**Appendix.** Interview quotes

| Themes | Sub-theme | Enablers | Inhibitors | Participant suggestions |
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| COMMUNITY NURSING PERCEPTIONS | Broad perceptions | …very much focused on looking at the person, looking at the individual, and questioning. (CP1) | I guess it's in other organisations that don't understand what you do, so they don't also appreciate that you have transferable skills. CP1<br>You get treated like dirt from your hospital colleagues. CP1<br>[Community nursing] it's an area that has been neglected… that the primary health focus and primary care focus, there hasn't been enough to prevent that high cost hospitalisation… we're still putting the cart before the horse… and it still needs a lot more resources and light shone on it, to get real outcomes for people… it's always in the sickness mode, not in the preventative mode… people quickly escalate onto the next stage of their disease if we're not focusing at the right end. (CP2) | |
| PRE-ENTRY<br>*No pre-entry participants* | Personal Self | [Reflecting on own clinical placement as undergrad student] I really thoroughly enjoyed my work in the [specialty area] field when I was doing my grad nurse, which was a different role. (CP7) | | I think all student nurses should have the opportunity that they should have to complete, I don't know, eight to twelve weeks of community health nursing in their training to get that idea, but I think it would be good to have, like, a specialist training program just for community nursing, because it is so very different to hospital nursing. (CP6) |
| | Professional Self | I got awesome placements. I got to do a lot of district nursing … That prepared me for community and I think the training overall prepared me. (CP1)<br>I wanted to+ further study and I'd done district nursing as part of training, prac[tice]. Loved it. (CP1)<br>I spent three days with the [name] nurses during my placement… that absolutely opened my | | |

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| | | eyes… gave me a broader picture… community development in the community health role. (CP4) | | |
| | Transition processes | | | I think there needs to be a [considering what a new graduate might need] - like, in your third year or in a post grad year you could opt to do that, an extra or a certificate in community, on top of in a, you know? Like your third year, maybe do - if you think you're going to go down that community path you do more of your placements in a community setting, because it is very different and you are on your own. You're completely on your own and it's purely that - I'm sure I - it's because I went from working in a specialised unit to dealing with that specialised condition in the community, that I wasn't as thrown by it I think. (CP5) |
| INCOMER<br>*Entry-to-practice* (New Graduate) pathway | | | I've had quite a few girls come to me straight from school and I've put them through their Cert 3s [Certificate 3]. Seen some potential and encouraged them to actually further their careers, and when they finish their nursing, whether that be as an EN, do their diplomas, or they do their degrees for RN, I strongly discourage them. (CP1) | I would say [to a new graduate] go for it, because it's incredibly rewarding, great job, but I guess also I think they need to have a couple of years' experiences before they go in, because a lot of times you're working on your own which you're not used to in the hospital. (CP6)<br>[Advice to a new graduate] I think, I would say go for it if that's what you want to do, I think that's a great role, but I think they need to get the support behind them, they need to get the education behind them. (CP7)<br>I would tell them [a new graduate] that it's a very rewarding area to work in. For me, personally, I am glad that I consolidated my knowledge of the acute patient first. So that when I went into the patient's |

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| | | | | home I could actually - it was easier for me to identify quickly when they were starting to deteriorate. That's what I - that was my personal feeling, is that I was very glad that I had consolidated my uni knowledge. But, you know, maybe there's an argument for if you went straight into community, you would actually become a specialist of wellness. (CP5)<br>Clinical skill set in community is very [different] – like they [new graduate nurses] come out lacking wound care knowledge. (CP1) |
| INCOMER *RN entry* (Experienced) pathway | Personal self | I felt that I could probably do a bit more in the community in their homes than I could in the hospital. (CP6)<br>I just liked the idea of just going into people's homes. It was more of a relaxed atmosphere than in the hospital, and I felt that you could probably do a bit more in the community in their homes than you could in the hospital. (CP5) | Hit the ground running … that was kind of scary…and you're suddenly out on the road going, there's no one to tell me about morning tea … I was able to prioritise my clients, [but] I wasn't shown how to. (CP1)<br>The time I did feel it confronting was when I went into a new programme. I was, well, what do you call it? I was seconded over into a different position, and it wasn't my area of expertise, and I found that a little bit more confronting, even though I'd already been in the community working environment, because it wasn't my specific field, I found that more confronting because I didn't know if I had the knowledge and the resources that I would need to give these different class of patients. (CP5) | |
| | Professional self | I went from working in a specialised unit [in hospital] to dealing with that specialised condition in the community. (CP5)<br>I did my midwifery [first]… then I wanted to be able to support the mums more than just that first | Other organisations don't understand what you do… they don't also appreciate that you have transferable skills… see you as an aged care professional and a glorified bum washer. (CP1)<br>So it was sort of like I started this new role and I'm brand new | |

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| | | week. So I decided to do my child health nursing… then there was an opportunity to go out as a generalist nurse… working with older people out in the community…<br>I'll tell you why I coped with that. It's because it was a specialist area of community nursing. So it was a respiratory - it was a home based nursing intervention for respiratory patients. So I'd come from a respiratory unit in the hospital. And then I just transferred that knowledge into the community setting. (CP5) | at it and didn't know a whole lot about it and I really struggled with from the beginning. (CP7)<br>I'd done some [training in community]… touched on community nursing subjects during my uni years… no formal community specific education. (CP5)<br>I've got a young lass at the moment [new graduate], she's not been with us very long, and she trained, went into a residential unfortunately after her training, and I didn't realise she had trouble prioritising her clients. She didn't know how to. She didn't know what to look for, to see who you should do first. Whereas I just assumed as a nurse, she'd know. (CP1) | |
| | Transition processes | Being introduced to the other health staff around the area, you know, like the hospital staff, the doctor. Being, also, knowing what was the really important part is, who can I refer to, where can I go to, to get help if this is beyond me? (CP4)<br>I tend to look at it and look at the person and go, "What's your background." You know, all those kinds of things? "How are you feeling?" Get feedback from the people they've been buddied with, and then start them on a nice easy. You know what I mean? Give them some simple stuff, see how they go and then expand it. (CP1)<br>There was a weekly orientation timetable that was there with Monday to Friday, all the times, this is where I was going, who I was going to be with, which | I can't do their orientation because in their infinite wisdom, all the orientation went online because that would be awesome because you can just sit there and, "Welcome to [name of service], here's a computer screen, please sit there for the next two days and just go through all these training modules." CP1<br>There are some centres I know that don't buddy them. They just basically, "Here's a run sheet, off you go." Or, "Here's the phone, off you go." CP1<br>So anything I've done, I've done myself… Had to take sick leave to do the exams. Professional development, there is nothing... There is nothing that supports learning. (CP1)<br>Yes, it was pretty much nothing in that transition stage and then you kind of… it's a change of pace, it's a change of focus. (CP2)<br>I suppose all I got shown was the processes, you know, how | |

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| | | was just great; it was just good that it was all organised and that was there. And then the following week I got to shadow colleagues within my team, go out with them, which was really good. (CP6)<br>I was buddied, which was great, but you came back to the centre. So the team was very good. You had your group of clients that you were allocated and you came back, or you could come back at any stage during the day. If you're unsure, there was always, like the Director of Nursing was here for feedback, or you came back at morning tea, the other RNs were here, or lunch. That was good. That was a nice supportive environment, I guess. (CP1)<br>I remember that I was shadowed with another nurse for about a week and then I was put on my own … but I remember at the time we had two senior nurses were there and they were just really good, happy to share their knowledge, approachable, so you could go to them which was great. (CP6) | that particular service was run. (CP4)<br>So basically, yeah, supernumerary for a week and that was really - I mean, I'd done some, you know, you touched on community nursing subjects during my uni years, and always thought it was an area I was interested in. But no formal community specific education. (CP5)<br>I wasn't supported by my management to get to those training days either. So, a lot of time it was done in my own time. (CP7)<br>What wasn't so good is, I guess, that you didn't have that – you didn't have any modules, like they didn't do competencies to make sure that you were med competent. There were none of those. No manual handling competencies, no environmental or risk assessment training. You were going into people's homes, so a lot of that stuff that didn't happen, and didn't occur within the organisation. (CP1)<br>I just learnt on the job through trial and error, looking at opportunities for in-services. Yeah, would have to say that I created a lot of that myself. (CP4)<br>We didn't have a very good orientation, wasn't good at all and there was another nurse working there as well but then she became sick so then I was kind of it and then I was kind of just thrown in, so I found that really difficult, not having that orientation. (CP6)<br>My induction and orientation was, "Hello, my name's whatever-whatever."<br>Introduced to the staff, "You'll be buddied with so and so," which I did for two days, and | |

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| | | | that was it. CP1 | |
| | Sense of Belonging | Initially it was probably the hours that you had, school-based hours, because I had a family and you didn't have to work weekends. (CP7)<br>I think all nurses should have clinical supervision. It was just so good having that person as a mentor a bit higher that was there to be able to help you. You have the sessions that you can discuss, things that you don't know, debrief about clients, challenging clients, strategies to manage clients. It was just great having that person, you knew that it was a confidential setting as well, so I just found that was really great. (CP6)<br>You liaised directly with the GPs, and they actually listened to your advice. (CP1)<br>I just liked the idea of just going into people's homes … relaxed atmosphere … I felt that I could probably do a bit more in the community in their homes than I could in the hospital. (CP6) | You have to connect networks, know what's there already, and then again, it was all try not to duplicate services, so that you could just hook in with what was already there if it was working. (CP2)<br>I had a lot more knowledge and abilities than what I was being allowed to use. (CP4) | |
| INSIDER | Personal Self | You have to be really honest with yourself. Have a good understanding of where your strengths are, where are areas that you might need to work on, what skills do you need… be flexible. (CP2)<br>So you have to, I think, have a professional maturity about you and just an overall maturity in the work space, from whatever line that you come from, to just jump into community because you're working | I jumped in blindly I'd have to say, I'd done a few post-grad courses around management and law…totally at my own cost. (CP2) | |

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| | | with everybody, from housing, and it always becomes the social issues. (CP2)<br>It's a steep learning curve… I'm going to bring… majority of those learnings from there [ED] because you need networks, you need alliances and all those sorts of pathways. (CP2) | | |
| | Professional self | I am glad that I consolidated my knowledge of the acute patient first so that when I went into the patient's home it was easier for me to identify quickly when they were starting to deteriorate. (CP5)<br>Coming from an ED, you'd have more… knowledge around what's out there, because you've had to know how to connect those people with services quickly. (CP2)<br>And I think they're some of the skills that people need, that broader, really broader assessment skills, looking at how do you identify, how do you start bringing up the conversation of how are people managing at home, so you know, looking at home visiting, assessing the situation in the house, stuff like that. (CP4)<br>Because it's so new [my current role], knowing what's out there, already happening, and recognising gaps and then knowing … you really have to be looking at the big picture if you're really going to service community clients well. (CP2) | Unprepared for community practice saying that perhaps education in the undergraduate years could change, saying, "in your third year or in a post grad year you could opt to do a course as an extra or a certificate in community… and placements in a community setting. (CP5)<br>Hit the ground running. And that was kind of scary when you consider like I was – well you come out of your hospital like you're so used to a routine, and I can remember out in the community going because I was so used to being allocated. You know your morning tea, you went to first or second, lunch first or second, and you're suddenly out on the road going, there's no one to tell me about morning tea. Like you had to prioritise, and so you got very good at triaging your clients, planning your day. All of those skills that, to be quite frank, hospital nurses lack, because they're so routined. (CP1) | |
| | Transition | We had two senior nurses | I just learnt on the job through | |

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| | | who were just really good, happy to share their knowledge, approachable. (CP6)<br>We had weekly care review case conference with our team... we had monthly nurses' meetings for the nurses, because in community mental health it was multi-disciplinary so there were social workers, psychologists, occupational therapists, and nurses… we could discuss any issues that we had with our nursing within the organisation… a team member would also give an in-service on a relevant topic. (CP6) | trial and error. (CP4) | |
| | Sense of belonging | Yes, it's trying to see what's working and what's not, trying not to duplicate what's already there and wasting resources, so it's a whole new learning experience. Not just for me, I'm going to say, but for everyone that's going to, every time I say what the program is, everyone goes, "What, what, what," and then opening up a few more avenues, and then they go, "That should be good," but it's having the right supports in place I guess at this point, which at the moment there isn't a lot, from my perspective anyway. (CP2)<br>I like the remote setting … and the nursing side of things has always been interesting for me to participate in a regional area, to get an idea of what's involved and how things are different for us. What we take for granted … in the metro areas. (CP3) | | |

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| BELONGING | Personal self | You make decisions... I really liked that… you manage your own clients. (CP 1)<br>It's important that you look at being able to identify what are the trends, what are the areas that are of health, that are maybe growth areas in this area? So I started seeing a lot of people coming in with dementia, particularly undiagnosed dementia. And - so I took it upon myself, okay, I want to learn more about that so that's what I used my professional development towards. (CP4) | | |
| | Professional self | It's a very rewarding area to work in… I found it exciting. (CP5)<br>You were autonomous, you liaised directly with the GPs, and they actually listened to your advice. (CP1)<br>…knowing what was the really important part is, who can I refer to, where can I go to, to get help if this is beyond me. (CP4)<br>It's about getting people to start questioning and looking at, well, okay, hang on, I need to do something about this, and taking ownership I suppose. Getting our clients to own their health, own what's happening to them. (CP4)<br>So you have to, I think, have a professional maturity about you and just an overall maturity in the work space, from whatever line that you come from, to just jump into community because you're working with everybody, from housing, and it always | There's no means of upskilling, there's no career pathways at all and there's little education. (CP1)<br>Some of the things I didn't really like in [service] nursing, it was difficult to get away for training. We didn't have a lot of training, I mean, you rarely had time when you're out on the run in the car for morning, afternoon tea, we didn't always get comprehensive discharge summaries from the hospitals so that made it really difficult. Also, I think the hospital nurses didn't really have a lot of knowledge on the community nurses, and I know sometimes they would just write on their referral, you know, please give this intramuscular injection, but we would have no doctor's orders. They didn't think – well, we're in community, we could just give the injection but we needed to have that doctor's order for an injection, so we encountered that a lot. (CP5) | You need a degree of management I guess, yes, just to be able to prioritise, budget, all those sorts of things. Law and justice is always a good one as well as, as well as the legal guardianship type of stuff, to know your boundaries and that sort of stuff, and again, recognising those vulnerable communities. (CP2) |

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| | | becomes the social issues, what I can draw one conclusion, it's always social issues that prevent people from accessing services. (CP2) | | |
| | What needs to change? | You still need a lot of the skills that the acute care nurses have… how do we empower people to live in the community with their chronic illness or whatever it is that they have… it's about getting people to start questioning and looking at… I need to do something about this, and taking ownership… Getting our clients to own their health, own what's happening to them. (CP4)<br>I liked the autonomy, and I also liked the relationship that you formed with your patients in the community, because it was very different to a hospital setting. And I also like the education aspect of the community nursing. Yeah, educating the patients. Like, when you - you know, the opportunity to be educating the patients. (CP5) | We've got to be careful that we don't create dependence. (CP4)<br>Not having direct nursing leadership, because it comes under the [scale], on a different funding model and health model. So [I am] making it up as I go along. (CP2)<br>[Referring to what participants would like to change] - Your job's not secure, so unless you're in a position where you're happy to contract for a short period of time… there's no job security… (CP1)<br>I guess until you connect all the dots from the different streams that we're all in, in community, maybe there's focus there or funding there where we can come together as a group of community nurses and bring all of that knowledge into one space to go, you're doing this, have you connected with this? (CP2) | You need to have a good management head… to understand funding. Because there are so many different funding streams, with different guidelines… [Community nursing] is a business now. (CP1)<br>I think a big element is also there is an element of community development in the community health role. And I think they're some of the skills that people need, that broader, really broader assessment skills, looking at how you identify, how you start bringing up the conversation of how people are managing at home, so you know. Looking at home visiting, assessing the situation in the house, stuff like that. (CP4)<br>When we're all acting in siloes, it is working but it's taking too long. So there needs to be that better networking process for all sorts of reasons, and I guess the major one of those for me would be to support each other as colleagues. (CP2)<br>[Regarding ongoing funding] - The lack of understanding of what's needed, none of its really supported. Until you can put a case forward and then it always comes down to funding. (CP2)<br>[Referring to what participants would like to change] - So we're still, for me, still putting the cart before the horse, and it still needs a lot more resources and light shone on it, to get |

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| | | | | real outcomes for people, rather than once they're in this acute system as you know, it's always in the sickness mode, not in the preventative model. (CP2) |