create relationships.	1	2	3	4	5
I am learning about and put into practice the specific cultural protocols and practices which are necessary for my work.	1	2	3	4	5
My colleagues who are Aboriginal, immigrants or minorities consider me an ally and know that I will support them with culturally appropriate ways.	1	2	3	4	5
I work hard to understand the perspectives of others and consult with my diverse colleagues about culturally respectful and appropriate courses of action.	1	2	3	4	5
I know and use a variety of relationship building skills to create connections with people who are different from me.	1	2	3	4	5
Personal Motivation					
I recognise that my knowledge of certain cultural groups is limited and I am committed to creating opportunities to learn more.	1	2	3	4	5
I commit to really listening to people's answers before asking another question.	1	2	3	4	5
I will make mistakes and faux pas, and will learn from them.	1	2	3	4	5
I will not hide behind the claim of "colour blindness" or say to groups different to mine: "I thought you wanted equality".	1	2	3	4	5
I want to learn how to more effectively value diversity.	1	2	3	4	5
I view human difference as positive and a cause for celebration.	1	2	3	4	5

Calculate the average score for each section. Where do you need to do better?

A guide to each section

Personal Cultural Self-Awareness

This scale measures the degree to which you're aware that you bring your own cultural background into every interaction with others. As we grow up, we see our own culture as being the "norm", when in actual fact – the "norm" is different depending on what culture you belong to. Being aware of this is the first step to creating a culturally safe environment.

Cultural Sensitivity and Humility

This scale measures the degree to which you're aware of the impact cultural differences might make on your own level of comfort, as well as the level of comfort and confidence of the people you are interacting with. Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience. It's important to remember that you don't need to be an expert in someone else's culture to be sensitive to the difficulties that they may be experiencing as a result of living and operating in our new culture. It's really just taking empathy to the next level.

Developing Personal Cultural Competence

This scale measures the degree to which you currently engage in actions that help you to develop your own levels of cultural safety and competence. The extent to which you try to consciously practice and develop your competence by putting yourself in situations that will challenge you, educate you, and expand your experience. It also gives an indication of how willing you are to support and champion the diverse groups you come in contact with.

Personal Motivation

This scale measures the degree to which you are personally motivated to develop your cultural competence and safety. It gives an indication of the extent to which you are willing to go the extra mile and create learning opportunities for yourself, so that you can continue to grow your own ability to provide a culturally safe space for others.

What were your thoughts as you completed the questions? What surprised you?

About Cultural Safety

Cultural Safety first came to prominence in the late 1980s and early 1990s, and was spearheaded by the work of Moari nurses like Irihapeti Ramsden. What she wrote about cultural safety in nursing education then still strikes a chord all through our modern enlightened society.

> *You people talk about legal safety, ethical safety, and safety in clinical practices and a safe knowledge base, but what of cultural safety*?[2]

Her Indigenous nursing students were experiencing ongoing institutional racism, and lack of appropriate opportunities. Sound familiar?

One definition of cultural safety that has emerged from years of reflection, argument and discussion between Indigenous and non-Indigenous staff and students, is the following:

> *Cultural Safety is more or less - an environment which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening.*

Developing Cultural Safety

The process toward becoming culturally safe includes three key elements: Cultural awareness, cultural sensitivity and cultural safety. Although these are related concepts, it is important to understand that they are not the same as each other. All need to be achieved to be in a position to negotiate culturally safe interactions with others. A person who can understand his/her own culture and the concept of transfer of power between dominant and less dominant groups can be culturally safe in a number of contexts.

Cultural Awareness	→	**Cultural Sensitivity & Humility**	→	**Cultural Safety**
The first stage of Cultural Awareness involves developing knowledge and understanding of cultural differences, and of the social, economic and political context in which people exist.		The second stage of Cultural Sensitivity and Humility is where cultural differences are 'legitimated' through a process of self-exploration that enables an individual to reflect on how their culture, worldview and actions impact on others.		The final stage is where culturally safe and respectful services, as defined by those who receive the service, are provided to the minority cultural group.

How culturally safe are you?

An important principle of cultural safety is that it doesn't ask people to focus on the cultural dimensions of any culture other than their own. Instead, cultural safety is primarily:

- about examining our own cultural identities and attitudes, and
- being open-minded and flexible in our attitudes towards people from cultures other than our own.

Identifying what makes someone else different is simple - their English isn't very good or they don't do things in the same way as others (Morris, 2010). Understanding our own culture and its influence on how we think, feel and behave is much harder. However, in the increasingly multicultural environments in which we all live and work, the importance of being culturally safe in what we do cannot be underestimated.

Strategies that enhance the ability to be culturally safe include:

- reflecting on one's own culture, attitudes and beliefs about 'others'
- clear, value free, open and respectful communication
- developing trust
- recognising and avoiding stereotypical barriers
- being prepared to engage with others in a two-way dialogue where knowledge is shared
- understanding the influence of culture shock

Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix G.

Graduate Nurse Program Expansion Curriculum for Remote Areas in the Northern Territory

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Rationale

Access to primary health care (PHC) is fundamental to the wellbeing of individuals, families, and communities (WHO, 2018a). However, remote Aboriginal communities are experiencing a staffing crisis, with non-Indigenous clinical staff turnover reaching 162% annually, excluding agency staff (Veginadu et al., 2024). This turnover worsens due to geographic isolation, with some clinics reporting overall staff turnover as high as 355% (Veginadu et al., 2024). Such workforce instability undermines continuity of care and adversely impacts health outcomes (Van Walraven et al., 2010).

A targeted solution to this crisis is the establishment of a Graduate Nurse Program (GNP) within Aboriginal Community Controlled Health Services (ACCHS) in the Northern Territory (NT). Graduate nurse programs serve as critical pipelines for the recruitment, training, and retention of skilled nursing and midwifery staff (Rogers et al., 2023). While remote area nursing is appealing to many New Graduate Nurses (NGN) due to its perceived professional challenges and rewards, barriers such as the expectation of prior experience and specialised education have deterred their entry into Remote Area Nursing roles (Hart et al., 2014). Many NGNs cite concerns around timing and the increasing difficulty of transitioning into remote practice as contributing factors.

In order to address these barriers, the proposed Graduate Nurse Program Expansion (GNPE) builds upon the successful Central Australian Aboriginal Congress (CAAC) GNP, aiming to extend structured, culturally-safe transition-to-practice support across ACCHS' in the NT.

Background

Remote health

Remote health, while often grouped with rural health, has distinct characteristics. It involves greater geographic isolation, limited service availability, and smaller, more transient populations—many of whom are Aboriginal and Torres Strait Islander peoples (Wakerman et al., 2017). Residents in rural and remote areas face shorter life expectancies, higher rates of illness and injury, and increased hospitalisations when compared with metropolitan populations (AIHW, 2024b). These disparities are compounded by socioeconomic disadvantage and lower access to PHC services. Despite higher service delivery costs in remote areas, funding *per capita* remains significantly lower than in urban centres (Nous Group, 2023).

Indigenous health

Indigenous Australians make up a large proportion of remote populations, particularly in the NT where they account for 31% of the population (AIHW, 2024). Their overall health status remains disproportionately poor,

contributing significantly to the burden of disease in remote regions (AIHW, 2024). Between 2018 and 2022, the age-standardised death rate for Indigenous Australians was 1.9 times higher than for non-Indigenous Australians, and the mortality gap has widened in recent years despite overall declines (AIHW, 2024c; AIHW, 2024d). These outcomes are strongly influenced by the social and cultural determinants of health, including systemic exclusion and socioeconomic disadvantage (AIHW, 2024d). Nonetheless, Indigenous people in remote areas report higher wellbeing than those in urban settings—likely due to stronger connections to Country and cultural practices such as ceremony, caring for Country, and traditional activities (Schultz et al., 2018).

Remote health workforce

Access to health professionals in remote and very remote areas is significantly limited compared to major cities, especially for allied health professionals and medical practitioners (AIHW, 2024; NRHA, 2019a; NRHA, 2019b). While nursing is more evenly distributed, small rural towns and very remote areas still suffer from shortages. Nationally, the nursing and midwifery workforce grew by 77,000 between 2013 and 2023, but this growth was largely concentrated in metropolitan (27%) and regional (36%) areas. In contrast, the proportion of nurses in rural and remote settings declined by 2.6%, with the NT showing the slowest growth nationally at just 13% (Ajayi et al., 2024).

Lower turnover among nurses and Aboriginal Health Practitioners (AHP) is associated with improved health outcomes and reduced health system costs (Wakerman et al., 2019; Zhao et al., 2019). High staff turnover and reliance on costly fly-in fly-out (FIFO) and agency models are widespread in remote PHC, increasing financial strain and weakening workforce stability (Russell et al., 2017). Estimates suggest that halving turnover and reducing the use of short-term staff in the NT could save up to A$32 million annually (Zhao et al., 2019).

Role of the remote area nurse

In very remote communities, Remote Area Nurses (RAN), alongside Aboriginal and Torres Strait Islander Health Practitioners (ATSIHP), are the primary providers of health care, supported intermittently by visiting general practitioners and allied health staff (AIHW, Aitken et al., 2023; Argent et al., 2022; 2024c). RANs perform advanced practice roles across acute, chronic, public health, and health promotion domains, often in cross-cultural contexts requiring adaptation to differing languages and knowledge systems (Aitken et al., 2023).

A major distinction between the roles of Registered Nurses (RN) and RANs is the emphasis on non-emergency client consultations, which account for around 80% of their workload (Lenthall et al., 2024a). However, consultation skills are not typically covered in undergraduate nursing curricula. The revised Remote Area (RA) Nursing Model of Consultation (Lenthall et al., 2024a) has therefore been incorporated into the GNPE curriculum in order to address this gap.

RANs are authorised to examine, diagnose, and dispense medications under standing orders. They also deliver public health interventions including screening, surveillance, early intervention, and health education—all within a primary health care framework (Aitken et al., 2023).

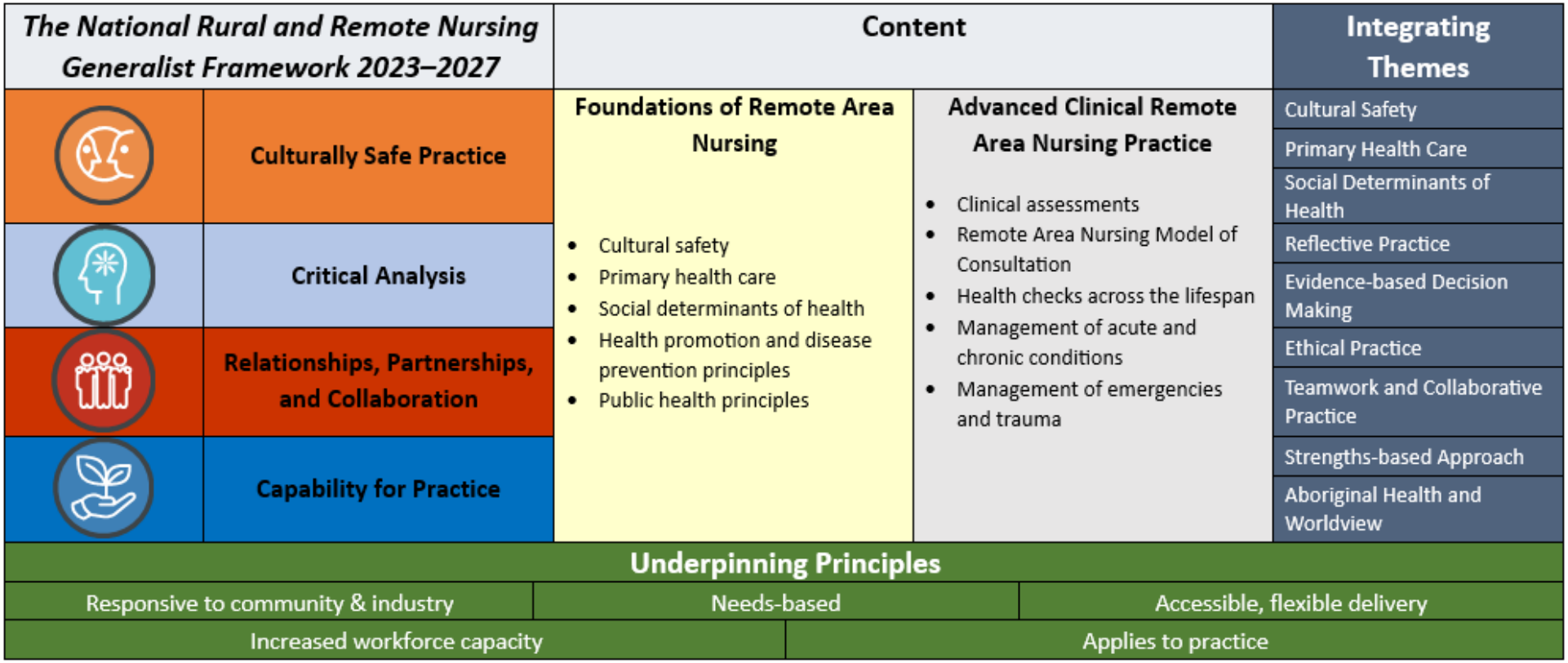
Community control

Aboriginal community control, as defined by the National Aboriginal Community Controlled Health Organisation (NACCHO, 2024), is a process that enables the local Aboriginal community to participate in its affairs, following the protocols or procedures that the community determines. Evidence demonstrates high cost-effectiveness of community-controlled care when primary, secondary, and tertiary prevention align with community needs and priorities (NACCHO, 2024).

Four interconnected components form the basis of the developed curriculum: 1) the domains and capabilities of the *National Rural and Remote Nursing Generalist Framework 2023–2027* (Office of the National Rural Health Commissioner, 2023); 2) the major content areas of Foundations of Remote Area Nursing, which encompass the principles and philosophical foundations of remote area nursing and Advanced Clinical Remote Area Nursing Practice; 3) the integrating themes that weave throughout the curriculum; and 4) a set of underlying principles (Figure G1).

Graduate Nurse Program Expansion Curriculum Model

Figure G1. Graduate Nurse Program Expansion for a remote area nursing curriculum model



National Rural and Remote Nursing Generalist Framework 2023-2027

The *National Rural and Remote Nursing Generalist Framework 2023–2027* (the Framework) describes the unique context of practice and core capabilities for rural and remote registered nurses in Australia (Office of the National Rural Health Commissioner, 2023). The framework contextualises the comprehensive skill set necessary for nurses to work to their full scope of practice as rural and remote nursing generalists. The Framework recognises that rural and remote RNs often provide primary health, acute, and aged care in very small teams, or in isolation. It acknowledges the legacies of prior rural and remote health service delivery with limited resources, and the effect this has on current rural and remote health outcomes.

The Framework provides guidance for:

- RNs who wish to transition to rural and remote nursing generalist practice;
- States and Territories, employers, educators, mentors, and health administrators employing and/or working with RNs in rural and remote healthcare settings; and
- the nursing and midwifery staff and other professional colleagues who support the capabilities of the RN workforce (Office of the National Rural Health Commissioner, 2023).

The Nursing and Midwifery Board of Australia (NMBA) *Code of Conduct for Nurses* (NMBA, 2023) and the Framework recognise that 'cultural safety' is defined by Aboriginal and Torres Strait Islander peoples (NMBA, 2023; Office of the National Rural Health Commissioner, 2023). The *Code of Conduct for Nurses* acknowledges Australia's historical and ongoing cultural and linguistic diversity (NMBA,). The Framework extends this premise by defining one's own cultural safety to all culturally and linguistically diverse (CALD) people. It reflects that the NMBA's *Registered Nurse Standards for Practice*:

> 1.3 respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures.
>
> (NMBA, 2017)

Connections between cultural safety, workforce, and improving health equity is recognised in the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031* (DHAC, 2022b), and are upheld in the Framework.

The Framework consists of four domains, supported by capabilities and capability statements that reflect the unique context and requirements for RN practice in rural and remote healthcare settings:

Domain 1. Culturally safe practice includes the capabilities safety and quality, critical reflection, and advocacy.

Domain 2. Critical analysis includes the capacities of culturally safe-quality care, evidence-based decision making and technology-enabled practice and care.

Domain 3. Relationships, partnerships, and collaboration includes the capabilities of effective communication, collaborative holistic care, and professional practice.

Domain 4. Capability for practice includes the capabilities of care of self and others, lifelong-learning and accountability to self and the profession.

Figure G2 reflects that culturally safe practice wraps around the domains of critical analysis, relationships, partnerships and collaboration, and capability for practice. Culturally safe practice is also interwoven throughout the capabilities because it is essential that every rural and remote RN provide culturally safe care.

Figure G2. The Framework domains and capabilities

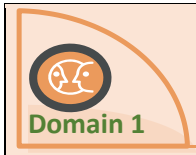


Capability levels

The Framework has three capability levels, recognising the development of nurses from formative, to intermediate, to proficient. The GNPE Curriculum has been mapped against the domains and capacities. The level of learning outcomes is aligned from formative to intermediate. Participants in the GNPE program for remote practice are new practitioners and as such are not expected to reach the level of proficiency in some areas until the end of the program.

Mapping of GNPE Curriculum to the National Rural and Remote Generalist Framework 2023–2027

Table G1a. The Graduate Nurse Program Expansion (GNPE) Curriculum as mapped to the *National Rural and Remote Generalist Framework 2023–2027.* Domain 1: Culturally safe practice.



Culturally Safe Practice

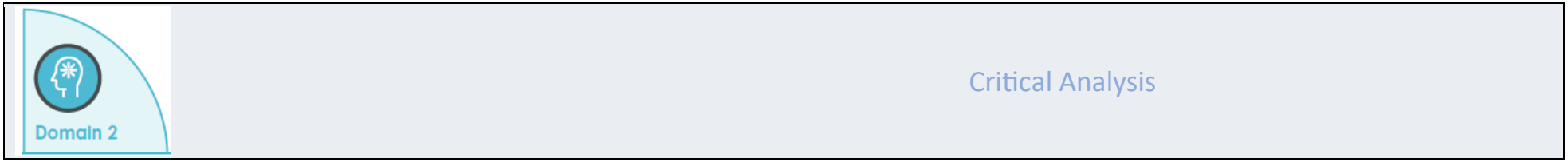
Capabilities	Description	Learning Outcomes
1.1 Safety and Quality		
Applies evidence and strength-based, holistic, clinically, and culturally safe nursing care within the rural or remote context to deliver optimal and equitable individual and population health outcomes. Actively supports and respects the person's right to determine their own cultural safety. Acts and leads inclusively to provide a Culturally safe work and healthcare environment by supporting the rights, dignity, and safety of all.	Supports Aboriginal and Torres Strait Islander self-determination and ways of knowing, being and doing, in the context of history, culture and diversity, and affirms and protects these factors in nursing practice through continuing professional development. Ensures that all healthcare measures protect cultural safety and understands the inextricable link between cultural safety, workforce, and health outcomes, recognising that this can only be defined by Aboriginal and Torres Strait Islander or culturally and linguistically diverse (CALD) peoples for themselves. Utilises lifelong learning skills to develop culturally safe nursing practice including an understanding of Aboriginal and Torres Strait Islander health and Aboriginal Community Controlled Health Organisations (ACCHO). Integrates the important role of Aboriginal and Torres Strait Islander health professionals, CALD advisors and knowledge from relevant organisations and communities into care, building effective partnerships.	Define and describe: • cultural safety, • self-determination, • strength-based approach, and • decolonisation. Describe the role and importance Aboriginal Community Controlled Health Services (ACCHS) and of Aboriginal and Torres Strait Islander health professionals. Analyse the principles of Primary Health Care (PHC) and describe how these may be implemented and further strengthened in remote Aboriginal communities. Describe trauma informed care and outline ways to incorporate principles into remote area (RA) nursing practice.

Capabilities	Description	Learning Outcomes
	Applies principles of trauma-informed care when working with Aboriginal and Torres Strait Islander people, and people from CALD and marginalised backgrounds. This includes using appropriate human and other resources and demonstrating personal humility about cross-cultural understanding and knowledge. Actively promotes inclusivity in healthcare.	
1.2 Critical Reflection		
Undertakes ongoing learning and personal reflection, seeking cultural mentorship and guidance on how dominant cultural paradigms influence perceptions and interactions with all people and communities, applying learnings to the provision of rural or remote healthcare.	Recognises the impact of history and colonisation on contemporary Aboriginal and Torres Strait Islander health outcomes. Acts to eliminate all forms of racism in practice and in the workplace. Continuously reflects how one's own culture, values, attitudes, assumptions, and beliefs influence interactions with people, families, community, and colleagues. Understands that safe, accessible healthcare requires recognition of power differentials in behaviour, knowledge and skill that do not privilege any group above another and actively works to counter racism to prevent and address health inequities.	Analyse the impact of history and colonisation on contemporary Aboriginal and Torres Strait Islander health outcomes. Outline strategies to address racism in practice and in the workplace. Analyse how one's own culture, values, attitudes, assumptions, and beliefs influence interactions with people, families, community, and colleagues. Analyse power differentials between clinicians and clients, and Aboriginal peoples and health services and the wider community.
1.3 Advocacy		
Regardless of sexuality, sex, gender, disability, ethnicity, race, religion, culture, political beliefs, or other personal characteristics: • advocates for fairness and equity for all people in rural and remote communities, and • actively contributes to social change, challenging beliefs based on assumption.	Promotes and supports equitable health services and affirms the principles of the *United Nations Declaration on the Rights of Indigenous Peoples*, and other human rights instruments, in order to support Aboriginal and Torres Strait Islander peoples to attain equitable health outcomes. Demonstrates leadership and resilience in advocating for equitable health outcomes for culturally safe services whilst managing change resistance in all health care settings, including disability, aged care, youth residential care and correctional facilities. This includes using people's nominated names and pronouns.	Describe the *United Nations Declaration on the Rights of Indigenous Peoples,* and other human rights instruments, and analyse how these support Aboriginal peoples to attain equitable health outcomes. Identify strategies that would advocates for and act to facilitate access to quality and culturally safe health services for Aboriginal and Torres Strait Islander peoples.

Capabilities	Description	Learning Outcomes
	Advocates for and acts to facilitate access to quality and culturally safe health services for Aboriginal and Torres Strait Islander peoples and all minority and marginalised groups.	

Permission was granted by the Office of Rural Health to use symbol of the domain from the *National Rural and Remote Nursing Generalist Framework 2023–2027.*

Table G1b. The Graduate Nurse Program Expansion (GNPE) Curriculum as mapped to the *National Rural and Remote Generalist Framework 2023–2027.* Domain 2: Critical analysis.



Capabilities	Description	Learning Outcomes
2.1 Culturally Safe Quality Care		
Recognises the impact of colonisation on the social determinants of health, and within past and current healthcare service models for rural and remote residents. Adopts reflexive, evidence-based practices to address context-specific inequities and deliver optimal health outcomes.	Actively and openly incorporates professional and cultural knowledge in the assessment, planning, delivery, and evaluation of safe, quality, person, and family-centred care. Operates with cultural humility and respect, undertaking clinical assessments and plans that consider population and public health actions developed in collaboration with individuals, families, relevant care partners, and the multidisciplinary health care team. Undertakes critical reflexivity that leads to improved holistic, culturally safe care whilst undertaking quality improvement activities to monitor and evaluate outcomes of care.	Assess and manage clinical presentations following the Remote Area Nursing Model of Consultation.

Capabilities	Description	Learning Outcomes
2.2 Evidence-Based Ethical Practice		
Utilises relevant data to identify best practice-, place- and strengths-based person-centred interventions, co-designed with people, families, communities and the multidisciplinary team in the rural and remote context, recognising legacy challenges, and existing inequities.	Critically evaluates and implements practice standards, policy, guidelines and legislation into practice. Uses data monitoring and analysis to inform and prioritise inclusive action, optimise health outcomes, minimise risk, and maintain personal and cultural safety. Ensures appropriate and ethical use of health data, respecting confidentiality, and data sovereignty. Provides place-based multidisciplinary population health activities across the lifespan in partnership with the local community, identifying and overcoming risks through evidence- and strength-based co-design. Implements and coordinates evidence-based and co-designed health interventions and programs to meet community priorities and needs, by embedding health promoting aims and values into practice.	Identify and evaluate practice standards, policies, guidelines, and legislation for RA nursing practice in relation to ethical practice. Interpret and apply the use of health promotion theory in communities with a PHC framework. Implement health promotion, health interventions and programs in partnership with the community using a strength-based approach. Manage chronic diseases and/or on-going health problems in partnership with individuals, families, and communities. Perform health checks on children, women, and men in partnership with individuals, family, community, and the multidisciplinary team.
2.3 Technology Enabled Practice and Care		
Utilises and connects the available technology in the rural and remote context to enhance assessment and planning for holistic care and collaboration, in order to provide comprehensive PHC.	Maintains currency with digital health platforms and technologies to assist access to health care, inform care planning, delivery, and evaluation of health outcomes, connecting care across the continuum. Demonstrates recognised professional standards in utilising digital tools for professional development. Ensures procedural knowledge in the use of digital tools in healthcare to align with policy, legal, ethical, security, and privacy requirements. Uses digital tools to build and maintain a professional online identity and reputation, in compliance with the Australian Health Practitioner Regulation Agency's (AHPRA) social media policy.	Utilise and connect available technology to enhance assessment and planning for holistic care and collaboration. Utilises and interprets available Point of Care (POC) testing.

Permission was granted by the Office of Rural Health to use the symbol of the domain from the *National Rural and Remote Nursing Generalist Framework 2023–2027.*

Table G1c. The Graduate Nurse Program Expansion (GNPE) Curriculum as mapped to the *National Rural and Remote Generalist Framework 2023–2027.* Domain 3: Relationships, partnerships and collaboration.



Relationships, Partnerships and Collaboration

Capabilities	Description	Learning Outcomes
3.1 Effective Communication		
Communicates effectively with individuals, their care partners, and the comprehensive primary health care team, cognisant of their dignity, culture, values, beliefs, and rights, and how one's own culture, values, attitudes, assumptions, and beliefs influence interactions.	Actively and respectfully engages the person, their family, care partners, and community support networks including Aboriginal and Torres Strait Islander health professionals and other CALD advice, as appropriate, in the therapeutic relationship to plan, deliver and evaluate evidence-based care. Communicates effectively with the multidisciplinary team to provide wrap around care that is person focused, co-designed, and place-based. Always promotes and enables health literacy to address identified need, in partnership with the person, care partners, local community, and the multidisciplinary team. Builds sustainable relationships with people from diverse groups including Aboriginal and Torres Strait Islanders, CALD, and marginalised groups, in order to support collaborative decision making for optimal healthcare. Facilitates culturally safe, evidence-based health education that strengthens confidence and supports self-care. Develops culturally safe partnerships that recognise the importance to many rural and remote families and communities of defining health care needs as collective, rather than as individual.	Identify and implement effective communication strategies with individuals, family, community, and other health professionals. Identify and utilise strategies that promote and enable health literacy. Identify and utilise strategies to build sustainable relationship with individuals, families, and community.

Capabilities	Description	Learning Outcomes
3.2 Collaborative Holistic Care		
Initiates and demonstrates culturally safe collegial relationships that promote inclusive workplaces, supports community control, and use appropriate digital and other technologies to overcome rural and remote barriers to healthcare.	Utilises collaborative partnerships to deliver evidence-based comprehensive and holistic care, drawing on the collective experience, knowledge, and expertise of others. Delivers culturally safe care in collaboration with the person, family, care partners, and community support systems, recognising historical and contemporary impacts on professional approaches, perspectives, and practice. Collaborates to strengthen the multidisciplinary team, to develop, implement and evaluate care that supports the person's independence and self-management. Applies trauma-informed care using all available resources, demonstrating humility and cross-cultural understanding within the relationship, as required. Embeds patient monitoring systems, data collection, relevant documentation, and communication tools, linking population health activities to holistic care and connectivity across the care continuum.	Identify and utilise strategies that build culturally safe collaborative partnerships.
3.3 Professional Practice		
Creates a supportive learning environment by generously sharing knowledge and skills, and demonstrates humility in learning from others. Understands the critical importance of relationships and partnerships within small communities and teams, and establishes appropriate personal and professional boundaries. Advocates for recognition and advancement of the role of nursing in promoting health and wellbeing of individuals and communities.	Builds resilient relationships by providing and receiving professional mentorship, including across disciplines within the rural and remote multidisciplinary practice setting. Develops professional and community partnerships in low resource isolated settings as appropriate to assist with innovation and support staff safety. Advocates for the recognition and advancement of the role of rural and remote nurse generalists in improving health outcomes, and to highlight health inequities and social injustice. Delivers comprehensive clinical care in a variety of contexts, including complete episodes of care, prevention, and health promotion, as appropriate for age and demographic. Embraces multidisciplinary collaborative team care, inclusive of all rural and remote generalists and care partners, in order to provide wrap around care and support. Utilises clinical leadership and professional judgement in guiding delegation, supervision, coordination, consultation, and referral, within culturally safe and respectful professional relationships, in order to optimise health outcomes.	Describe the importance of relationships and partnerships within small communities and teams, and implement strategies to facilitate these partnerships.

Permission was granted by the Office of Rural Health to use the symbol of the domain from the *National Rural and Remote Nursing Generalist Framework 2023–2027.*

Table G1c. The Graduate Nurse Program Expansion (GNPE) Curriculum as mapped to the *National Rural and Remote Generalist Framework 2023–2027.* Domain 4: Capability for practice.



Capabilities	Description	Learning Outcomes
4.1 Care of Self and Others		
Develops and maintains the capability of delivering evidence-based care that enables people to make informed decisions for their health in the rural or remote setting, strengthening own and other's wellbeing, and supporting colleagues to deliver culturally safe quality healthcare.	Maintains own health, wellbeing, and resilience through self-care strategies, such as peer support and mentorship, clinical reflective supervision, and employee assistance. Recognising the demands of rural and isolated remote practice on self and others, demonstrates proficiency in comprehensive assessments in a range of settings, often in isolation with reduced access to immediate clinical supports, using resources innovatively to plan, treat, and evaluate care, to full scope of practice. Promotes a safe work environment through adherence to relevant legislation, standards of practice and safety protocols that reflect cultural and local requirements in isolated settings. Engages in inter-professional collegial support and learning aligned to the rural or remote context.	Prepare a self-care plan, recognising culture shock, transition to practice and the demands and stressors associated with working in a remote Aboriginal community. Recognises and supports colleagues experiencing culture shock, post-traumatic stress, vicarious trauma, occupational stress, and burnout.
4.2 Lifelong Learning		
Demonstrates commitment to ongoing personal and professional learning and development.	Maintains currency and capability in professional standards of practice, in order to influence and strengthen rural and remote peoples' autonomy for their health across their lifespan. Engages in personal reflection and continuing professional development with nursing, remote, and rural health professional organisations in order to enhance quality and culturally safe care for individuals, community, and population groups. Utilises a skills-based approach to educational pathways and standards that enable practice to accommodate the needs of the community.	

Capabilities	Description	Learning Outcomes
	Ability to critically think, analyse data and demonstrate clinical reasoning in challenging environments with limited resources and caring for known individuals within a small community.	
4.3 Accountability to Self and the Profession		
Reflects on the process and quality outcomes of own practice and always acts to promote and improve the status of rural and remote nursing.	Prepares for context of practice by identifying and acquiring extended knowledge and skills, undertaking professional development and education in order to safely deliver multidisciplinary team-based care. Understands and takes accountability for personal and professional actions and decisions, and for the actions of others to whom they have delegated responsibilities. Seeks and responds to feedback to improve and develop professional capability for both self and colleagues. Understands and responds constructively to concerns around other health professionals' practice by providing support in enhancing their capability to improve rural and remote health across the care continuum. Actively works to enhance and promote multidisciplinary, rural generalist teams to support better rural and remote health outcomes for current and future generations. Maintains currency and capability to embed patient monitoring systems, data collection, relevant documentation, and communication tools, which link population health activities to holistic care and connectivity across the care continuum.	Identify one's own capabilities and skills and develop a learning plan to practice as a remote area nurse. Provides support and guidance, where appropriate, to other health professionals in a constructive and positive manner.

Permission was granted by the Office of Rural Health to use the symbol of the domain from the *National Rural and Remote Nursing Generalist Framework 2023–2027.*

Major Content Areas

Foundations of remote health practice

The key foundations of remote area nursing are cultural safety and primary health care. The foundations of practice lie not so much in what is done, but rather *how* it is done. ACCHS' and RANs have been leaders in Australia in implementing comprehensive primary health care.

Cultural safety

'Cultural safety' is a phrase originally coined by Māori nurses and nursing students from New Zealand who felt that they and their people were unsafe in the mainstream health system. They defined cultural safety as nursing practice where there is no assault on a person's identity (Papps & Ramsden, 1996) and as:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. …. The nurse delivering the nursing care will have undertaken a process of reflection on their own cultural identity and will recognise the impact their personal culture has on their professional practice.
>
> (p. 491)

Unsafe cultural practice comprises any action that diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual. Cultural safety involves recognition of the power balances and historical, political, social, and economic structures. Rather than treating people regardless of their ethnic and social background, cultural safety requires that patients are treated *regardful* of their backgrounds. The beginning step of cultural safety is described as cultural awareness that leads to cultural sensitivity through the acceptance and respect for differences, thereby creating an environment that is spiritually, socially, and emotionally safe (Williams, 2022).

The Nursing and Midwifery Board of Australia's *Code of Conduct for Nurses* (NMBA, 2023) states that "culturally safe and respectful practice requires having knowledge of how a nurse's own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues" (p. 9).

Cultural safety has been endorsed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), who emphasise that cultural safety is as important to quality care as clinical safety. However, the 'presence or absence of cultural safety is determined by the recipient of care, it is not defined by the caregiver' (AHMAC, 2016).

Cultural responsiveness in action framework

Indigenous Allied Health Australia (IAHA) states that:

> Cultural responsiveness has cultural safety at its core. Cultural responsiveness is what is needed to transform systems; how individuals work to deliver and maintain culturally safe and effective practice. It is innately transformative and must incorporate knowledge (**knowing**), self-knowledge and behaviour (**being**) and action (**doing**). It is about the approaches we take in engaging with people and how we act to embed what we learn in practice. This requires genuine dialogue to improve practice and health outcomes. Cultural responsiveness is the means by which we achieve, maintain and govern cultural safety.
>
> (Indigenous Allied Health Australia (IAHA), 2019)

Primary health care

Primary health care is an approach to health that was established at the International Conference on Primary Health Care by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at Alma Ata in the Soviet Union in 1978. The *Declaration of Alma Ata* includes this definition of PHC:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.
>
> (WHO, 1978)

The *Declaration of Astana* (WHO, 2018b) reaffirmed the definition of PHC and emphasised the critical role of primary health care worldwide. The declaration aims to refocus efforts on PHC in order to ensure that everyone everywhere can enjoy the highest possible attainable standard of health. It envisioned:

- **Governments and societies** that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;
- **Primary health care and health services** that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;
- **Enabling and health-conducive environments** in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;

- **Partners and stakeholders** aligned in providing effective support to national health policies, strategies and plans.

(WHO, 2018b)

In Australia, PHC has been implemented most noticeably by ACCHS'.

Social and cultural determinants of health

Evidence supports the close relationship between people's health and the living and working conditions that form their social environment (Baum, 2018; Marmot & Wilkinson, 2006). Factors such as socioeconomic position, educational attainment, conditions of employment, the distribution of wealth, empowerment and social support – together known as the social determinants of health – can act to strengthen or undermine the health of individuals and communities (Baum, 2018; Marmot & Wilkinson, 2006).

The WHO describes social determinants as

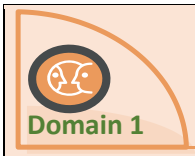
> The non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems encompass economic policies and systems, development agendas, social norms, social policies and political systems.
>
> (WHO, 2023)

The traditional model of the 'social determinants of health' often takes a dominant approach, consequently positioning Indigenous identities in deficit relative to non-Indigenous populations and framing poor health as a consequence of an inability of Indigenous people to meet the socioeconomic standards and 'norms' of dominant cultures. This approach likely misses important structural, political, and cultural contexts that present and enable opportunities to improve health (Verbunt et al., 2021). However, there is growing recognition for the importance of a strengths-based approach that focuses on the cultural determinants of health that centre on an Indigenous definition of health. Family and /or community, Country and place, cultural identity, and self-determination were found to have a positive impact on the health and wellbeing outcomes of Indigenous peoples (Verbunt et al., 2021). There is increasing evidence that caring for Country and involvement in cultural activities result in improved health outcomes for Indigenous peoples (Schultz & Cairney, 2017).

Advanced clinical nursing practice

Because of the lack, and maldistribution, of medical practitioners in Australia, a key difference between RNs and RANs is the everyday client consultation. Although generally a General Practitioner (GP) skill, everyday client consultation makes up about 80% of the everyday work of a RAN (Table G2).

Table G2a. Revised Remote Area Nurse Model of Consultation. Domain 1: Culturally Safe Practice.

	Culturally Safe Practice 1.1 Safety and Quality 1.2 Critical Reflection 1.3 Advocacy

Safety and Quality

- Implements evidence-based and strengths-focused best practices in remote and Aboriginal and Torres Strait Islander healthcare.
- Fosters a comfortable environment for the client through effective communication and cultural sensitivity.
- Addresses gender-related considerations and assesses the need for interpreter services.
- Utilises appropriate language that respects cultural nuances.
- Empowers the client by sharing decision-making power and acknowledging their control over their own life.

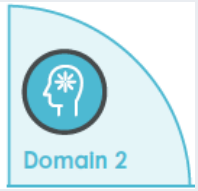
Critical Refection

- Examins and reflectis on how one's own culture and dominant cultural paradigms influence beliefs about and interactions with Aboriginal and Torres Strait Islander peoples.
- Recognises Aboriginal and Torres Strait Islander peoples' ways of knowing, being, and doing in the context of history, culture, and diversity, and affirms and protects these factors through ongoing learning in health care practice.

Advocacy

- Actively advocates for the client with fellow health professionals and other services.

Table G2b. Revised Remote Area Nurse Model of Consultation. Domain 2: Critical Analysis.

	Critical Analysis 2.1 Culturally Safe Quality Care 2.2 Evidence-Based Ethical Practice 2.3 Technology Enabled Practice and Care

Culturally Safe Quality Care

- Explores client's experience of their illness, how it impacts them, and their therapeutic goals.
- Holistic, systematic, and comprehensive.
- Respects control over own life and encourages client to share in decision making.
- Builds client's self-reliance and health literacy.
- Involves family as appropriate.

Evidence-Based Ethical Practice

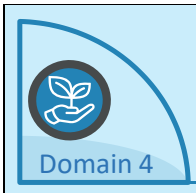
- Is guided by public health and primary health care principles.

Domain 2	Critical Analysis 2.1 Culturally Safe Quality Care 2.2 Evidence-Based Ethical Practice 2.3 Technology Enabled Practice and Care
• Considers local disease patterns, along with age/place/risk. • Considers chronic diseases, on-going health problems, and/or age-appropriate screening and preventative health care. • Recognises repeat presentations or an outbreak. • Use checklists, clinical references, and/or clinical decision support tools. **Technology Enabled Practice and Care** • Uses calibrated point of care testing and tele-imaging. • Uses telehealth to enhance diagnostics.	

Table G2c. Revised Remote Area Nurse Model of Consultation. Domain 3: Relationships, Partnerships and Collaboration.

Domain 3	Relationships, Partnerships & Collaboration 3.1 Effective Communication 3.2 Collaborative Holistic Care 3.3 Professional Practice
Effective Communication • Negotiates and explains history taking, investigations, and management plan options, including any factors impacting on care, such as transport, housing, and discusses findings. • Recognises the importance of a comprehensive health record. • Clinical summaries to nominated services and to 'My Health Record'. **Collaborative Holistic Care** • Recognises the importance of shared care. • Collaborates with colleagues, and health and other services. • Builds partnerships with Aboriginal and Torres Strait Islander health practitioners. • Coordinates complex care. • Responds to and activates recalls and follow-ups. • Documents comprehensively. **Professional Practice** • Uses at least three patient identifiers. • Utilises clinical leadership.	

Table G2d. Revised Remote Area Nurse Model of Consultation. Domain 4: Capability for Practice.



Capability for Practice
4.1 Care of Self and Others
4.2 Lifelong Learning
4.3 Accountability to Self and the Profession

Care of Self and Others

- Reflects on own and colleagues' wellbeing.
- Debriefs as appropriate.

Critical Thinking

- Demonstrates ability to critically think, analyse data, and utilise clinical reasoning.
- History (including past history) informs examination.
- Considers what is most likely, clinically significant conditions, and what you can't afford to miss.
- Rules in and out as required, including worst case scenario.
- Identifies red flags.
- Recognises risks and the deteriorating patient.

Avoid Diagnostic Errors

- Premature closure – once you think you have the answer you stop looking.
- Failure to consider all diagnostic possibilities.
- Affective error – personal feelings (positive or negative) about a patient affect clinical decisions.
- Focussing on the presenting complaint and ignoring other health issues.

Accountability to Self and the Profession

- Takes accountability for personal and professional actions and decisions.
- Seeks and responds to feedback to improve and develop professional capability for both self and colleagues.
- Reflects on each consult and what has been learnt and what could be improved.
- Actively works to enhance and promote multidisciplinary, rural generalist team.
- Is aware of scope of practice and own ceiling of competence.

Table G3. Revised model of remote area nursing consultation – Steps. Adapted from Lenthall et al. (2024b)

Steps
Open consultation **Before seeing client** • Review clinic records, note last visit and outstanding actions, and review past investigations. • Get more information if needed. • Ensure room is comfortable, well lit, and private. • Ensure appropriate equipment. • Consider own and client's safety. • Seeing client **If not an emergency** • Greet; establish rapport. • Note general impressions – appearance, speech, hearing, gait, posture, symmetry, tremors, odour, colour, skin, hands, mental state. • Observe interaction with others. • Check name, chart number, date of birth (DOB), next-of-kin, need three identifiers. • Use appropriate language. • If appropriate, offer interpreter, if necessary, involve family, or offer gendered health professional if available.
History **Reason for presentation** **Acute / chronic disease review / screening** • Story of why the client presented today. • Opening question "Why have you come in today?" Use silence appropriately. • Establish concerns and expectations. • OLDCARTS (onset, location, duration, aggravating / relieving factors, treatments, associated signs, and symptoms). • Explain what you are doing and/or thinking; why you need to ask more questions. • Listen actively, encourage openness, don't interrupt. • Ask if they been doing anything differently lately: travel, work, activities. • If you can't work it out – work backwards. "What were they doing, what did they eat or drink that morning, last night, yesterday?"
Current health status • Appetite, nausea, change in weight. • Sleep, energy, physical activity. • Smoking. alcohol, and/or other substance use – readiness to quit if indicated. • Urine, bowels, menstruation, sexual health. • Interest in life, emotional health and/or anxiety, self-harm. • Ask "Do you ever feel unsafe?" **Medicines** • Prescribed — what, when, how long, any problems. • Do they take medications as prescribed. • Do they take over the counter, herbal, traditional, or other people's medications? • Contraception (if appropriate).

Steps
Allergies • What happens when exposed, and how are allergies managed. **Immunisations** • Review status.
Clinical examination • Rapid Physical Assessment. • Screening tests as indicated, including BGL, Hb, BMI, waist circumference, U/A, pregnancy test, ECG, and other point-of-care tests. • Systematic assessment of relevant systems – LOOK, LISTEN, FEEL. • If client consents and timing appropriate, consider screening investigations as indicated by history, local epidemiology, and age/place/risk.

Assessment and discussion
Make an assessment of:
• Reason for presentation.
• Other health issues.
• Consider
  ○ Age/Place/Risk – What is this client at risk of, considering their age and setting?
  ○ What things are often missed and/or can't be missed?
  ○ What is most likely?
  ○ Consult best practice treatment manuals.
  ○ Seek further advice remote medical practitioner or more experienced team member.
  ○ Summarise and reflect findings with client.
  ○ Explore client's knowledge and clarify misunderstanding – use 'teach-back' method as appropriate.
  ○ Discuss long and short-term goals.
  ○ Assess and use opportunities for brief intervention and health promotion.

Negotiate management plan • Review best practice treatment manuals for management guidelines. • Discuss goals and/or priorities including immunisation, negotiate management including referrals with client and significant others as appropriate. • Confirm management plan is acceptable to client and family, including what to expect, and what to do if gets better or gets worse. • Advocate for client as appropriate with health and other services. • Consider context and environment in negotiating management plan. • Plan follow up and long-term management for identified risk factors, public health and/or preventive health issues and screening. • Ask if there are other questions, encourage, and reassure. • Agree on follow-up.
Close consultation • Check client's understanding and agreement of management plan. • Provide appropriate illustrated and/or written material.
Documentation • Be clear, legible, concise, contemporaneous, progressive, and accurate. • Include information about assessments, action taken, outcomes, reassessment processes (if necessary), risks, complications, and changes.

Steps
• Meet all necessary medico-legal requirements for documentation. • Update client record. • Enter information as appropriate into electronic system. • Follow the documentation style required by the organisation. • Refer as necessary for further investigations, support, and management. • Update recall system. • Make use of the Shared Electronic Health Record as appropriate and with consent.
Reflection • How did the consultation go? • What went well? • What could have been done better? • Identify own learning needs in relation to this condition and/or management, etc. • Consider your own self-care and other colleagues.

Learning Outcomes

Foundations of remote area nursing

- Define and describe:
    - cultural safety,
    - self-determination,
    - strength-based approach, and
    - decolonisation.
- Analyse the impact of history and colonisation on contemporary Indigenous health outcomes.
- Describe the role and importance of ACCHS' and of Aboriginal and Torres Strait Islander health professionals.
- Outline strategies for addressing racism in both practice and in the workplace.
- Analyse how one's own culture, values, attitudes, assumptions, and beliefs influence interactions with people, families, community, and colleagues.
- Analyse power differentials between clinicians and clients, First Nation peoples and health services. and the wider community.
- Describe the *United Nations Declaration on the Rights of Indigenous Peoples* and other human rights instruments and analyse how these support First Nation peoples in attaining equitable health outcomes.
- Identify strategies that would advocate for and act to facilitate access to quality and culturally safe health services for Aboriginal and Torres Strait Islander peoples.

- Interpret and apply the use of health promotion theory in communities with a PHC framework.
- Analyse the principles of PHC and describe how these may be implemented and further strengthened in remote Indigenous communities.
- Describe the significance of relationships and partnerships within small communities and teams, and outline strategies by which to facilitate these partnerships.
- Prepare a self-care plan, recognising culture shock, transition to practice, and the demands and stressors associated with working in a remote Indigenous community.
- Recognise and support colleagues experiencing culture shock, post-traumatic stress, vicarious trauma, occupational stress, and burnout.

Advanced clinical practice

- Identify one's own capabilities and skills, and develop a learning plan to practice as a remote area nurse.
- Provides support and guidance, where appropriate, to other health professionals in a constructive and positive manner.
- Assess and manage clinical presentations, following the RA nursing Model of Consultation.
- Identify and evaluate practice standards, policies, guidelines, and legislation for remote area nursing practice.
- Implement health promotion, health interventions and programs in partnership with the community using a strength-based approach.
- Manage chronic diseases and/or on-going health problems in partnership with individuals, families. and the community.
- Perform health checks on children, women, and men in partnership with individuals, family, the community, and the multidisciplinary team.
- Identify and implement effective communication strategies with individuals, family, the community, and other health professionals.
- Utilises and interprets available Point of Care (POC) testing.
- Identify and utilise strategies that promote and enable health literacy.
- Identify and utilise strategies by which to build sustainable relationships with individuals, families, and the community.
- Describe trauma-informed care and outline ways to incorporate principles into RA nursing practice.

Integrative themes

The following themes are integrated throughout the entire curriculum. They represent the core content areas that are important for RA nursing practice.

- **Cultural Safety** – The program integrates the development of the knowledge, skills, and attitudes required for RANs to practice in a culturally safe manner within a remote cross-cultural environment and with vulnerable populations.
- **Primary Health Care** – The curriculum is strongly embedded within a primary health care framework, which is based on the philosophy of equity and social justice.
- **Social and Cultural Determinants of Health** – The program addresses key determinants that influence health outcomes and are areas where nurses can intervene or advocate. These include early life experiences, social and economic disadvantage, exposure to stress, limited educational opportunities, and social exclusion—all of which contribute to the poorer health of Indigenous Australians (Schultz & Cairney, 2017; Verbunt et al., 2021; World Health Organization (WHO), 2023). The program also recognises the positive health impacts of connection to Country and participation in cultural practices (Schultz et al., 2018).
- **Reflective Practice** – Defined as 'active, purposeful thought applied to understand the meaning of that experience for the individual' (Carmel, 2006), reflective practice requires the critical appraisal of experiences, which results in increased knowledge and improved practice (Cadorette et al., 2023).
- **Evidence-based Decision-making** – Central to the program is the fostering of future leaders who can locate, access, develop, and use the available clinical and public health evidence, think critically, collaborate and undertake research in order to inform their practice.
- **Teamwork and Collaborative Practice** – The multidisciplinary nature of remote practice demands that RANs work effectively as part of a diverse team within their extended scope of practice, the nature of the community, the service, and their activities.
- **Strength-based Approach** – Recognising the resilience and strength of Aboriginal and Torres Strait Islander peoples, cultures, and communities, a strengths-based approach attempts to counter 'deficit discourse' where Aboriginal and Torres Strait Islander people are viewed in terms of deficiency, failure, or being problematic. It does not appropriately acknowledge the significant role broader social determinants and institutional racism have on health outcomes.
- **Aboriginal Health** – Participants of this program will predominately work in Aboriginal communities in the NT; therefore, a strong focus is applied to the health status and needs of Aboriginal peoples who also suffer a much greater burden of disease.

Underpinning principles

- **Responsive to Community and Industry** – The program was developed with considerable consultation with partnership with ACCHS' and industry stakeholders.
- **Needs-based** – The program was developed based on the needs, standards, and guidelines applicable to remote area nursing in the Northern Territory.
- **Increased Workforce Capacity** – The program was designed to increase the pipeline of nurses into remote area nursing.
- **Accessible and Flexible Delivery** – The program was designed to use a variety of innovative and flexible modes of delivery.
- **Application to Practice** – The program was designed to apply evidence and theory to the realities of RA nursing practice.

Delivery

Initial two-week workshop

The initial two-week face-to-face workshop aims to introduce participants to the foundations of remote area nursing and advanced clinical practice.

Foundations of remote area nursing

- Define and describe:
    - cultural safety,
    - self-determination,
    - strength-based approach,
    - decolonisation, and
    - the roles and importance ACCHS' and of Aboriginal and Torres Strait Islander health professionals.
- Analyse how one's own culture, values, attitudes, assumptions, and beliefs influence interactions with people, families, community, and colleagues
- Analyse the impact of history and colonisation on contemporary Aboriginal health outcomes.
- Outline strategies to address racism in practice and in the workplace.
- Analyse the principles of PHC, and describe how these may be implemented and further strengthened in remote Indigenous communities.

- Describe the significance of relationships and partnerships within small communities and teams, and outline strategies by which to facilitate these partnerships.
- Prepare a self-care plan, recognising culture shock, transition to practice, and the demands and stressors associated with working in a remote Indigenous community.

Advanced clinical practice

- Identify one's own capabilities and skills and develop a learning plan to practice as an RAN.
- Demonstrate the ability to perform health checks on children, women, and men in partnership with individuals, family, the community, and the multidisciplinary team.
- Identify and utilise strategies by which to build sustainable relationship with individuals, families, and the community.
- Describe trauma-informed care and outline ways to incorporate principles into RA nursing practice.

Weekly online tutorials

Participants in partnership with the remote educator will have one afternoon each week in which to undertake learning. Weekly tutorial resources are listed below.

NT Remote Locum Program eLearning modules

Available from NT Remote Locum Program (2024) – https://ntrlp.com.au/elearning-resources/elearning

- Anaemia Screening using Rad67
- Chronic conditions management
- Communication and education
- Continuous quality improvement in the NT
- Early sepsis recognition and management
- Introduction to Aboriginal and Torres Strait Islander health
- Introduction to Remote Area Nursing scope of practice
- Machado Joseph Disease (MJD) Foundation
- Major incident management
- Managing medical emergencies
- Managing scabies and crusted scabies
- Maternity
- Mental health
- Paediatrics
- Wound care and suturing in remote Indigenous communities

- Ear health
- Eye health and diabetes
- Oral health
- Primary eye care checks
- Trachoma
- Administration of Bicillin
- Introduction to Acute Rheumatic Fever (ARF) & Rheumatic Heart Disease (RHD)
- Sexual health in a primary health care setting
- Syphilis in remote Australian communities

Lung health in First Nations children

First Nations Children: Improving Outcomes Through Culturally Secure Care – the management of chronic wet cough, protracted bacterial bronchitis, and bronchiectasis training package (Lung Foundation, 2025) – https://lungfoundation.com.au/health-professionals/training-and-events/training/chronic-cough/

Menzies School of Health Research

Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare, as available from Menzies (2025) – https://www.menzies.edu.au/page/Resources/Ask_the_Specialist_Larrakia_Tiwi_and_Yol%C5%8Bu_stories_to_inspire_better_healthcare/

1. **Get to know your patient**

   "Is it ok to make eye contact?" is one of the most frequently asked questions about working with Aboriginal patients in the Northern Territory of Australia. In this first episode of *Ask the Specialist* you'll get practical tips on how to develop rapport with your patient, learn how to say 'hello' in the Tiwi language and get an answer to the eye contact question. Getting to know your patient is part of delivering good health care. The Specialists say that if you spend a little time getting to know your patient, patient outcomes will improve.

2. **Communicating with your patient**

   Communication is often called a soft science. The suggestion is communication is easy, but it's not. Not being able to communicate is stressful for you and your patient. Poor communication is one of the ways patients experience racism. Poor communication has led to patients dying. But the good news is, there are many things you can do to improve communication.

3. **Communicating with interpreters and your patient**

In the Northern Territory of Australia, there are about 75 thousand Indigenous people and about 100 Indigenous languages and dialects are spoken. So, unless you speak an Indigenous language, or many languages, communicating with patients through Indigenous interpreters seems like a good option to consider. Unfortunately, at Royal Darwin Hospital in 2020, only a small number of patients who needed an interpreter got one. Take a listen to how you can work with interpreters to improve patient outcomes.

4. **Patient centred care**

Host Stuart Yiwarr McGrath says when a health professional is talking to an Indigenous person, they automatically feel inferior. The Specialists have some suggestions about how to redress the power imbalance so you can deliver patient centred care. Plus, what to do when a patient needs to leave hospital for Sorry Business or other obligations.

5. **Informed consent**

As a health professional working in a hospital, gaining informed consent is critically important. Unfortunately, patients often sign the consent form without understanding the procedure and associated risks. In this podcast, Tiwi Elder Pirrawayingi Puruntatameri shares his own hospital experience and the Specialists share tips on how to ensure your patient is fully informed.

6. **Recognising and addressing racism**

"Hospitals aren't a place that people really want to be, but is it that unpleasant for people that it's a horrible sort of racist place? What's it like being a patient there?" In this podcast, the Specialists address doctors' questions about racism. For many Indigenous people, hospital has a lot of negative connotations and for some that means they will choose not to accept hospital treatment. The Specialists also talk about why Indigenous people don't like going to hospital and what you, as a health professional, can do to make patients feel safe.

7. **Perspectives on health and well-being**

Some Indigenous patients may have a different perspective on health compared to the Western biomedical approach which underpins mainstream healthcare delivery. A culturally safe health professional has an awareness of differing worldviews and also reflects on their own culture and how they can change. In the final episode in this series, you'll gain insights into Indigenous perspectives on health and sickness.

Study blocks

The program is designed to allow participants two-week study blocks, four times a year, to a total of eight weeks per year. This allows NGNs to attend short courses, have regular time outside the community, and concentrate on learning without the burden of working in the clinic.

Short courses

Understanding Vaccines and the National Immunisation Program

Understanding Vaccines and the National Immunisation Program is a HESA-accedited online program available from Immunisation Learning Courses (2025) – https://immunisationeducation.sahealth.sa.gov.au/course/details/national-immunisation-program

The program aims to equip health professionals with the knowledge and skills to competently deliver a high quality and safe immunisation service by:

- introducing the learner to immunisation as a public health measure in Australia and globally;
- explaining immunology principles of vaccination and vaccine types and components;
- discussing the epidemiology of vaccine preventable diseases and explaining the National Immunisation Program in Australia;
- explaining the legislation and ethics of immunisation practice; and
- providing the comprehensive requirements in which to provide a safe and effective immunisation service.

Pharmacotherapeutics for remote area nurses

Finders University, available from Pharmacotherapeutics for Remote Area Nurses – https://www.flinders.edu.au/study/short-courses/pharmacotherapeutics-for-remote-area-nurses

This online self-paced course provides nurses with the knowledge and skills to manage medicines safely in remote settings and advanced practice. The nurse will develop knowledge on essential aspects of pharmacology, therapeutics, and clinical decision making, including drug selection, dosing, administration, and monitoring, as tailored to the unique challenges of remote and Indigenous health. The course comprises eight modules that are structured to build on participant knowledge and experience.

Cultural responsiveness training

Offered by Indigenous Allied Health Australia, cultural responsiveness training is available at Cultural Responsiveness in Action Framework – Indigenous Allied Health Australia Cultural Responsiveness in Action

Framework – Indigenous Allied Health Australia – https://iaha.com.au/workforce-support/training-and-development/cultural-responsiveness-in-action-training/

This training focuses on action-orientated and strength-based outcomes. It is aimed at critical self-reflective practice identifying one's impact on another. Because of this structure, within the Framework the complete program has four main levels with a blend of online and face-to-face learning options. It is a highly interactive course that centres around three driving principles:

1. What do we need to know *(knowing)*;
2. Whom do we need to be *(being)*; and
3. How do we transform behaviours and systems to be culturally safe and responsive in meeting Aboriginal and Torres Strait Islander people's needs (doing).

Face-to-face short courses

Framing Indigenous Health

Framing Indigenous Health, as offered by Flinders University explores the social determinants of health, the cause-and-effect relationship of Australia's colonisation in relation to the poorer health outcomes experienced by Indigenous Australians. The course provides a foundation for developing a better understanding of practice in the remote health workforce, including the importance of self-care. Cultural safety and primary health care are presented as strategies towards improving Indigenous health outcomes through the provision of clinically sound and culturally respectful services and providers.

Remote Advanced Nursing Practice

The Remote Advanced Nursing Practice course offed by Flinders University develops foundational skills and knowledge for advanced nursing practice in remote areas. The Remote Area Nurse Model of Consultation is the basis for clinical reasoning and assessment, clinical communication, and collaborative practice. Standard treatment manuals are used to guide evidence-based practice.

Table G4. Clinical skills booklet.

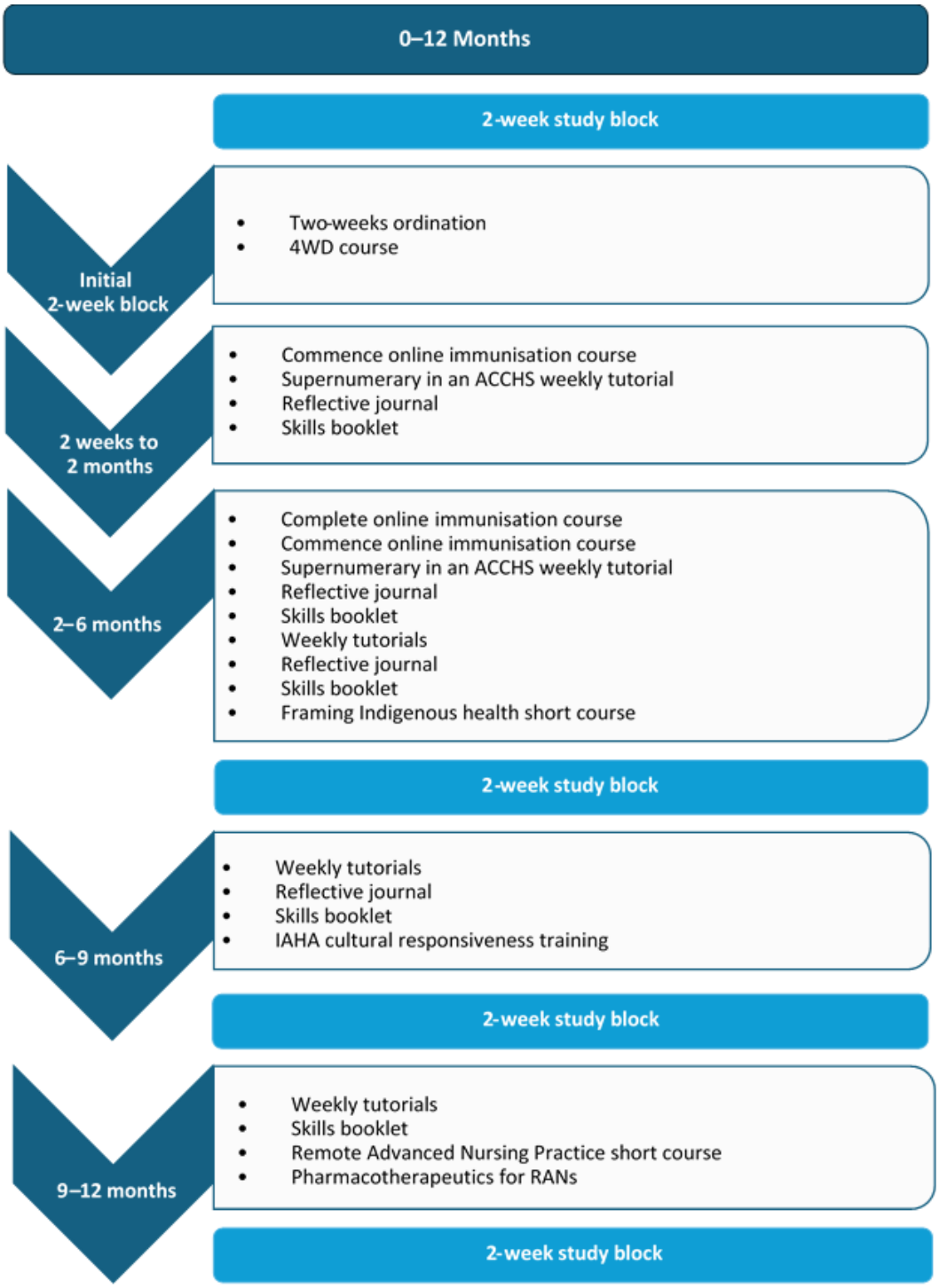
Topic	Skill
CARPA standard treatment manual and clinical procedures manual review sections	REWS / Clinical observations Medicines dosage table Rheumatic heart disease, acute rheumatic fever & giving BLA Anaemia Chest pain presentation Abdominal pain presentation Z-Track injection, IM injection Anaphylaxis Scabies and skin sores Asthma
Registered nurse (RN) skills refresher	ECG Wound care/dressings Z-Track injection, IM injection
Remote area nursing skills	Administer BLA Ferinject iron infusion Venepuncture IV cannula Urinary catheter insertion Suturing Spirometry Nasogastric tube insertion Respond to call-outs Calculate REWS De-escalating a violent patient and/or family
Indigenous adult health check 15 years – Item 715	Preform a comprehensive Adult Health check as per Item 715, including: • Social and medical history • Immunisation status • Full set vital signs, weight, height • Screening assessment – visual acuity, ears, dental • STI screening • SNAP questionnaire • Calculate cardiovascular risk
Aboriginal Indigenous over 55 years health check	Perform a comprehensive over 55's Aboriginal and Torres Strait Islander health check, including: • Gaining informed consent • Comprehensive social, family, and medical history • Immunisation status • SNAPE assessment • Mental health assessment • Continence assessment • Cardiovascular risk assessment/score • Activities of daily living questionnaire • Cognition assessment • Physical assessment including foot pulses and sensation, vital signs, visual acuity, urinalysis

Topic	Skill
	• Pathology/investigations • Intervention/action, health education and advice
Child Health Check	Perform a child health assessment including: • Childhood Immunisations • Child ear and throat examination • Measure and chart height, weight, and head circumference • Measure haemoglobin and manage childhood anaemia as per CARPA
Immunisation	• Perform adult Immunisation • Perform child immunisation
Point of care testing	Perform point of care testing including • INR PoCT • Hb PoCT • Syphilis PoCT • HbA1c PoCT/QAAMS • HemoCue Hb PoCT
Communicare	Management of recalls Review and access care plans
Remote Area Nursing Model of Consultation	Perform a comprehensive assessment and manage non-emergency presentations including assessments and management of the following the Remote Area Nursing Model of Consultation • Ear • Eye • Respiratory system • Cardiovascular system • Gastrointestinal and Genitourinary system • Musculoskeletal • Nervous (mini-neuro) • Mental status examination • Mental health risk assessment

Graduate Certification

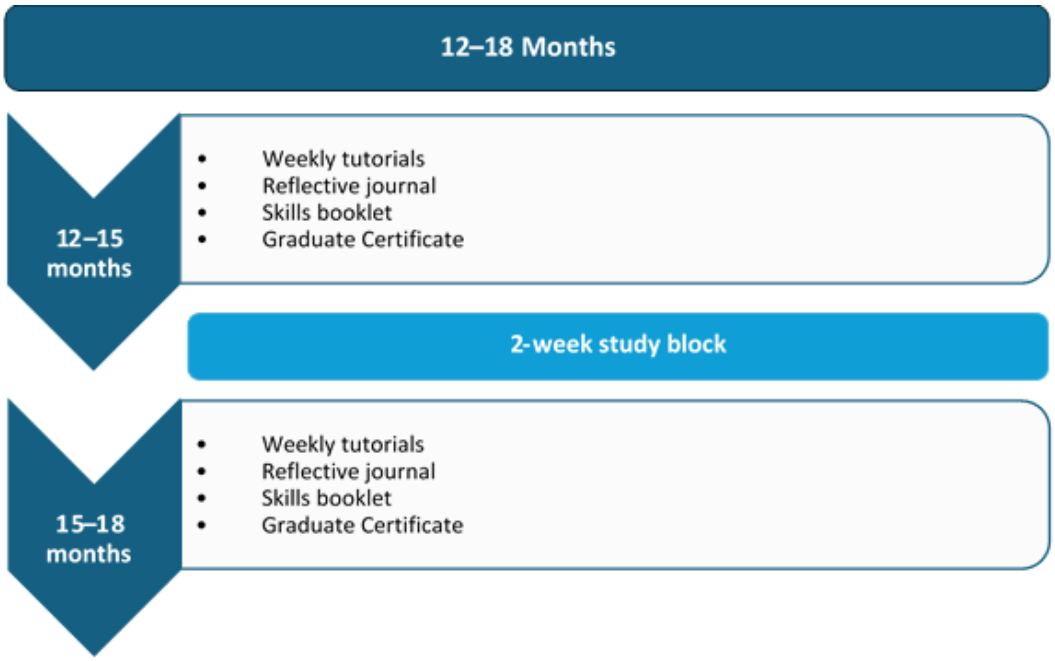
In the second year of the program, participants will have the opportunity to undertake an appropriate Graduate Certificate through a scholarship.

Figure G3. Program timeline– Year 1.



4WD: Four-wheel drive; ACCHS: Aboriginal Community Controlled Health Services; IAHA: Indigenous Allied Health Australia; RAN: Remote Area Nurses.

Figure G4. Program timeline – Year 2.



Glossary

Adapted from Office of the National Rural Health Commissioner (2023).

Term	Definition
Clinical courage	Describes when rural and remote clinicians practice beyond their usual scope in isolated and resource poor contexts, in order to meet patient and community healthcare needs (Dunlop & MacLellan, 2011; Konkin et al., 2020; Wootton, 2011).
Co-design	The practice of designing solutions collaboratively with people or communities impacted by a problem. It can bring consumers, carers, families, and health workers together to improve services. It seeks to create an equal and reciprocal relationship between stakeholders, allowing them to design and deliver services in partnership with each other (New South Wales Government Agency for Clinical Innovation, 2021).
Collegial generosity	Mutual trust and respect in professional relationships, as recognised in the *Registered Nurse Standards for Practice* (NMBA, 2017).
Comprehensive primary health care	Healthcare that provides medical, nursing, and allied health services from prevention to treatment, that factors equity of access, community empowerment and participation in services (Hurley et al., 2010). It can also incorporate services beyond individual treatment to a population health focus.
Cultural humility	Cultural humility involves a lifelong process of critical self-reflection, redressing power imbalances, mutually beneficial partnerships, and advocating on institutional accountability (Tervalon & Murray-Garcia, 1998).
Cultural respect	Cultural respect is defined as the recognition, protection, and continued advancement of the inherent rights, cultures, and traditions of Aboriginal and Torres Strait Islander people (AHMAC, 2016).
Cultural safety	Cultural safety centres on the attitudes and behaviour of the nurse, while, for the patient, cultural safety is a mechanism that allows the recipient of care to say whether or not the service is safe for them to approach and use (Ramsden, 2002). The Nursing and Midwifery Board of Australia (NMBA) and Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) joint statement on culturally safe care (NMBA, 2018) recognises racial discrimination has been well documented as a contributing factor to poor health outcomes for Aboriginal and Torres Strait Islander Australians. The NMBA *Code of Conduct for Nurses* (NMBA, 2023) and the *Registered Nurse Standards for Practice* (NMBA, 2017) advocate for culturally safe and respectful practice, and require nurses to have knowledge of how their own culture, values, attitudes, assumptions, and beliefs influence their interactions with people and families, the community, and colleagues.

Term	Definition
	The CATSINaM-supported NMBA *Code of Conduct for Nurses* (NMBA, 2023) defines nurses' cultural safety requirements, wherein: • nurses need to acknowledge Australia has always been a culturally and linguistically diverse nation; that Aboriginal and Torres Strait Islander people have inhabited and cared for the land as the First Peoples of Australia for millennia, and that their histories and cultures have uniquely shaped our nation. • nurses must understand and acknowledge the historic factors that help to inform care, such as colonisation and its impact on Aboriginal and Torres Strait Islander peoples' health. In particular, Aboriginal and Torres Strait Islander people bear the burden of gross social, cultural and health inequality. • clear guidance and set expectations must be provided for nurses and midwives in supporting the health of Aboriginal and Torres Strait Islander peoples.
Data sovereignty	Data sovereignty refers to a jurisdiction's control or legal authority asserted over data because its physical location is in jurisdictional boundaries. Data sovereignty is essential for data security (Macquarie Government, 2025).
First Nations Australians, Aboriginal and Torres Strait Islander peoples, Indigenous	Used interchangeably to refer to a collective of individual people from different Aboriginal and Torres Strait Islander Nations across Australia.
Full scope of practice	Refers to Registered Nurses regularly practicing to the full extent of their knowledge and skill, and which factors an individual's context in which they practice, level of competence, and the health needs of the community (CRANA*plus*, 2018; Halcomb & Ashley, 2019).
Holistic care	A system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person; their response to illness; and the effect of the illness on the ability to meet self-care needs. Holistic nursing is the modern nursing practice that expresses this philosophy of care (O'Toole, 2022, p. 2582).
Health literacy	An individual's ability to read, understand and use healthcare information (DHAC, 2022a, p. 56).
Health inequities	Health inequities are avoidable inequalities in health between groups of people within countries and between countries. These inequities arise from inequalities within and between societies. Social and economic conditions and their effects on people's lives determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs (WHO, 2013).

Term	Definition	
Modified Monash Model classifications (DHDA, 2025)	**Modified Monash category (MM)**	**Inclusions**
	MM 1	Metropolitan areas: Major cities accounting for 70% of Australia's population. All areas categorised Australian Statistical Geography Standard - Remoteness Area (ASGS-RA) 1.
	MM 2	Regional centres: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are in, or within 20 km road distance, of a town with a population greater than 50,000.
	MM 3	Large rural towns: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM2 and are in, or within 15 km road distance, of a town with a population between 15,000 and 50,000.
	MM 4	Medium rural towns: Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM2 or MM3 and are in, or within 10 km road distance, of a town with a population between 5,000 and 15,000.
	MM 5	Small rural towns: All other areas in ASGS-RA 2 and ASGS-RA 3.
	MM 6	Remote communities: All areas categorised ASGS-RA 4 and islands that are separated from the mainland in the Australian Bureau of Statistics (ABS) geography and are less than 5 km offshore. Islands that have an MM5 classification with a population of less than 1,000 without bridges to the mainland (2019 Modified Monash Model classification only).
	MM 7	Very remote communities: All other areas that are categorised ASGS-RA 5 and populated islands separated from the mainland in the ABS geography that are more than 5 km offshore.
Multidisciplinary	When professionals from a range of disciplines work together to meet as many of the patient's needs as possible. Multidisciplinary care can be delivered by a range of healthcare professionals functioning as a team under one organisation umbrella, or by professionals from a range of organisations, brought together as a unique team. As a patient's condition changes over time, the composition of the team may change to reflect the changing clinical and psycho-social needs of the patient (Mitchell et al., 2008). In the context of rural and remote nursing practice, a multidisciplinary team can include healthcare professionals and workers such as nurses, medical practitioners, midwives, allied health professionals, Aboriginal and Torres Strait Islander health workers and practitioners, all working collaboratively to address patient needs. This may also include non-clinical staff within the multidisciplinary team.	

Term	Definition
Person-centred care or interventions	Practice that follows the principle of incorporating the person's (patient's) perspective that can mean care is patient-directed because they are sufficiently and appropriately informed to self-determine their care and level of engagement (Santana et al., 2017).
Place-based approach	In a place-based approach, the characteristics of the community and location are brought together in an integrated 'person and place' approach that focuses on outcomes for people. In this context, the community and its needs are at the centre of any development. Involving community in planning, selecting, designing, and governing their physical and social infrastructure can be just as important as the facilities and services themselves (DHAC, 2022b, p. 106).
Reflection	The NMBA's *Registered Nurse Standards for Practice* (NMBA, 2017) states that Registered Nurses develop practice through reflection on experiences, knowledge, actions, feelings, and beliefs in order to identify how these shape practice. Reflection in nursing is a learning strategy, and formal process to help nurses and nursing students develop crucial skills and competencies in clinical practice settings (Scheel et al., 2021).
Reflexivity	An action and skill of being attentive to the self in relation to others; that is, how our ways of knowing, being, and doing shape our interpretation of and behaviour towards people (Pillow, 2003; Wilson, 2014). Reflexivity is also defined, conceptualised, and operationalised in a varied way across and in fields and disciplines (Dawson et al., 2022, p. 2). Critical reflexivity is also recognised as a skill with which to engage in culturally safe practice to improve healthcare delivery for First Nations Australians (Dawson et al., 2022, p. 2).
Rural health workforce support activity	The Rural Health Workforce Support Activity (RHWSA) program aims to meet current and future regional, rural, and remote community health workforce needs through workforce planning. The activity aims to: • improve access to essential primary health care for those living in rural and remote areas, • build the capability of local health workforce to ensure communities can access the right health professional at the right time, and • grow the sustainability of the rural health workforce, strengthening long-term access to qualified health professionals
Social determinants of health	The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at the global, national, and local levels (DHAC, 2022b, p. 107).

Term	Definition
Strengths-based approach or intervention	A strengths-based approach that views situations realistically and looks for opportunities to complement and support existing strengths and capacities, as opposed to a deficit-based approach that focuses on the problem or concern (DHAC, 2022b, p. 107).
Trauma-informed care or interventions	Actions by health and social service providers, based on psychosocial empowerment principles that recognise the impact of trauma to facilitate both physical and psychosocial healing in a safe, collaborative fashion (O'Toole, 2022, p. 5439).

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Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix H.

Establishment of a University Department of Rural Health

Charles Darwin University

December 2023

Establishment of a Charles Darwin University Northern Territory University Department of Rural Health

Introduction

The Australian Government Department of Health and Aged Care convened the Northern Territory (NT) Primary Health Care Workforce Summit in August 2023, following the second Charles Darwin University (CDU) Health Workforce Symposium (March 2023). Both forums discussed the urgent need for solutions to the NT health, disability, and aged care workforce crisis and prompted CDU to formulate a high-level proposal for the establishment of a new NT-based University Department of Rural Health (UDRH).

Building on existing collaborations, expertise, and successful case studies—in particular the James Cook University Murtupuni Centre for Rural and Remote Health—the UDRH would provide infrastructure and academic and/or support networks, by which to deliver an innovative, NT-led, rural, and remote on-Country health education and training model. This model would support the growth of aspiration and the enabling of community members to work in primary care roles. Following discussions about this initiative with Aboriginal Medical Services Alliance NT (AMSANT), CDU is in the process of planning and conducting further consultation with our NT Aboriginal Community Controlled Health Organisation partners.

Purpose

The new UDRH would support the establishment of a distributed model of on-Country health education and training from four centres in MM6 and MM7 locations.[1] These locations could, for example, be Katherine, Alice Springs Tennant Creek, Nhulunbuy, Jabiru, on the Tiwi Islands, or elsewhere in the NT, where there is some opportunity to leverage existing CDU activity and infrastructure as well as a potential student cohort. Established concurrently, and in partnerships, the centres would have a clear mission to improve access to people in these regions, health education pathways, nursing, and allied health programs. The co-design of the UDRH, by which to ensure the cultural appropriateness and geographical identity of the regions within which it will operate, will be a priority.

The aim of this proposal is to contribute to a solution to the ongoing and chronic workforce shortages in remote Indigenous communities in the Northern Territory.

[1] The Modified Monash Model (MMM) is how we define whether a location is metropolitan, rural, remote or very remote. MM6- remote communities, MM7 very remote communities. Modified Monash Model | Australian Government Department of Health, Disability and Ageing

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Approach

Through co-design of appropriately funded, and well-supported on-Country education and training, the UDRH centres will deliver a pipeline of health students by which to grow the local workforce. The education and training programs will learn from, and build upon, many successful case studies—as show-cased at the CDU Symposia in March 2023—and will be evidence-informed.

It is proposed that the UDRH will:

- Make joint leadership appointments at each centre, with partners in the Aboriginal Community Controlled Health sector, in order to drive strong connections and ensure the delivered education and training will meet local health and aged care service delivery needs.
- Leverage (where possible) existing CDU infrastructure and resources and undertake the refurbishment of and/or the construction of new student accommodation at the UDRH centres, where required. Accommodation and associated support will be provided free of charge for all the centres' First Nations students.
- Enable the expansion of CDU's 'First Nations Introduction to University (Health)' program, bridging courses in academic literacy and key science subjects in an on-Country residential approach. This program provides pathways into further tertiary education, including nursing and allied health, as determined by, and tailored to, each student.
- Address the educational disadvantage experienced by many First Nations students, particularly those from remote or very remote NT, through the provision of the wrap-around support that it is widely recognised as required: safe and accessible accommodation close to community, tutoring, mentoring, and flexible approaches to learning, teaching and assessment.
- Utilise training and education that recognises and builds on existing strengths such as language and cultural knowledge, offers alternative selection processes and recognition of prior learning, and embeds First Nations ways of knowing, being, and doing in health and education training curricula.
- Learn from previous effective programs in order to guide future planning in regional and remote health and education programs, including navigation into courses and pathways, offering adult English literacy classes and financial support to enable study, delivering courses to First Nations students in their home communities and on-Country, and ongoing engagement with and ownership by local communities.

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- Grow the existing strong partnerships between leaders in healthcare, government, education, Aboriginal Community Controlled Health Organisations (ACCHO), and the private sector in order to grow unique health education, training, and employment opportunities on-Country.
- Prioritise and provide adaptive funding support to First Nations students in health disciplines who wish to undertake regional and remote clinical placements, including accommodation, scholarships, and flights.

Proposed Timeline of Key Activities

Year 0. Stakeholder consultation: the co-design of programs and confirmation of centre locations, developing leadership and staffing requirements, and customising the approaches of each centre.

Year 1. The refurbishment and/or construction of infrastructure, establishment of resources, and delivery of the first residential First Nations health pathway program.

Year 2. The delivery of health education and training programs as determined by each centre. Review, evaluate and refine.

Year 3. The delivery of health education and training programs as determined by each centre. Review, evaluate and refine.

Next Steps

CDU's 'Better Health Futures' Symposium and the subsequent Primary Health Care Workforce Summit brought together key organisations in the NT health services, health research and health education sectors, ACCHOs, and peak bodies. Evidence-informed solutions and opportunities for collaboration to address the NT health workforce crisis were shared, discussed, and solutions were offered to the immediate and long-term health workforce needs of the NT. These included investing in First Nations pathway programs and developing strong place-based workforce partnerships across health and education in order to deliver a sustainable and culturally-safe health workforce supported by flexible funding arrangements and adaptive training solutions.

CDU has developed this UDRH paper as an initial high-level proposal for the Australian Government by way of a follow up to the Primary Health Care Workforce Summit and to offer an NT-led potential solution in order to contribute to addressing the chronic health workforce shortage in the NT.

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Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix I.

Estimated Cost of Graduate Nurse Program Expansion

Table I1. Estimated cost of the Graduate Nurse Program Expansion (GNPE).

		Year 1 (0–12 Months)			Year 2 (12–18 Months)		
Cost Category	*Item*	*Cost per NGNs (N2)*	*Cost x 6 NGNs (N2)*	*Cost x 12 NGNs (N2)*	*Cost per NGNs (N3)*	*Cost x 6 NGNs (N3)*	*Cost x 12 NGNs (N3)*
Marketing and Recruitment							
		$4,000	$24,000	$48,000	-	-	-
Salaries							
	Program Coordinator*	$25,000	$150,000	$150,000	$12,500	$75,000	$75,000
	NGN Salary	$76,035	$456,210	$912,420	$53,968	$323,808	$647,616
	Oncosts (25%)	$19,009	$114,053	$228,105	$13,492	$80,952	$161,904
	Remote Educator Salary and Oncosts (25%) *	$25,000	$150,000	$300,000	$12,500	$75,000	$150,000
Accommodation							
	Orientation (14 nights at $120 per night)	$1,680	$10,080	$20,160	-	-	-
	Study Blocks ($120 per night)	$3,600 (10 nights x 3)	$21,600	$43,200	$1,200 (10 nights)	$7,200	$14,400
	Relocation costs	$4,000	$24,000	$48,000			
Travel							
	Travel allowance ($3,000 per return-to-homebase trip)	$6,000	$36,000	$72,000	$3,000	$18,000	$36,000
	Travel to short courses	$6,000	$36,000	$72,000	$3,000	$18,000	$36,000
Short Courses							
	4WD Driving Course (2 days)	$440	$2,640	$5,280	-	-	-
	Immunisation Course	$385	$2,310	$4,620	-	-	-
	Framing Indigenous Health Course	$1037	$6,222	$12,444	-	-	-
	Advanced Remote Nursing Practice	$1037	$6,222	$12,444	-	-	-

		Year 1 (0–12 Months)			Year 2 (12–18 Months)		
Cost Category	*Item*	*Cost per NGNs (N2)*	*Cost x 6 NGNs (N2)*	*Cost x 12 NGNs (N2)*	*Cost per NGNs (N3)*	*Cost x 6 NGNs (N3)*	*Cost x 12 NGNs (N3)*
	Pharmacotherapeutics for RANs	$650	$3,900	$7,800	-	-	-
	Remote Emergency Care (REC)	$900	$5,400	$10,800	-	-	-
	Maternity Emergency Care (MEC)	$900	$5,400	$10,800	-	-	-
	IAHA Cultural Responsiveness (Stage 1–3)	$770	$4,620	$9,240	-	-	-
Graduate Certificate Scholarship							
	Scholarship	-	-	-	$4,400	$26,400	$52,800
Retention							
	Completion Bonus	-	-	-	$10,000	$60,000	$120,000
Total		**$176,443**	**1,058,657**	**$1,967,313**	**$114,060**	**$684,360**	**$1,293,720**
Total *if program coordinator and remote educators are externally funded*		***$126,443***	***$758,657***	***$1,517,313***	***$89,060***	***$534,360***	***$1,068,720***

Remote educator salary has been calculated as for a N4 position, salary $120,114 annually, plus 25% $30,0284, rounded to $150,000

WD: Four-wheel drive; IAHA: Indigenous Allied Health Australia; N2: Level 2 of the Northern Territory (NT) nursing career structure – Registered Nurses; N3: Level 3 of the NT nursing career structure – Clinical Nurses or Clinical Midwives; NGN: New Graduate Nurse; RAN: Remote Area Nurse.

Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix J.

New Graduate Nurse Experience Survey

Adapted from Casey-Fink Graduate Nurse Experience Survey© (revised 2023)

Kathy Casey, PhD, RN, NPD-BC and Regina Fink, PhD, APRN, AOCN, CHPN, FAAN

It is suggested that New Graduate Nurses complete this survey every three months in order to provide information on their progress. This survey should inform their learning plan. Results of the survey will also identify areas where the program can be improved.

New Graduate Nurse Experience Survey

Section I – Role Transition Experience

The following questions are about your experience as you transition into the professional nursing role. All responses are anonymous and will be kept confidential. Please select the response that best describes your recent clinical experience.

		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	I am confident prioritising patient care needs.				
2.	I feel confident delegating tasks to others.				
3.	I am comfortable making suggestions to the doctor / senior clinician about changes to the plan of care.				
4.	I feel confident communicating with doctors, allied health professionals, Aboriginal Health Practitioners, and other providers.				
5.	I feel confident using best evidence when making clinical decisions.				
6.	I feel confident communicating a plan of care with patients, families, and caregivers.				
7.	I have confidence in my clinical decision-making skills.				
8.	I can accurately recognise changes in my patient's condition.				
9.	I can complete my patient care assignment on time.				
10.	I feel confident managing my patient workload.				
11.	I can organise my time effectively in order to complete my patient care tasks.				
12.	I can prioritise competing tasks during my shift.				
13.	I feel supported by my peers.				
14.	I feel comfortable asking for help from other nurses on my team.				
15.	Co-workers are available to help me during new situations and procedures.				
16.	I feel supported by the nurses in my clinical practice area.				
17.	My team works well together during stressful shifts.				

		Strongly Disagree	Disagree	Agree	Strongly Agree
18.	I feel safe asking my co-workers questions.				
19.	I am satisfied with the clinical practice area I am currently working in.				
20.	I feel valued for the work I do.				
21.	My team debriefs after difficult clinical situations.				
22.	I have resources at my work to help me manage my stress.				
23.	I am satisfied with my current role in nursing.				
24.	I feel that I am a valued member of the health care team.				
25.	I feel included in my clinical practice area.				
26.	I would recommend nursing as a career to a friend.				
27.	I consistently feel overwhelmed by my workload.				
28.	I consistently feel high levels of stress while at work.				
29.	I feel exhausted at the end of my shift.				
30.	I am experiencing stress in my personal life that is affecting my work.				
31.	I feel overwhelmed by the patient acuity in my clinical practice area.				
32.	I feel stressed because of my workload.				
33.	I feel comfortable if I need to handle bullying from others.				
34.	I feel comfortable managing incivility from co-workers if / when it occurs.				
35.	I feel confident handling stressful situations on my own.				
36.	I tend to bounce back quickly after difficult clinical situations.				
37.	When faced with difficult tasks, I am certain that I will accomplish them.				
38.	Even when things are tough, I believe that I can perform my role quite well.				
39.	I feel a strong commitment to stay at this organisation.				
40.	This organisation's values align with my professional values.				
41.	I am likely to be working at this organisation in one year.				

Preceptorship or Supervisor

Please select the response that best describes your recent clinical experience.

		Strongly Disagree	Disagree	Agree	Strongly Agree
42.	My preceptor provides feedback about my work performance.				
43.	My preceptor helps me to develop confidence in my practice.				
44.	My preceptor guides my ability to make clinical decisions.				
45.	My preceptor helps me learn from my mistakes.				
46.	My preceptor helps me become familiar with my clinical practice area routines / policies.				
47.	My preceptor helps me integrate into my clinical practice area.				
48.	My preceptor engages me in critical thinking opportunities.				

Section II – Learning Needs Assessment of Skills

Please rate your confidence in doing these **skills** using the following scale:

		Not Confident	Somewhat Confident	Highly Confident	Not relevant to my practice area
1.	Utilising Remote Primary Health Manuals				
2.	Performing an ECG (electrocardiogram)				
3.	Wound care/dressings				
4.	Administering a Z-track injection				
5.	Administering an IM injection				
6.	Performing a Blood Glucose Level				
7.	Administering a Ferinject iron infusion				
8.	Performing venepuncture				
9.	IV (intravenous) cannula insertion				
10.	Urinary catheter insertion				
11.	Performing suturing				
12.	Spirometry				
13.	Nasogastric tube insertion				
14.	Responding to call-outs				
15.	Calculate remote early warning scores (REWS)				

		Not Confident	Somewhat Confident	Highly Confident	Not relevant to my practice area
16.	De-escalating a violent patient / family				
17.	Preforming a comprehensive adult health check as per Item 715				
18.	Performing a comprehensive over-55's Aboriginal and Torres Strait Islander Health Check				
19.	Performing a child health assessment				
20.	Performing adult Immunisation				
21.	Performing child immunisation				
22.	Performing international normalized ratio (INR) Point-of-care testing (PoCT)				
23.	Performing hemoglobin (Hb) PoCT				
24.	Performing Syphilis PoCT				
25.	Performing a hemoglobin A1C (HbA1c) PoCT / QAAMS (Quality Assurance for Aboriginal and Torres Strait Islander Medical Services)				
26.	Performing a HemoCue Hb PoCT				
27.	Managing recalls through Communicare				
28.	Reviewing and accessing care plans through Communicare				
29.	Medicare billing				
Performing a comprehensive assessment and managing non-emergency presentations following the Remote Area Nursing Model of Consultation with the following systems					
30.	Ear				
31.	Eye				
32.	Respiratory system				
33.	Cardiovascular system				
34.	Gastrointestinal and genitourinary systems				
35.	Musculoskeletal				
36.	Nervous (mini-neuro)				
37.	Mental status examination				
38.	Mental health risk assessment				

Section III - Demographics

Please complete the response that represents the most accurate description of your individual professional profile.

1. **Age**

   a. 20–24 years
   b. 25–29 years
   c. 30–34 years
   d. 35–39 years
   e. 40–44 years
   f. 45–49 years
   g. 50–54 years
   h. 55–59 years
   i. 60–64 years
   j. ≥ 65 years

2. **Gender**

   a. Female
   b. Male
   c. Non-binary, transgender, or gender fluid
   d. Other (please specify) _____

3. **Race/Ethnicity**

(select what **best** matches your own identity)**:**

   a. Aboriginal
   b. Torres Strait Islander
   c. Aboriginal and Torres Strait Islander
   d. Non-Indigenous

4. **Select your current practice setting**

   a. Very remote Aboriginal Community-Controlled primary health care clinic
   b. Town-based primary health care clinic, including Katherine, Darwin, and Tennant Creek
   c. Regional Hospital

5. Previous health care experience

a. None

b. Enrolled nurse

c. Other (please specify) _____

6. When are you completing this survey?

a. At the beginning of the program

b. After the 2-week orientation block

c. At 3 months

d. At 6 months

e. At 9 months

f. At 1 year

g. At 15 months

h. At 18 months

i. At 21 months

j. At 2 years

7. Please share any comments or suggestions you have about the program

Scoring Instructions for the Casey-Fink Graduate Nurse Experience Survey© (revised 2023)

Section I – Role Transition Experience

Compute the mean score for each sub-scale based on its items. For each skill, scores are assigned to each confidence level as follows:

1 Strongly disagree	2 Disagree	3 Agree	4 Strongly agree

Subscales		Mean Score (Range: 1–4)
Role Confidence (8 items):	1, 2, 3, 4, 5, 6, 7, 8	
Manage Patient Care (4 items):	9, 10, 11, 12	
Support (6 items):	13, 14, 15, 16, 17, 18	
Role Satisfaction (8 items):	19, 20, 21, 22, 23, 24, 25, 26	
Stress and Burnout* (6 items):	27, 28, 29, 30, 31, 32	
Resilience (6 items):	33, 34, 35, 36, 37, 38	
Organisational Commitment (3 items):	39, 40, 41	

* The Stress and Burnout subscale represents a negative construct, where lower mean scores represent lower levels of stress and burnout, and higher mean scores represent higher levels of stress and burnout.

Preceptorship

Compute the mean score for the Preceptorship subscale based on its items. Scores are assigned to each confidence level as follows:

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree	N/A Not applicable

Subscale		Mean Score* (Range: 1–4)
Preceptorship (7 items):	42, 43, 44, 45, 46, 47, 48	

* Do not include the N/A category in the mean calculation. Higher mean score represents receiving higher levels of preceptorship during unit orientation.

Section II – Learning Needs Assessment of Skills

Compute the mean score for the subscale based on its items. For each skill, scores are assigned to each confidence level as follows:

0 Not confident	1 Somewhat confident	2 Highly confident	N/A Not relevant

Subscale	Mean Score* (Range: 0–2)
Skills (38 items)	

* Do not include the N/A category in the mean calculation. Higher mean score represents higher levels of confidence in performing these skills.

Graduate Nurse Program Expansion: Scoping & Co-Design Project for Aboriginal Community Controlled Health Services

Appendix K.

An Indicative Evaluation Plan for New Graduate Nurse Program for Remote Aboriginal Community Controlled Health Services

Aim

Evaluate program effectiveness.

Objectives

The following objectives will help determine whether the program effectively prepares new graduate nurses for a successful transition into professional practice, as well as supporting retention, and enhancing patient care quality.

The objectives will measure and evaluate the following.

- Support for transition to practice.
- Skill competency and preparedness.
- Impact on retention and turnover rates.
- Cost-benefit and resource utilisation.

Support for transition to practice

- Measure how well the program facilitates the transition of new graduate nurses from students to practicing Remote Area Nurses.
- Evaluate the support systems in place, such as mentorship and preceptorship, and their effectiveness.
- Assess the new graduate nurses' confidence, stress levels, and job satisfaction as they transition into practice.

Skill competency and preparedness

- Measure the new graduate nurses' competency in the critical skills required for patient care.
- Assess the clinical knowledge, technical skills, decision-making abilities, and critical thinking skills of the new nurses'.
- Determine how prepared the new graduate nurses feel for independent practice by the program's end.

Impact on retention and turnover rates

- Compare the retention rates of the new graduates who complete the program versus those who do not.
- Evaluate turnover rates and reasons for turnover within the first year of practice.
- Identify factors that contribute to program completion and job satisfaction.

Feedback and satisfaction of participants

- Collect feedback from program participants on their satisfaction with the program.
- Analyse the relevance and quality of the training materials and methods.
- Assess perceptions of support, workload balance, and overall program value.
- Use feedback to identify areas for improvement and understand participant needs.

Impact on patient care quality and safety

- Assess any improvements in patient care quality and safety metrics, as attributable to program graduates.
- Evaluate specific quality indicators, such as incident reports, patient feedback, and adherence to best practices.
- Identify how the program contributes to building a workforce skilled in delivering safe, high-quality care.

Cost-benefit and resource utilisation

- Analyse the program's cost-effectiveness and resource allocation.
- Evaluate the balance between program costs (e.g. instructor time, training resources) and benefits (e.g. reduced turnover costs, improved patient outcomes).
- Identify opportunities to optimise resource use and make the program more sustainable.

Alignment of program content

- Determine the alignment of program content with nursing competencies and organisational needs.