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POPULATION STUDY

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Nurse and midwife navigator resilience, well-being, burnout, and turnover intent: A multi-methods study

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Abstract

Purpose: To explore levels of Navigator resilience, well-being, burnout, and turnover intent.

Design: A longitudinal, multi-methods study concurrently collected quantitative and qualitative data over three years.

Methods: A survey and Action Learning Groups.

Findings: No statistically significant change in resilience, well-being, burnout, or turnover intent. Supports, self-care and leaving the position, were used to maintain well-being.

Conclusions: While quantitative measures did not change, qualitative data demonstrated how adaptive coping mechanisms maintain well-being. Recommendations for nurses working in Navigator, or similar community/public health roles include work-based programs targeting support, good leadership, governance systems including their impact on turnover intent.

Clinical evidence: Job turnover intent can be used as a mechanism to monitor resilience and well-being.

KEYWORDS
burnout, nurse navigators, resilience, turnover Intention

1 | INTRODUCTION

The Nursing Guarantee Policy implemented by Queensland Labor Government introduced 400 Nurse/Midwife Navigators in 2016 (Queensland Health, 2015). For this study, Navigators were defined as experienced Registered Nurses and Midwives employed as Navigators by Queensland Health within their 16 Hospital and Health Service (HHS). Throughout the paper, Nurse and Midwife Navigators will be referred to as "Navigators." Navigators first appeared in the United States of America, as patient advocates and referral services for patients of low socioeconomic status experiencing breast cancer (American Cancer Society, 1989), and were introduced to Australia in 2017.

Navigators employed in this program are predominately senior registered nurses (clinical nurse consultants, nurse practitioners) and/or midwives (including midwife practitioners), who take on the responsibilities of care coordination, mediation, negotiation, and advocacy (Byrne et al., 2020). Midwife Navigators may be solely qualified midwives or dually qualified as Registered Nurse and Registered Midwife. Navigators provided person-centered care (Queensland Health, 2018), with the aim of optimizing patient self-management while, at the same time, reducing avoidable presentations to the Emergency Department (ED), and admissions to hospital (Queensland Health, 2015).

They are guided by a "Toolkit" (Queensland Health, 2018), which focuses the service on four pillars: person-centered care, care coordination, building partnerships, and service improvement. The role includes care management of people across a care trajectory (usually 12 months) and setting the required goals to transition patients from highly intensive care needs to self-managing their disease processes and care needs. The Midwife Navigator's role is to work with a woman, normally one with complex care needs, providing both ante-natal and postnatal care. Being the central point of care for people, Navigators often have long-term complex relationships with patients and are often the major liaison people within the public hospital system (in and between the HHS in which they are employed) as well as other primary care and specialist providers, as they manage the social, clinical and material needs of the person. Thus, Navigators may work with other health professionals such as general practitioners, specialist doctors, nurse practitioners, public hospitals (sometimes across state boundaries), private hospitals, and allied health clinicians, as well as with welfare organizations and systems (Harvey et al., 2021). While some work that Navigators do is similar to that of community or primary care nurses, Navigators work across the gamut of healthcare services to deliver person-centered care to individuals and families. Indeed, the introduction of navigation signaled an important shift in the recognition that health care and social care are inextricably linked, especially in addressing the social determinants of health that impact on management of care (Carter et al., 2018). Navigators provide "anticipatory guidance" (p. 84) stemming from a genuine connection and understanding of a person's needs. Fillion et al. (2012) describe patient centered care as the key distinction between case management and navigation: "The professional navigator role corresponds to a more comprehensive medical or social model of case management that values humanization of the care trajectory and empowerment of the patient and family" (p. 59). As Navigators traverse multiple sectors within the healthcare environment, and care for the complex psychosocial and medical care needs of individuals and families, they are an important addition to community and public health care, and to nursing. Investigating their resilience, well-being, burnout and turnover intent, is an important area of investigation.

While there is no specific resilience definition for midwives, nurse resilience is defined as:

> a complex and dynamic process, influenced by individual factors, as well as modifiable workplace conditions, organizational philosophy, management performance, and the teams nurses work within. These factors influence the extent to which resilience can be sustained, to enable nurses to positively adapt to workplace stressors, avoid psychological harm, and continue to provide safe, high-quality patient care (Cooper et al., 2022).

In the health workforce, both individual and environmental factors have been linked to high or low levels of resilience, and these factors influence the ability of health professionals (nurses and medical practitioners) to build and maintain resilience (Cusack et al., 2016; Hegney et al., 2015; Tahghighi et al., 2019). Nurse resilience is influenced by a number of personal characteristics, and possessing resilience is protective against stressors (Cooper et al., 2021). Furthermore, nurse resilience is affected by the conditions in which nurses work, and the degree to which nurses are resilient can affect their intentions to stay in a position or the profession (Cooper et al., 2021). Similarly, the nursing profession experiences high levels of burnout which also influences turnover intention (Dall'Ora et al., 2020). Burnout and resilience can be outcomes of well-being (Campion & Nurse, 2007) and it is well documented that alterations to well-being influence job satisfaction and lead to increases in intent to leave a position or the profession (Harvey et al., 2020).

2 | AIM

The Navigator model of care focuses on patients with chronic care needs, and enables patient autonomy, self-management, and well-being. The trial of the model occurred within the publicly funded 16 HHS in Queensland Health from 2018 to 2021. The Navigator evaluation study gathered data to assess the social impact, economic outcomes, models of care variances, and professional capacity and capability (Harvey et al., 2021) of nurses, midwives and their clients. As it is not known how this model of care influences the well-being, resilience, burnout and turnover intent of the Navigator workforce, one element of the research question embedded in the study addressed resilience, well-being, burnout and turnover intent in the Navigator population. Specifically, the question asked "What is the impact (of the Nurse or Midwife Navigator role), on the well-being, burnout, resilience and turnover intent of the Navigator over time?"

3 | METHOD

The study used a longitudinal multi-methods approach to gather quantitative and qualitative data to evaluate this new role of the Navigators in Queensland (Harvey et al., 2019, 2021). The quantitative arm of the main study used C. S. Rees et al. (2015) model of individual workforce resilience using measures that have been predicted to have a relationship with psychological adjustment through the mediating influence of resilience (mindfulness, self-efficacy, coping, neuroticism) and measures of psychological adjustment (burnout, depression, anxiety, stress, compassion fatigue) that can impact individual resilience (C. Rees et al., 2016; C. S. Rees et al., 2015). Additionally, data were collected to measure turnover intent. The qualitative arm of the study collected the experiences of the Navigators through the use of Action Learning Groups.

3.1 | Sample

The Navigators in this study were employed in remote areas, small rural towns, and regional and metropolitan areas. Inclusion criteria included any Nurse or Midwife Navigator working for Queensland Health, whose health service consented to participate in the evaluation. However, there was staggered intake into the study over the three years. Specifically, seven HHS commenced in 2018 (all non-metropolitan), and a further nine HHS (including metropolitan areas) commenced in 2019. Following ethical approval, Site-Specific Approvals (SSA) were required for every participating HHS. The process and time to achieve this also influenced the recruitment of Navigators into the study. In particular, the lateness of the metropolitan HHS joining the study meant there was insufficient data supplied to be included in all of the analysis (Harvey et al., 2021). This particularly affected recruitment into the longitudinal arm of the quantitative data. Following SSA approval, an information sheet and consent form were provided to each participant, explaining the objectives, methods and contact details of the Chief Investigator.

3.2 | Data collection

Quantitative and qualitative data were collected concurrently from the Navigators from 2019 to 2021. Over the three years of the study, 419 Navigators were eligible to participate in the study.

3.2.1 | Quantitative data collection

Survey distribution to individual Navigators coincided with the recruitment of their HHS to the study. As recruitment of HHS was staggered, the surveys were sent to participants as each HHS joined the study. For each Navigator, surveys were sent out electronically at baseline immediately following the HHS recruitment (T1), and then every six months over two years (T2, T3, T4 and T5). Navigator participant recruitment commenced in February 2019, with final survey data collected in May 2021.

In recognition that nursing is both a high trauma and high-stress profession (Lock et al., 2020), and that both personality factors and environmental influences can impact on resilience, both state and trait resilience was measured at baseline and over four study points thus allowing the team to measure if this new role impacted the Navigators state and trait resilience (Lock et al., 2020). "A person's 'trait' level of resilience (is) construed as more distal and enduring, and a person's 'state' level of resilience (is) construed as more recent and fluctuating in response to life events" (Lock et al., 2020).

Burnout was defined as being "… a state of physical, emotional, and mental exhaustion caused by long term involvement in situations that are emotionally demanding" (Pines and Aronson, 1988 cited in Malach-Pines, 2000, p. 23). This study used Malach-Pines (2000) short burnout scale to measure variables that both existentially and psychodynamically influence burnout and the Professional Quality of Life (ProQoL) burnout sub-scale that measures burnout as a subscale of compassion fatigue (along with secondary traumatic stress) (Stamm, 2010).

Well-being for the purposes of this study was defined as a "… state (of wellbeing) in which an individual can realize his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization, 2001, p. 1).

Job turnover intent was defined as "… an employee's intention to voluntary change [their current employer] or [the nursing profession]" (Schyns et al., 2007, p. 660). The tools used to measure resilience, well-being, burnout and turnover intent are outlined in Table 1.

3.2.2 | Qualitative data collection

The research underpinning the Navigator evaluation used the Theory of Change framework that allowed for regular meetings with the Navigators to discuss progress, thoughts, and ideas in practice and to share research findings that were reviewed at pre-determined time points throughout the life of the project. This approach allowed for a cycle of reviewing practice and research that supports ongoing, real-time development of the role, informed by a collaboration between research and practice (De Silva et al., 2014). These regular meetings were called 'Action Learning Groups' and qualitative data collection followed this approach. Action Learning Groups are a method used in Theory of Change, of sharing information with participants to enable ongoing quality improvement over the life of a study and to get clarification on research findings as needed. They are similar to Action Learning sets where the focus groups that are part of each set are used to support participants "in clarifying issues and developing systematic, creative steps for change which [can] be tested, reviewed and incorporated into practice strategies" (Munns et al., 2016). They also ensure active participation and discussion to explore, expand and/or discuss the points that are presented (Jackson, 2013). A conversational, semi-formal focus group approach to the Action Learning Group meetings was adopted, to allow nurses to openly share their thoughts and ideas, and to explore concepts as they arose. Navigators within the 16 Queensland Health HHS participated in Action Learning Groups at key points in time, commencing in September 2019, with the last Action Learning Group held in February, 2021. Action Learning Group data were collected at a time and place convenient to the Navigators (by AB, CH and JB) or via the scheduled monthly online sessions (due to the vast differences in travel between the HHS and the lockdowns that occurred during the COVID-19 pandemic). Participation in the Action Learning Groups varied, due to workloads and competing priorities, and ranged from one (1) participant to eight (8). Action Learning Groups occurred across all 16 HHS, representing metropolitan, regional rural and remote areas. In keeping with conversational analysis approaches, meetings were conducted with open-ended questions. Researchers came to the meeting with information from the research and posed questions that needed clarifying. The group then discussed the points raised and shared their thoughts and ideas. Although there was not always a consensus reached, the discussions were always lively and thought provoking. Meetings were digitally recorded and later transcribed. Information from the meeting was added to the findings under scrutiny if clarification was achieved. All discussion was then also later reviewed in a final analysis looking for common themes across all meetings. This second analysis allowed for an overall view of the factors that influenced the nurse navigator role and its development. In relation to resilience in the nurses navigators, the meetings were explored for evidence pertaining to resilience, well-being, burnout and turnover intent.

TABLE 1 Tools used to measure constructs.

Construct measured	Name of tool	Description
Resilience (including burnout)		
Resilience (overall)	Connor-Davidson Resilience Scale (CD-RISC—25) (Connor & Davidson, 2003)	25-item measure of resilience utilizing a 5-point Likert Scale. Example item: "Even when things look hopeless, I don't give up."
Resilience (state/trait)	State-Trait Assessment of Resilience Scale (STARS) (Lock et al., 2020)	10-item measure using a 7-point Likert scale. It has two subscales, one measuring state resilience and the other measuring trait resilience. Example item: "I feel ready to deal with life's ups and downs."
Professional Quality of Life (compassion satisfaction, compassion fatigue, secondary traumatic stress/burnout)	The Professional Quality of Life Scale version 5 (Stamm, 2010)	30-items, 5-point Likert scale, containing three 10-item subscales (compassion satisfaction, compassion fatigue [secondary traumatic stress & burnout]). Example item: "My work makes me feel satisfied."
Coping	Cybernetic Coping Scale (Brough, O'Driscoll, & Kalliath, 2005)	14 item measure of coping with a 6-point response format acknowledging the function of coping as both an independent variable and an outcome. Example item: "I refused to think about the problem."
Mindfulness	Cognitive and Affective Mindfulness Scale, Revised (CAMS-R) (Feldman et al., 2007)	20-item self-report measure of trait-based mindfulness, using a 4-point Likert scale. Example item: "I am able to focus on the present moment."
Burnout	Burnout Measure –Short Version (Malach-Pines, 2005)	10-item version of the original 21-item scale. Example item: "Difficulties sleeping."
Well-being (individual and occupational)		
Well-being (overall)	The WHO (Five) Well-being Index [WHO Five] (Topp, Østergaard, Søndergaard, & Bech, 2015)	Five items rated on a 5-point Likert scale. Example item: "I have felt calm and relaxed."
Job Strain (individual)	General Health Questionnaire (Goldberg & Williams, 1988)	A 12-item measure that captures general psychological distress using a 4-point Likert Scale. Example item: "Felt constantly under strain."
Affect (individual)	Positive and Negative Affect Scale [PANAS] (Watson et al., 1988)	20-item measure of affective state that uses a 5-point Likert scale. It has two sub-scales; one measuring positive affectivity (PA) and the other negative affectivity (NA).
Job Satisfaction (individual)	Abridged Job in General (Russell et al., 2004)	8-item scale, a short version of the previous Job in General Scale.
Team Climate (Occupational)	Team Work Scale (Kivimäki et al., 2007)	14-item measure using a 5-point Likert scale. Example item: "We have a 'we are together' attitude."
Empowering Leadership (Occupational)	Empowering Leadership Scale (Amundsen & Martinsen, 2015)	18-item measure using a 7-point Likert scale. Example item: "My leader encourages me to take initiative."
Turnover intention		
Attrition (Organisational and Professional)	Three-item Turnover Intention Scale (Jaros, 1997)	Three items using a 5-point Likert scale measures how often respondents consider leaving their occupation, likelihood of leaving their occupation in the future and the likelihood of leaving the profession in the near future. Example item: 'How likely is it that you would leave your organization in the next year?

3.3 | Data analysis

3.3.1 | Quantitative analysis

Descriptive and frequency analyses were used to report on the demographic data collected. The mean item scores were examined for time-related change using box plots and both linear and non-linear mixed models fitted by restricted maximum likelihood mixed models (REML) with the fixed effect being time (T1-T4) and the random effect being Navigator ID. Due to the staged recruitment, not all Navigators were able to complete all time points before the completion of the evaluation, resulting in an under-representation of Navigators from metropolitan based HHS. Additionally, over the time of the survey, participation rates declined.

The mean item scores were examined for time-related change using box plots, and both linear and non-linear mixed models fitted by restricted maximum likelihood mixed models (REML) with the fixed effect being time (T1-T4) and the random effect being navigator ID. It is important to note that while other points are represented in the box plots, only those navigators who had data collected for three or more time points (T1 – T4) were used in the data analyses (nnavigator ID = 67, nobservations = 240).

3.3.2 | Qualitative analysis

This study used Braun and Clark's (2006; 2014) approach to thematic analysis to analyze the qualitative data. The transcribed Action Learning Group data were sent to two of the researchers (JB and DH) for independent thematic analysis. For the purposes of familiarization (Step 1 of Braun and Clark's phases of thematic analysis), the transcripts were read and re-read before preliminary coding was undertaken. Codes were then collated (Step 2) and preliminary themes and subthemes were developed (Step 3), prior to a consensus meeting (Step 4), where the final themes and subthemes were clarified, defined, and named (Step 5). Once consensus was reached on the themes they were validated by a senior researcher of the team (CH) against the data. Themes presented are not exhaustive of all the data from the Action Learning groups. Rather, where resilience, well-being, burnout and turnover intent were raised, these data were analyzed.

3.3.3 | Trustworthiness

Trustworthiness was managed using Lincoln and Guba's framework of quality criteria (Polit & Beck, 2010). Investigator triangulation was used to achieve credibility. Confirmability is demonstrated through participants' voices substantiating the findings, linking the raw data to interpretations of the themes and sub-themes, thus, giving opportunity for the voice of participants to dominate, rather than the investigators.

3.4 | Ethical considerations

A multi-site ethical clearance was granted by the Queensland Health Research and Ethics Committee in March 2018. The project also obtained ethical approval from the leading university. Navigators were provided with a participant information sheet at the time that they were recruited to the study. Navigators were made aware that participation was voluntary and that they could withdraw at any stage and that their HHS employer would not know the names of any of the participants in the study. Submission of a completed survey implied consent, while verbal consent was sought and recorded prior to the Action Learning Groups. Collected data were de-identified prior to distribution to the researchers for analysis.

TABLE 2 Most likely reason/s for navigators leaving the profession.

Reason	*n*	%
I want to retire	53	75.7
Family responsibilities	27	38.6
Health concerns	22	31.4
I feel disillusioned with my job	20	28.6
I can earn more money elsewhere	11	15.7
I see my career moving beyond health	10	14.3
Lack of a career pathway	10	14.3
I dislike shift work	5	7.1
I feel as though I have nothing left to give	5	7.1
I plan to start a family	2	2.9
Other	12	17.1

3.5 | Reporting guideline

This paper follows the Good Reporting of a Mixed Methods Study (GRAMMS) guidelines (O'Cathain et al., 2008).

4 | FINDINGS

4.1 | Quantitative findings

Of the 419 Navigators in the 16 HHS, 118 responded to the first survey, representing an overall base-line response rate of 28.16%. Response rates declined over time (T1 $n = 118$, T2 $n = 107$; T3 $n = 73$; T4 $n = 31$; T5 $n = 31$). For the purposes of this paper, data were analyzed from the 67 Navigators who completed three or more surveys (T1 – T4), providing 256 observations, which were examined for time-related change using regression models that incorporated both linear and non-linear change over the measurement periods.

The ages ranged from 25 to 64 years, with the average age being 48 years. They were predominately female (94%) and identified as Australian (78%), including of Aboriginal (6%) and Torres Strait Islander (3%) descent. They predominately worked in the community (54%), had extensive experience (average 25 years, range 2–44 years) and were highly qualified (70% had a post graduate qualification, at graduate certificate or higher). Navigators intend to continue to work in health for an average of 15 years (range 2–35 years), with retirement the most likely reason for planning to leave (75.7%). Table 2 outlines reasons given for leaving the job and the profession.

None of the measures indicated evidence of change in Navigator resilience and well-being due to time, suggesting that workplace well-being scores did not improve (nor worsen) over the measured period (Table 3). The Marginal R2 values (Table 3) show that less than 1% of the variation in the data was explained by the point in time (i.e., Marginal $R^2 < 0.01$), instead most of the variation (ranging between

TABLE 3 Effect of time 1 on resilience and well-being measures for navigators.

Construct measure	Measure	Data transformation[1]	Number of observations	*p*-Value (time)	Marginal R^2	Conditional R^2
Resilience	STARS State	LN	240	.208	0.003	0.517
Resilience	STARS Trait	SQRT	240	.764	0.000	0.654
Resilience	Connor-Davidson Resilience Scale	SQRT	240	.499	0.001	0.691
Well-being	WHO-5	LN	240	.803	0.000	0.511
Positive Affect	PANAS	None	240	.253	0.002	0.591
Negative Affect	PANAS	INV	240	.337	0.001	0.672
Job Strain	General Health Questionnaire	INV	240	.149	0.005	0.468
Secondary Traumatic Stress	Professional QoL	LN	240	.265	0.001	0.751
Compassion Satisfaction	Professional QoL	SQRT	240	.344	0.001	0.655
Burnout	Professional QoL	SQRT	240	.454	0.001	0.719
Burnout	Short Burnout Measure	LN	238	.739	0.000	0.705
Job Satisfaction	Abridged Job in General	INV	240	.764	0.000	0.693
Employer Attrition Intent	Three-item Turnover Scale	LN	240	.076	0.000	0.705
Nursing Profession Attrition Intent	Three-item Turnover Intention Scale	SQRT	240	.099	0.005	0.576

LN = natural log; INV = inverse; SQRT = square root, Fixed effect = Time (T1-T4. The data were used in the linear mixed model thereby creating a non-linear model).
Marginal R^2 provides the variance explained only by fixed effects and conditional R^2 provides the variance explained by the entire model.

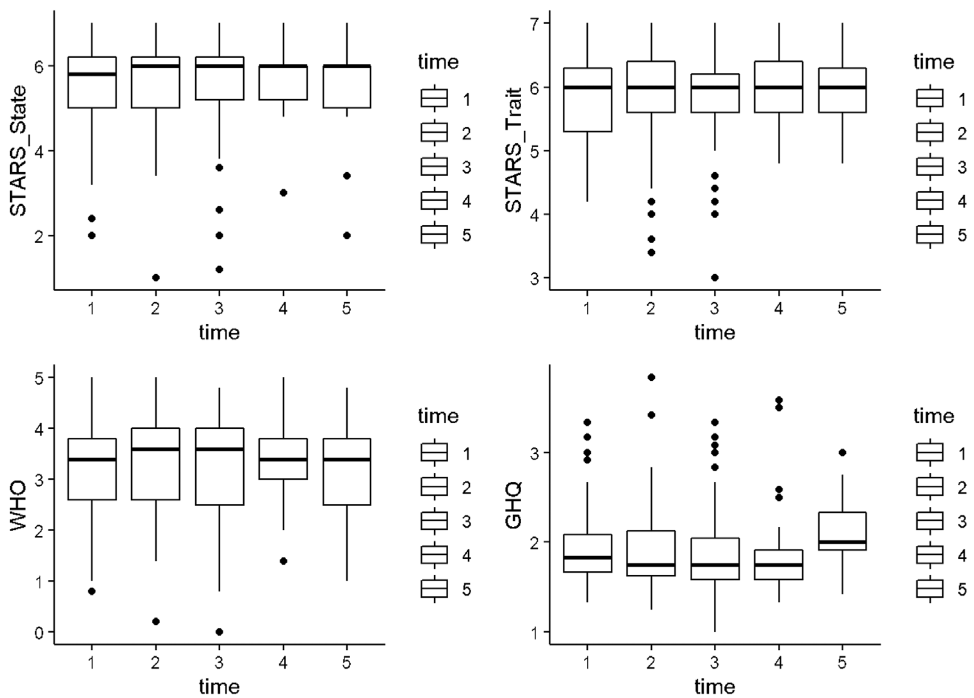

FIGURE 1 State and trait resilience (STARS), well-being (WHO) and job strain (GHQ).

47% and 75%) in the data was explained by the Navigator ID (i.e., variation in the individuals themselves). The box plots of the time-series data (Figures 1–4) are similar across all measurement periods, and the general linear mixed models don't suggest a time-related effect across the measurement periods on the outcome variables of interest.

4.2 | Qualitative findings

Four major themes emerged from the collated qualitative data, plus a theme related to the impact of COVID-19. These were: the work environment; personal responses to work; coping strategies; sources of

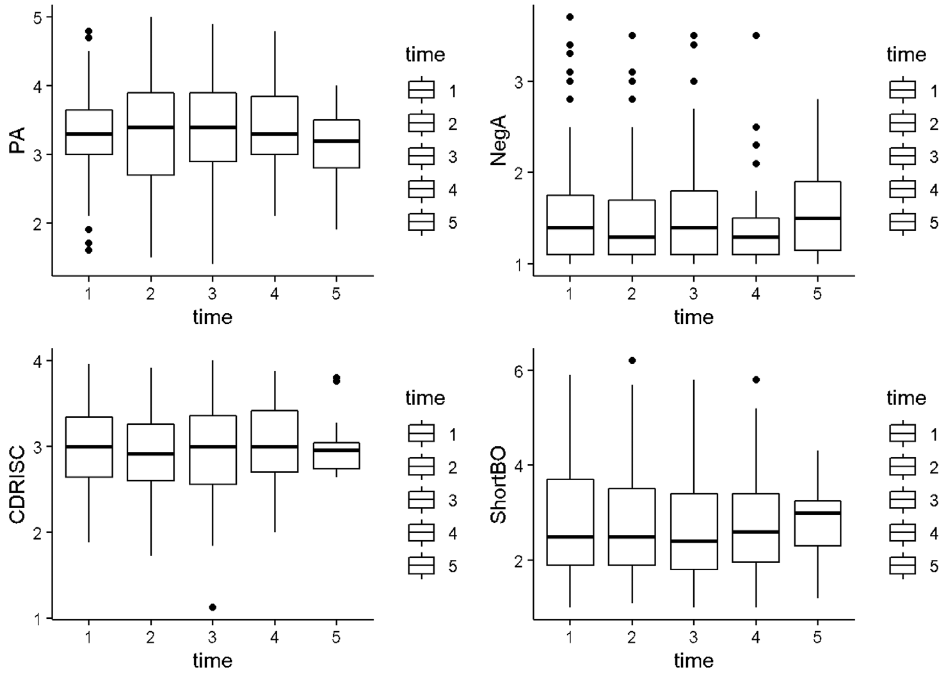

FIGURE 2 Positive and negative affect (PANAS), resilience (CD-Risc), and burnout (short-burnout measure).

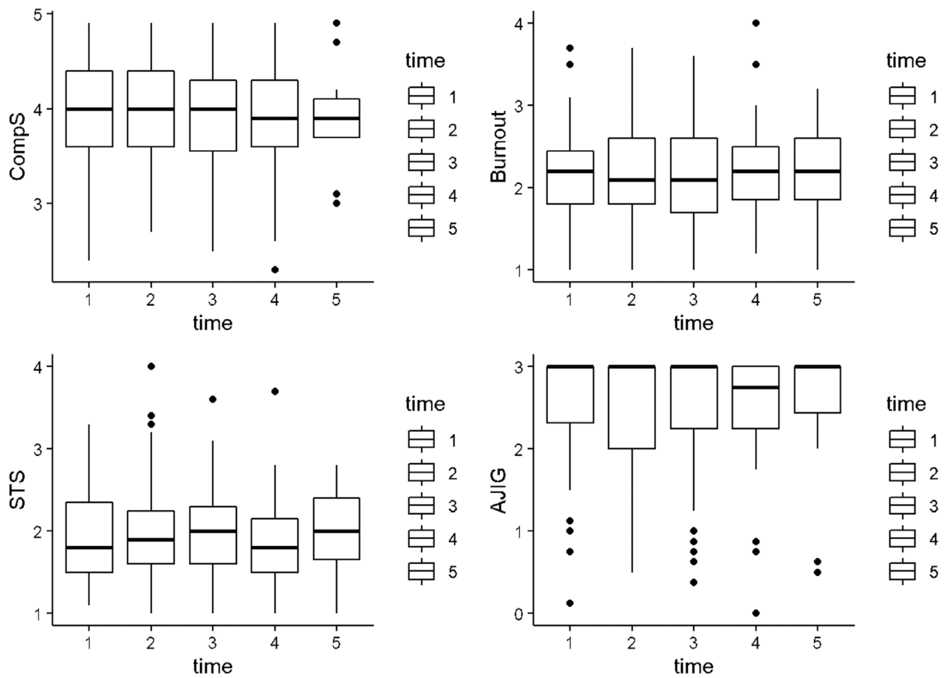

FIGURE 3 Compassion satisfaction (CompS—ProQoL), burnout (ProQoL), secondary traumatic stress (STS—ProQoL) and Job Satisfaction (AJIG).

support and outcomes; and COVID-19. Table 4 outlines the five themes and sub-themes and presents data to substantiate the findings.

5 | DISCUSSION

The aim of this study was to understand the impact of the Navigator role, on the well-being, resilience, burnout and turnover intent of the Navigator over time. The quantitative data suggest that the navigators are resilient clinicians who maintained their resilience over the two years of data collection. The qualitative data provide an insight into the quantitative results. That is, the Navigators discuss the mechanisms they have used to maintain their resilience and well-being, and prevent burnout. Several Navigators reported an intent to leave their position as a coping mechanism.

A number of coping strategies can be used to maintain resilience (Ching et al., 2020) some of which were evident in the Navigators

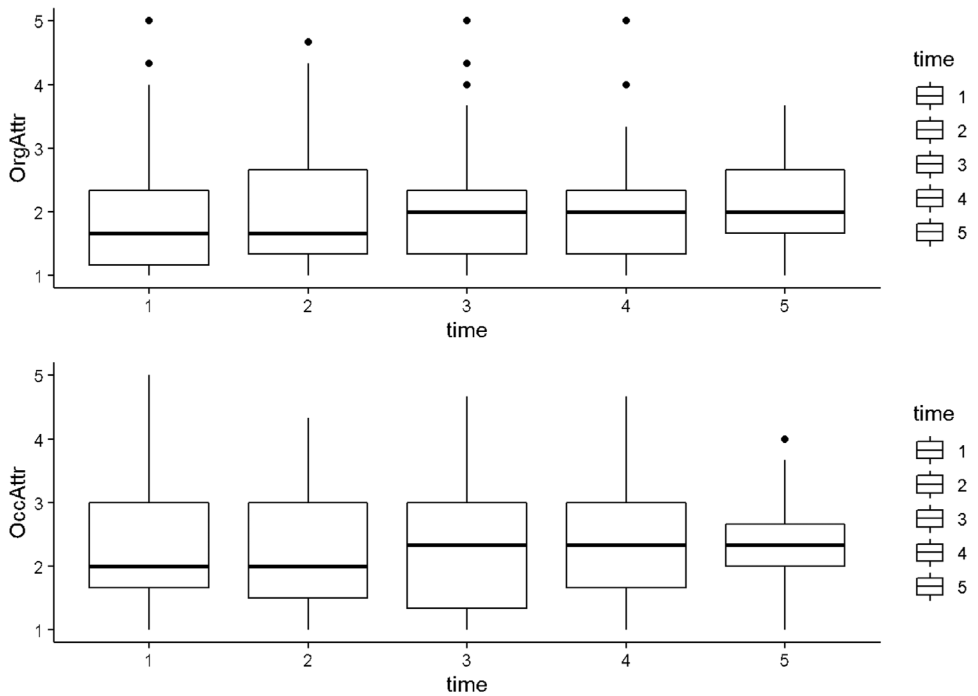

FIGURE 4 Occupation and organizational attrition intention.

and were used to build and maintain their resilience and well-being. The majority of the challenges outlined related to the perceived level and source of support from service management, from line management and from their colleagues. Smith (2011) found that nurses in case management roles were vulnerable to immense role ambiguity and conflict, largely because the role was not well defined. This in turn affects the well-being of the incumbent, thus reducing the motivation of the person alongside their capacity to make change in new roles (Blanco-Donoso et al., 2019). A few Navigators expressed mistrust of their management (line and organizational), believing that the Navigator role was not valued or supported. It is well known that building trust between nurses and their managers is important in building teamwork, engaging nurses in looking for new ways of working, whilst also reducing burnout and attrition rates (Wei et al., 2020). While outside the scope of this study, this may be true for Aboriginal and Torres Strait Islander Navigators, where trust, respect and strong leadership are essential to the growth of Indigenous workforce, alongside the outcomes of the people they care for (Taylor et al., 2020).

Some Navigators found that they had more support from their peers through the state-wide Navigator network that had been formed, than from their local HHS managers. Narrative such as, 'we have very strong support for each other and, I think, probably that's the real reason why we are still doing what we're doing' bears testimony to this. The value of collegial peer support on nurse well-being has been widely reported (Foster, Cuzzillo et al., 2018; Foster, Shochet et al., 2018; Hsieh et al., 2016; McDonald et al., 2012).

Burnout in nursing has been extensively studied and reported. Its link to the practice environment (particularly relationships with managers [support, leadership, recognition of achievements] and staffing adequacy) has previously been reported (C. S. Rees et al., 2019). In their study of Queensland nurses, C. S. Rees et al. (2019) found the major contributors to nurse burnout were individual variables, specifically resilience and trait negative affect. They concluded that:

Building positive, healthy workplaces requires commitment from management and all levels of staff. Equipping nurses with skills to promote resilience may be an important way to help reduce nurse burnout (C. S. Rees et al., 2019, p. 199).

The role of governance and leadership is important for both individual and occupational well-being, particularly when there is a new role introduced within an existing system, such as the Navigator role. There have been several integrative reviews undertaken that identify the need to ensure good communication, professional development opportunities, good leadership, and clear role delineation, particularly when changing roles or models of care (Blanco-Donoso et al., 2019; Khamisa et al., 2013). In the Action Learning Groups, a few Navigators reported feeling undervalued and unsupported by their managers. It is noteworthy that there is not one model of Navigator governance across the state of Queensland, and that the models were different or changed across the services in which the Navigator was employed. Navigators reported frustration with the system in which they were employed with some noting that they "gave up" and others noted that the lack of a governance model increased their intention to leave their positions, but not the profession. The findings are consistent with prior Australian research, which found that poor nursing leadership, particularly at the nursing unit manager level, is a major influence on nurses' turnover intent (C. S. Rees et al., 2019; Roche et al., 2015). Where nurses encounter and work with transformational leaders, they are less likely to leave the profession, but are also more likely to report job contentment and are less likely to be absent from the workplace (Labrague et al., 2020).

TABLE 4 Themes, sub-themes and qualitative data from the qualitative analysis.

Themes	Sub-Theme	Exemplar Quote
Work environment	Governance and Leadership	*Our biggest component has been the lack of medical support, which then indirectly is a lack of governance. I think morale within the team is extremely low at the moment. We're trying to understand where we are, who we are, what we are doing, where we fit and, obviously, the frustration about wanting to provide excellent care without effective parameters.*
Personal responses to work	Burnout (Emotional exhaustion, low personal accomplishment) Undervalued	*Yeah, that, you know, I probably am feeling quite burnt out. . . . And it's one of the reasons why I'm leaving my position. Which is, it's, it's a shame, but, you know, I think you can only handle things for so long. And in in our region, you know, there really aren't these other services that support you, as a clinician, you know, you sort of are on your own [which] can be quite exhausting. So having that overarching accountability always coming back to you has really, yeah, well-worn you down I've been providing the same reports and the same information for the last four years....it was never good enough but there was never any feedback. No one knew what navigators were. They thought we sat in a room, or maybe drank tea and made a few calls. I honestly thought that they really didn't understand what we did.*
Coping strategies	Within self (resilience, self-actualization, journaling, distancing) With others (family, colleagues)	*I suppose just try and put it into perspective and spend time with the family, you know, have a glass of wine, but obviously not too many. Just we love camping and the sort of things to get away. I'm a pretty independent and private person. I don't, I don't rely on others for my mental health. I get myself actualisation internally, not externally. I've been such a long time in the job. I know my, I think I know my faults and flaws. And I also know my strengths. . . . But the quirks and foibles of people's personalities, they're their own and I will just smile and move on. So that's how I totally manage. . . . because I have been on the other side of it, I know exactly what it's like. And using that knowledge to be able to support them to get where they need to be. But if they don't want to then that's their decision ultimately. It's actually made me I think that it's made me a better clinician, because I suppose I've done a lot of leadership stuff in the last 12 months about growth, mindset and resilience, emotional intelligence, all that sort of stuff. I do a lot of reflective practice. And journaling. And my colleague, who is the [name of Navigator's position] who has navigated we've kind of sit together in that space, and we bounce off each other and then a winge with each other, kind of like you know, and a debriefing session.*
Support	Support given Lack of support	*And then I went to my manager, and I spoke to her, and I just said, "look, I can't keep all the balls in the air." I'm going from here where I'm dealing with patients, and I've discovered that three quarters of my patients all have some sort of trauma, and I must be very trusting because they usually always tell me. Very strong support for each other and, I think, probably that's the real reason why we are still doing what we're doing. There was just a very strict management of the finances of the positions because they come with no financing to pay for any of the on-costs for vehicles and all that sort of thing or any of the administrative support.*
	Outcomes of lack of support Feeling abandoned Left position Giving up	*This is not worth my energy and my time, because I just didn't feel that I was supported. And what I was offering wasn't supported. Anyway, he said enough of this silliness, I'm leaving. Purely from the management. He had so much to offer, he was absolutely brilliant. But he just couldn't put up with it. And you just feel—you feel as you have not been heard, and you can push and push and push and then in the end you just give up.*
COVID-1	Impact on exercise used to maintain well-being. Anxiety from isolation	*That's what I hated about this COVID situation, I used to go to the gym. Straight after work I go from there to the gym, might only be for half an hour, but I feel like it helps clear my head. So I do feel more like probably that bit more anxious, uptight, without being able to get out. . .*

Compounding the role's ability to be embedded in the HHS was the pandemic. As well as changes to their work role, there was an individual well-being impact with the imposed lockdowns challenging their coping mechanisms, and therefore resilience, well-being and turnover intent. A systematic review of health care professionals resilience during the pandemic found that

> … resilience is mainly born out of their professional identity, collegial support, effective communication from supportive leaders along with flexibility to engage in self-care and experience growth' (Curtin et al., 2022).

In addition to demonstrating that the navigators are resilient clinicians, the quantitative data suggest the primary influence on Navigators decision-making about leaving their position was retirement. As the average age of the participants was 48, this is not an unexpected result. Other reasons (over 30%) given were family considerations and health concerns. A high level of intention to retire in Queensland nurses was noted by Eley et al. (2010) who found that about 85% of nurses in their study who were over 60 years of age expected to remain in nursing for about 5 years or less. The International Council of Nurses recently noted that the global attrition of nurses is directly related to a persistent and chronic underfunding of nursing services (International Council of Nurses, 2020). The Navigator role provides a clear and positive professional pathway to advancing nursing that keeps nurses and midwives in clinical practice, because they are utilising their expertise and experience effectively. In the Action Learning Groups, Navigators indicated that their feeling of worth came from their ability to use their skills to support better care, noting that it is this personal satisfaction that keeps them in the job. Given the current and predicted workforce shortages (Mannix, 2021; The Queensland Cabinet and Ministerial Directory, 2022; World Health Organization, 2020, 2021) it is imperative that effective nurse retention strategies, including nurses caring for patients with long term, chronic conditions, are adopted, in the interests of uninterrupted, high quality, and safe patient care.

6 | STRENGTHS AND LIMITATIONS

Due to the staggered recruitment into the study, there was inconsistent enrolment into the quantitative arm of the study. Navigators who were employed in the seven HHS, which were located in regional, rural or remote areas of Queensland, were more likely to participate over the three-year period than Navigators employed in metropolitan based HHSs, which may skew the data. Additionally, only 67 of the 419 Navigators completed surveys over at least three timepoints, resulting in a response rate of 15.99%.

The qualitative findings are limited to the data, experiences and stories that the Navigators involved in the study were prepared to report. However, participation in the qualitative component was widespread, with Navigators from metropolitan, regional, rural and remote areas participating in Action Learning Groups from 2019 to 2021.

Additionally, the participants in this research were employed by Queensland Health as a Navigator. Other services which manage complex and chronic diseases were not included in this research, however, we believe that the data collected from the Queensland Navigators could be applied across similar health care settings where similar structural and organizational challenges exist.

7 | RECOMMENDATIONS FOR FURTHER RESEARCH

Navigators are experienced nurses and midwives who have had long careers in the profession before becoming Navigators. As such they have developed strategies to cope with the demands of the profession. Despite their level of resilience and well-being, they reported a number of factors that have the potential to cause burnout and influence job retention, posing an area of future enquiry and research We recommend employment-based programs to bolster well-being and resilience are implemented in Navigators workplaces and that research is undertaken to determine the effectiveness of these programs on Navigators and their occupational and professional turnover intent.

There is also a dearth of information on how the work environment, such as role delineation, organizational support and structures, and supportive leadership influence well-being and therefore resilience. Further research on well-being as an indicator of turnover intent should be explored.

8 | CONCLUSION

Individually, the Navigators demonstrated no statistical changes in their resilience, or well-being over the four years of quantitative data collection. Both the quantitative and qualitative data demonstrated how resilient these experienced Navigators were. Evident in the qualitative data were the coping mechanisms used by the Navigators to maintain their resilience and well-being, including leaving the position, but not the profession.

The findings of this study of Navigator resilience, well-being, and turnover intent has highlighted the importance of good governance and leadership, collegial support and believing the role within the health care system and their individual contribution is valued, particularly when a new and innovative role is introduced into an existing system. The impact of the COVID pandemic on the role, like many who work in community and public health environments, was another challenge for nurses to maintain their well-being and resilience. Further, the Navigators who participated in this aspect of the study provide valuable information for health services' governance and leadership role when introducing a new role into an existing system. As experienced Registered Nurses and Midwives, the Navigators have demonstrated their resilience and the coping mechanisms used to maintain well-being and resilience as well as providing insights on what occupational and individual support mechanisms should be used to maximize their resilience and well-being.

AUTHOR CONTRIBUTIONS

Janie A Brown: data collection; data analysis; manuscript development and final approval. Clare L. Harvey: study conceptualization; funding acquisition; project administration; supervision: data collection; data analysis; manuscript development and final approval. Amy-Louise Byrne: project administration; data collection; data analysis; manuscript development and final approval. Desley G. Hegney: study conceptualization; supervision; data analysis; manuscript development and final approval.

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CONFLICTS OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study may be available from the corresponding author, (JB), upon reasonable request, however some ethical restrictions apply.

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