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THE PERCEPTIONS OF NEWLY QUALIFIED NURSES OF THEIR READINESS TO PRACTICE IN AN ACADEMIC HOSPITAL IN GAUTENG

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A research report submitted to the Faculty of Health Sciences, School of Therapeutic Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Nursing (Nursing Education)

Johannesburg, 2018

DECLARATION

I, Sithembile Siphiwe Shongwe, declare that this research report submitted for the partial fulfilment of the degree; Master of Science in Nursing (Nursing Education), at the University of the Witwatersrand, Johannesburg, is my own work and has not been submitted before for any other degree at any other institution.



……..

Signature of candidate

…28… Day of …May…2018…in The Faculty Health Sciences……

Protocol number: M170483

DEDICATION

This research report is dedicated to:

My **Jehovah Yahweh** for His unfailing love, which has made this venture a prosperous journey.

THANK YOU, LORD

ABSTRACT

Background: The literature reveals that newly qualified nurses are faced with challenges during their first year of professional practice. These challenges are attributed to the nursing education programme's inability to adequately equip them with the necessary skills for the role, lack of support during the transition to practice and a negative working environment.

Purpose: The purpose of the study was to explore the perceptions of newly qualified nurses of their readiness to practice in an academic hospital in Gauteng.

Methodology: a qualitative, exploratory research design, using semi-structured interviews was used to guide the study. Sixteen (16) newly qualified nurses (NQNs) working in an academic hospital in Johannesburg were interviewed. The interviews were digitally recorded and analysed using Braun and Clarke's phases of thematic analysis.

Results: The data were analysed under four themes: the transition from education to practice, support, working environment and settling in. The newly qualified nurses felt that their educational programme concentrated more on theoretical than practical knowledge. As a result, they were not ready for practice and expressed an inability to handle their professional responsibilities. Adapting to the professional role was further compounded by the lack of support, as indicated by complaints about the quality and the duration of on-the-job orientation, lack of supervision from some of the operational managers and senior nursing staff. The shortage of material and human resources was also cited as hindrances. However, their initial feelings of being overwhelmed gradually dissipated resulting in role acceptance and finally growth.

Recommendations: The researcher suggests that both theory and practical learning should be given equal value to avoid over prioritisation of one educational aspect to the other. The nursing education delivery systems and the healthcare delivery system must be restructured to facilitate a seamless transition of newly qualified nurses to practice.

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CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Several studies have shown that newly qualified nurses (NQNs) find the transition period from university or college to the world of work stressful and challenging due to failure to meet the expectations of the role (Al Awaisi, Cooke, & Pryjmachuk, 2015; Duchscher, 2008, 2009; El Haddad, Moxham, & Broadbent, 2016; Freeling & Parker, 2015; Monaghan, 2015). A study by (Al Awaisi et al., 2015) concluded that nursing educational programmes, formal support structures, and the working environment seem to influence the transition experience of the newly qualified nurses to practice. These three issues highlighted in the above study form the basis of this study. Understanding the practice-readiness of newly qualified nurses for practice would add valuable information in the era of nursing education reformation. In this study, the term newly qualified nurses (NQNs) refers to nurses who have recently graduated from a nursing education institution and are doing their community service year.

This chapter discusses the background of the study, the problem statement, research question, the purpose of the study, its significance, research objectives and the operational definitions.

1.2 BACKGROUND OF THE STUDY

Practice readiness of newly qualified nurses is a cause of concern in the nursing profession (El Haddad, Moxham, & Broadbent, 2013; Strauss, Ovnat, Gonen, Lev-Ari, & Mizrahi, 2016). However, the concept “practice readiness” has an unclear meaning as it reflects the divergent views of academic staff and clinical practice staff regarding the professional capabilities of newly graduated nurses (El Haddad et al., 2016). In a report by Wolff and The Coalition on Entry-level Registered Nurse Education (2007), a consensus was reached that practice readiness entails having broad foundational knowledge with some specific job abilities, delivery of safe patient care and demonstration of well-balanced cognitive and psychomotor skills.

A study by (Casey et al., 2011) which examined the readiness for the practice of senior nursing students showed that this group of student nurses had difficulty in performing specific skills. To their surprise, they found that the skills that they had challenges in performing were similar to those that graduate nurses who were undergoing their

residency program were incapable of doing as reported in their previous research work (Casey et al., 2011). The skills that the senior nursing students had difficulty in performing included managerial and leadership tasks such as delegation of duties, conflict management, decision making, assertiveness in handling negative behaviours or mistreatment. Also, fulfilment of multiple responsibilities and management of a massive number of patients, communicating with physicians, and making good and sound clinical judgments in response to the patients' needs also viewed as challenging responsibilities (Casey et al., 2011).

Del Bueno (2005) and Edward et al. (2017) stated that NQNs meet all the qualification requirements, but they have limited clinical experience, competence, and confidence to deliver safe patient care immediately. Glen (2009) said despite the repeated efforts to reform and refocus the nursing profession criticism persisted. The disapprovals originate back from the transfer of nursing education from the apprenticeship model to the academic institutions. The institutionalised educational model requires nurse educators' to be the 'jack of all trades;' being responsible for equipping student nurses with both academic and clinical knowledge (Glen, 2009). However, observations reflect that clinical practice gets less priority (Brandon & All, 2010).

Patricia Benner, in her theory "From Novice to Expert," revealed that novices lack organisation of knowledge to manage changes in the various situations during the first months of professional practice hence they require ongoing support from experienced nurses (Benner 1982). Dyess & Sherman (2009) held the same view and stated that supporting the NQNs in their first year of practice is necessary to ensure that the future nurses will serve the community safely. Several countries, especially those that are outside the African continent, have fully incorporated support structures to assist NQNs to transition with ease into the working environment. Support structures such as mentoring or coaching, preceptorship programs and formal support from experienced workmates are highly recommended (Whitehead, Owen, Henshaw, Beddingham, & Simmons, 2016). However, the global crisis of nursing shortages and the increasing burden of disease has led to the hastening or overlooking of such programs during the transition period (Dyess & Sherman, 2009; Sönmez & Yıldırım, 2016).

Duchscher (2008) gave an account of the experiences of the NQNs during the transition period so that health care stakeholders could adopt appropriate approaches when integrating the newly graduated nurses to practice. According to Duchscher

(2009), the NQNs adaptation journey is characterised by changing experiences, which take them through personal and vocational, emotional and intellectual skills, roles, and relationship alterations during the first twelve months.

Throughout the transition, the NQNs experience a honeymoon phase in which they show full excitement, but that does not last because they suffer from “reality shock” as they discover the true meaning of professional practice. The latter experience leaves the new nurses disoriented and disheartened. Duchscher (2008) stated that the NQNs eventually progress to the reclamation and resolution phase that leads to the regaining of the sense of professional maturity. The transition process of the NQNs is undeniably a complex experience as already highlighted. Hence, it was necessary to explore the perceptions of NQNs within the South African healthcare context, which has a different approach from the international context.

The South African Nursing Council (SANC) is responsible for setting the standards for basing the nursing education programme outcomes, and the accreditation of all learning programs including clinical learning programmes that meet the requirements of the Council (SANC, 2018). The regulatory Council (SANC) took an initiative to revitalise the nursing profession and the healthcare sector following a call for strengthening the nursing profession by the World Health Assembly (WHA) in 2001 (SANC, 2005). Efforts were directed to the resetting of the nursing profession learning systems to produce graduates who will adequately respond to the ever-changing healthcare needs. The 4-year diploma or degree programme, which leads to the registration of professional nurses and midwives served as a benchmark and was developed to produce a standard competency-based nurse (SANC, 2005). Furthermore, a model for clinical nursing education and training was proposed to strengthen the education and training systems (The Nursing Education Stakeholders (NES) Group, 2012).

South Africa has three basic categories of nurses: auxiliary nurses, who have completed one year in a training hospital. Then there are enrolled nurses who have completed two years in a nursing college. Lastly, some professional nurses qualify with a 4-year diploma at a nursing college while others with a 4-year baccalaureate degree at a university (Blaauw, Ditlopo, & Rispel, 2014). The professional nurse category is of interest to the current study. The South African Nursing Council (SANC) ensures the competency of all nurses upon qualification, safeguard quality and safe delivery of

healthcare services to the public in terms of section 31 of Nursing Act (33 of 2005) (SANC, 2005). The mandate applies equally to the NQNs, and as such, they are expected to assume full roles, responsibilities, and accountabilities as per their scope of practice as promulgated in the regulation: R 756 of 24 August 2007 (SANC, 2007).

A mandatory pre-licensure service called community service is undertaken by all South African nurses who intend to register their four- year diploma or degree qualification with the South African Nursing Council (Govender, Brysiewicz, & Bhengu, 2017). The community service was an initiative taken by the country to retain newly qualified health professionals in under-resourced healthcare sectors to ensure equitable distribution of human resource to all South Africans. The community service period also serves as an opportunity for developing and acquiring professional skills (Hatcher et al., 2014). The words community service nurses and newly qualified nurses will be used interchangeably as their first exposure to practice after qualification is community service.

The compulsory community service is seen as fulfilling by newly qualified health professionals in the country. However, there are some concerns raised about the implementation process of the service (Govender, Brysiewicz, & Bhengu, 2015; Govender et al., 2017; Hatcher et al., 2014; Roziers, Kyriacos, & Ramugondo, 2014). As a result, strategies to improve the implementation of the pre-requisite registration service were recommended. These included the initiation of a structured orientation programme and clarity on the roles and responsibilities, development of sustainable strategies to improve job satisfaction that will enhance retention of health professionals in rural areas and clarity on the issue of placement (Govender et al., 2017; Hatcher et al., 2014).

The compulsory community service is served in public healthcare sectors that are designated by the Republic of South Africa (RSA)-Department of Health (DoH) (SANC, 2007). The (Department of Health, 2012) has categorised public hospitals into; district, regional, academic, central and specialised hospitals. Newly qualified nurses upon qualification are deployed in any of these public hospitals, including primary healthcare settings to accomplish their mandatory community service duty. In this research, the researcher explored the perceptions of newly qualified nurses of their readiness to practice in an academic hospital in Gauteng. An academic hospital is a hospital that provides specialised healthcare services, serves as a centre for training health

professionals, and a platform for conducting research, as well as a specialist referral centre for regional hospitals and nearby health facilities (Department of Health, 2012).

1.3 PROBLEM STATEMENT

The transition period from the student nurse role to the role of a newly qualified nurse is a stressful experience. Studies demonstrate that formal support structures, academic preparation, and the working environment influence the transition period (Al Awaisi et al., 2015; Duchscher, 2009; Freeling & Parker, 2015; Monaghan, 2015).

According to the researcher's observations and personal experience newly qualified nurses at the workplace commonly receive negative criticism instead of being supported. However, there are few studies, which have explored the perceptions of newly qualified nurses in the South African setting regarding their readiness to practice during the transition period. This study aims to explore the perceptions of the newly qualified nurses of their readiness to practice in an academic hospital.

1.4 RESEARCH QUESTION

What are the perceptions of newly qualified nurses regarding their readiness to practice in an academic hospital?

1.5 PURPOSE OF THE STUDY

The purpose of the study was to explore the perceptions of newly qualified nurses of their readiness to practice in an Academic Hospital in Gauteng.

1.6 THE SIGNIFICANCE OF THE STUDY

The results of the study will help to create a better understanding of the perceptions of newly qualified nurses of their readiness to practice in an academic hospital in Gauteng during the transition period. The findings of this study will help in the future, guide nurse educators and healthcare stakeholders to develop an orientation program to prepare students who are in their fourth year of study for their community service year.

1.7 THE OBJECTIVES OF THE STUDY WERE TO EXPLORE

- The feelings of newly qualified nurses of their readiness to practice in the academic hospital.
- The educational preparation received by the newly qualified nurses from their nursing education institutions (NEIs).
- The formal support structures available in the academic hospital to assist newly qualified nurses during their community service period.
- The views of newly qualified nurses about the working environment in the academic hospital.

1.8 OPERATIONAL DEFINITIONS

Clinical preceptor: is a qualified professional nurse employed by a higher education institution to work closely with a group or groups of student nurses in a particular clinical facility or facilities to maximise the clinical learning experience of student nurses in formal nursing education programmes (The Nursing Education Stakeholders (NES)-Group, 2012).

Community service (CS): is a mandatory service for "any person who is a citizen of South Africa intending to register for the first time as a professional nurse in terms of the Nursing Act (33 of 2005). The individual is expected to perform remunerated service for a period of one year at a designated public healthcare facility" (SANC, 2007).

Newly qualified nurses: nurses who have recently graduated from a nursing education institution and are doing their community service year.

Orientation programme: refers to the structured support given to the newly qualified nurses after the induction process. The aim of having an orientation programme is to facilitate the transition process.

Practice readiness: entails having broad foundational knowledge with some specific job abilities, delivery of safe patient care and demonstration of well-balanced cognitive and psychomotor skills (Wolff & The Coalition of Entry-Level Registered Nurse Education 2007).

The transition period: time spent when a newly qualified nurse is adapting from the student nurse role to the role of an independent professional nurse during community service.

1.9 CONCLUSION

The next chapter will present the literature surrounding the practice-readiness of newly qualified nurses for practice.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

In the previous chapter, the research plan was outlined. In this chapter, the literature surrounding practice readiness of newly qualified nurses (NQNs) is presented. The following issues are covered: academic preparation for practice readiness, the transition to practice, support systems, and the working environment.

2.2 ACADEMIC PREPARATION FOR PRACTICE READINESS

Preparing graduate nurses who are 'work ready' is the primary concern for nursing education institutions, health organisations and the regulatory council (Wolff, Pesut, & Regan, 2010). Edward et al. (2017) reported that ever since the shift from hospital-based training to institutions of higher education, the nursing profession has advanced in knowledge, but that came with a cost of loss of "work readiness." Work readiness was defined as the extent to which the newly qualified nurses demonstrate knowledge, skills, and ability to work independently upon placement. Practice readiness is believed to be the possession of basic knowledge and skills of a specific job and demonstration of reasonable balance between knowing, thinking and doing.

Differing perspectives between clinical practitioners and those who are in academia regarding the issue of practice readiness of newly qualified nurses are recorded in the literature (Dlamini et al., 2014; Wolff et al., 2010). Nurse educators view newly qualified nurses as work ready while nurses in practice felt that they are not fully equipped to handle the contemporary health care needs of the patients (Dlamini et al., 2014; Wolff et al., 2010). Wolff et al. (2010) reported that the existing nursing shortage crisis compels managers to expect the newly qualified nurses to "hit the ground running." The health sector is troubled by several issues other than the nursing shortages they include financial constraints, high demand for quality and patient safety. Also, the complex patient needs the influx of information and the use of advanced technology (Benner, Sutphen, Leonard, & Day, 2010; Dyess & Parker, 2012; Giddens & Brady, 2007; Wolff et al., 2010). However, the implementation of innovative teaching and learning strategies will assist in resolving the challenges that affect the readiness of newly qualified nurses (Benner, 2012; Glen, 2009; Spector & Odom, 2012).

2.2.1 Strategies to address the educational challenges

Stanely & Dougherty (2010) stated that nurse educators are in the process of reviewing the nursing education delivery systems. The focus is now on a student-centered approach, as advocated by the National League for Nursing (2003) as opposed to the traditional teacher-centred approach (Cadorin, Bagnasco, Rocco, & Sasso, 2014). The belief is consistent with that of Benner (2012) who pursued the call for the radical renovation of nursing education programs. The educational transformation move focuses on addressing the widely debated practice-education gap or the lack of clinical expertise among newly qualified nurses to better prepare nurses who are responsive to the complex health care needs of the society (Benner, 2012; Benner et al., 2010)

Similar to the international community of nursing education, authors in South Africa have advocated the transformation of their nursing education system by adopting the framework that was established by the World Health Organisation (WHO) (Armstrong & Rispel, 2015). Several issues were addressed in their study using the WHO six building blocks for transformative education. Two of those elements were of interest to this discussion: the national standards on accreditation, regulations and vocational qualifications and the curricula, faculty, and education. Their study participants found the existing nursing curriculum unresponsive to the health needs of the people of South Africa and that of the healthcare system (Armstrong & Rispel, 2015).

The concerns about the unfulfilling nursing curriculum were associated with the progressing perceptions about the lack of competencies of the newly qualified nurses. Newly qualified nurses were said to be lacking in social skills, assertiveness, integrating theory with practice to solve patient problems, foundational nursing skills and aspects of professionalism (Armstrong & Rispel, 2015; Rispel, 2015). The curricular issues were coupled with the absence of innovative teaching strategies among nurse educators, especially those who are based in nursing colleges (Armstrong & Rispel, 2015).

Despite the progressive changes noted within the nursing profession and the healthcare environment, the use of traditional teaching techniques that is dominated by the rearrangement of the same content material and static PowerPoint presentations were highlighted (Benner et al., 2010; Dalley, Candela, & Benzel-Lindley, 2008). However, this approach can be changed if nurse educators could become forward thinking when creating the nursing curriculum (Dlamini et al., 2014; Giddens & Brady, 2007). Armstrong & Rispel (2015) suggested the incorporation of social accountability to the new nursing education reforms to improve the professional competencies of new nursing graduates. Armstrong & Rispel (2015) defined social accountability as a necessary mandate, which requires medical schools to ensure that their teaching, research and service undertakings address the leading health concerns of the people that are under their context.

2.2.2 Curriculum models to promote innovative teaching and learning

“Nurses are far more than beings of memorisation” (Brandon and All, 2010, p. 89). Duane & Satre (2014) claim that learning in nursing occurs through social interaction and collaboration with others within and outside the learning environment. As already mentioned, the radical reformation of nursing education supports the move from traditional educational approaches to innovative approaches which are founded on the constructivism learning theory (Benner et al., 2010) rather than cognitivism and behaviourism (Cadorin et al., 2014). Constructivism is a learning model that seeks to provide opportunities for creative learning (Duane & Satre, 2014). In this approach, learners work interdependently to construct their knowledge in a supportive learning environment, and the educator facilitates the learning process (Duane & Satre, 2014).

The literature supports the view of basing the nursing curricula on constructivism because its characteristics are suited for preparing learners who will be responsive to the ever-changing needs exhibited by the profession as well as the healthcare sector. Constructivism empowers the learner to be self-directed, to self-critique, and to engage in reflective practice, to become critical thinkers who can synthesise information, link concepts and become lifelong learners (Brandon & All, 2010). In addition to those features, constructivism ensures that meaningful learning takes place (Cadorin et al., 2014), as well as collaborative learning (Duane & Satre, 2014). Constructivism can form the basis of various approaches such as concept-based curriculum (Sportsman & Pleasant, 2017); competency-based curriculum (Spector & Odom, 2012); problem-

based learning (Nyback, 2013) and case-based learning (Kantar & Massouh, 2015). Furthermore, constructivism is easily incorporated into the clinical learning settings because the students are taught concepts rather than vast amounts of content-loaded materials (Brandon & All, 2010).

2.2.3 The constructivism approach benefits

Nurses who are produced under the constructivism learning frameworks would adapt better during the transition from the student nurse status to becoming experienced practitioners (Peters, 2000). The same view was proclaimed by Hein (1991), who highlighted that the constructivism approach prepares learners for the 'real' world as opposed to learning that is based on rigid structures. Also, education is accomplished through collaboration rather than individualistic learning, which is integral to the nursing profession (Duane & Satre, 2014). Constructivism enables seamless collaboration within the nursing education fraternity, including clinical learning to ensure that students achieve the programme outcomes (Brandon & All, 2010). Collaborative learning, which forms part of the constructivism model, was found to enhance student-learning abilities by promoting the development of essential nursing skills (Duane & Satre, 2014).

Other features that are effective in responding to the dynamism of the health sector are that the constructivism approach incorporates the development of critical thinking skills and encourages spontaneous adaptation to changes in evidence-based practice (Brandon & All, 2010). The use of the constructivism approach was also found responsive in limiting content-laden curriculum, which restricts time for processing information critically and the use of scientific knowledge in practice (Dalley et al., 2008). In this case, students are taught concepts, which enhance clinical learning as well (Brandon & All, 2010).

2.2.4 Clinical learning

Acquisition of clinical skills is mandatory for student nurses who are expected to achieve a specified number of clinical hours during their nursing education program (Cant & Cooper, 2017). The clinical environment is crucial in the preparation of student nurses for their professional roles because it gives them exposure to the realities of the profession (Henderson, Cooke, Creedy, & Walker, 2012; Papathanasiou, Tsaras, & Sarafis, 2014). Effective clinical learning can be assured by having clinical nurses

who are knowledgeable about handling the dynamics of the working environment (Papathanasiou et al., 2014). However, simulation-based learning can offer student nurses similar clinical experience. Several studies have confirmed that simulation-based education improves students' clinical knowledge (Cant & Cooper, 2017).

2.2.5 Integration of theory with practice

The literature shows that nurse educators struggle to equip student nurses with the knowledge to facilitate the translation of theoretical knowledge to practical experience (EL Hussein & Osuji, 2016). Integrating theoretical knowledge with practice is imperative in gaining clinical credibility (Handley & Dodge, 2013) or the art and science of nursing (Mabuda, Potgieter, & Alberts, 2008). Student nurses should be assisted in achieving this integration (The Nursing Education Stakeholders (NES)-Group, 2012).

According to Brandon & All (2010) integration of theory with practice is the primary responsibility of nurse educators. During clinical learning, nurse educators take on the role of coaches, or facilitators and develop innovative teaching methods that will produce competent professionals. The clinical instructor collaborates with the course coordinator to promote meaningful learning in each clinical placement or before a clinical rotation (Brandon & All, 2010). A similar proposition was made in the new model for clinical nursing and training in South Africa (The Nursing Education Stakeholders (NES)-Group, 2012). Kirschling & Erickson (2010) revealed that recent studies have indicated that there is a disconnection between nurse leaders in academia and those who are in clinical practice. The lack of association between the two sectors is attributed to the transformation of nursing from hospitals to nursing education institutions or universities. Even though the change yielded good results, some unintended effects emerged such as the failure to implement clinical practice initiatives for students and aligning the course content with current clinical practices commented (Kirschling & Erickson, 2010).

2.3 TRANSITION TO PRACTICE

In South Africa, newly qualified nurses undergo a one-year mandatory service called community service before licensure (SANC, 2007; Roziers, Kyriacos & Ramugondo, 2014; Govender, Brysiewicz & Bhengu, 2015, 2017). The community service period marks the newly qualified nurses' transition period to professional practice. The community service period is perceived as fulfilling because it offers an opportunity to

gain work experience and development of professional roles and responsibilities (Govender et al., 2015, 2017; Roziers et al., 2014). However, some newly qualified nurses felt overwhelmed, expressing feelings of dissatisfaction due to the lack of clarity of their roles as community service nurses. Such experiences were compounded by insufficient orientation and support from registered nurses (Govender et al., 2015, 2017; Roziers et al., 2014; Thopola, Kgole, & Mamogobo, 2013).

Challenges associated with the transition experience were not unique to the South African setting. Whitehead who explored the preparedness of British newly qualified nurses for practice uncovered that they have a fear of the accountability status; not being supported; new clinical setting; and the loss of security from being a student. These findings confirm some of the challenges that were articulated by Duchscher (2009) who reiterated that the transition from student nurse to employment generates a considerable amount of pressure due to exposure to extensive change, coupled with an environment that has a new set of rules and regulations, responsibilities. Duchscher (2008) summarised the transition process into three stages as the doing stage, the being stage and the knowing stage. While several authors (Gentile, 2012; Liou, Cheng, Tsai, Chang, & Liou, 2014) have completed studies using the work of Duchscher (2008), none has suggested an alternative classification of these stages.

2.3.1 The transition stages

Duchscher (2008) identified, and named, the transition stages, in her study involving fourteen female undergraduate nurses within the first year of professional practice role, in a hospital setting in Canada. The transition stages described the experiences of graduate nurses during the process of becoming registered nurses.

2.3.1.1 The doing stage

According to Duchscher (2008), the newly qualified nurses upon entry to practice face a wide range of intense and fluctuating emotions. They come in with a lot of enthusiasm, but all that disappears as they learn about the realities of the workplace as well as their role expectations. All the knowledge they acquired during their educational preparation melt away due to lack of self- confidence, which is compounded by clinical experience deficit, and the dynamics of the healthcare environment. In response to this “mysterious” situation, the newly qualified nurses manoeuvre through the processes of discovering, learning, performing, concealing,

adjusting and accommodation. This first stage approximately encompasses the first three to four months of the transition period.

2.3.1.2 The being stage

The being stage commences after the initiation phase. It is characterised by progressing development of nursing knowledge, skills, and critical thinking abilities. The nurses became aware of their professional identity, and they begin to challenge the pre-graduate philosophies of nursing by revealing the inefficiencies, and the inadequacies of the healthcare system. During this stage, the newly qualified nurses start to disengage, question, search, show, recover, accept and ultimately re-engage with their chosen career. Another vital aspect of this stage is that the newly qualified nurses begin to interpret everything from their perspective. This stage approximately starts after the fourth month up to the eighth month (Duchscher, 2008).

2.3.1.3 The knowing stage

The knowing stage is the final stage of the transition process. This stage is a continuation of the second stage whereby the newly qualified nurses continue with the recovery process. Towards the middle period of this stage, the newly qualified nurses take some time exploring and examining their professional landscape. Some moderate stress occurs at this stage, due to the realisation of the hierarchal organisation of the healthcare system, which shows that nurses exist at the bottom of this chain of command of authority and power. Finally, by the twelfth-month, all the newly qualified nurses feel more comfortable and confident in performing their professional roles and responsibilities.

2.4 SUPPORT DURING THE TRANSITION PERIOD

A structured transition programme guided by skilled and experienced preceptors foster the acquisition of expert nursing skills (Bratt & Felzer, 2011). Whitehead et al. (2013) revealed that the United Kingdom Central Council for Nursing, Midwifery and Health Visiting decreed that all newly qualified nurses should undergo a preceptorship programme to support them during the transition period. This consensus was reached following a belief that nurses who are educated outside the apprenticeship model would not be adequately equipped for the realities of nursing practice. Preceptorship in the context of the United Kingdom refers to the process whereby registered nurses

and midwives provide support to newly qualified nurses and midwives (Whitehead et al., 2013). The council further specified that the preceptors should have at least one-year clinical experience and hold a teaching qualification. These specifications vary from country to country (Whitehead et al., 2013).

In South Africa, a clinical preceptor is only responsible for supporting and teaching nursing students. The clinical preceptor should be a registered nurse, licensed to practice, have at least three years clinical experience, above-average clinical knowledge and have excellent communication and interpersonal skills. They should be computer literate, having a positive attitude to self, students, the nursing profession and clinical environment, and lastly, must possess a valid driver's license (The Nursing Education Stakeholders (NES)-Group, 2012). However, to some healthcare stakeholders, the introduction of preceptorship programs to support newly qualified nurses appeared to be accidentally telling employers that their products were not yet ready for work despite obtaining qualifications from an accredited nursing program (Candela & Bowles, 2008).

Support during the transition period is deemed necessary for the facilitation of skills acquisition, as articulated by Benner (1982) in her theory from "Novice to Expert." Newly qualified nurses are categorised as advanced beginners in Benner's theory. At this level, the newly qualified nurses need support because they rely on classroom knowledge, which may not be easy to apply in different challenging clinical situations upon placement (Benner, 1982). The author further stated that novice nurses have limited ability to prioritise patient care. Ongoing support throughout the first- year of practice, which is inclusive of debriefing sessions would improve the development of clinical judgement, and enhance the acquisition of skills necessary to provide safe and quality care to patients (Bratt & Felzer, 2011; Dyess & Sherman, 2009; Strauss et al., 2016). Zhang et al. (2017) supported this idea and stressed that mentoring programs promote nursing competency and good work relations that contribute to positive patient outcomes. Dyess & Parker (2012) stated that nurse managers are in a better position and are well suited for providing support to the newly qualified nurses during the transition period. However, running a support program is very costly, taking into consideration the existing fiscal constraints within the health care sector and the gross shortage of nurses (Dyess & Parker, 2012).

2.4.1 Barriers to support for newly qualified nurses in clinical settings

Ebrahimi et al. (2016) linked the perceived lack of support during the transition period to the attitudes of the newly qualified nurses towards their profession. In their study, licensed nurses highlighted that some new graduates showed no interest at all in their nursing profession. The lack of interest was demonstrated by self-exclusion from ward routines, spending too much time sitting, overuse of mobile phones, no behavioural change after in-service education and the lack of assertiveness regarding support-seeking behaviour to enhance skill acquisition (Ebrahimi et al., 2016). In a study by Dlamini et al. (2014), the lack of passion for the profession was associated with laziness and dislike of bedside nursing.

On the other hand, the lack of support was attributed to the work overload, which originates from the nursing shortages. The experienced nurses become too exhausted, and that leaves them with no desire or strength to support the newly qualified nurses (Ebrahimi et al., 2016). However, some nurses tend to withhold their support because they believe that the nursing education institutions had equipped the new graduate with the necessary skills and knowledge for the role (Ebrahimi et al., 2016).

2.5 THE WORKING ENVIRONMENT

The healthcare sector demands nursing education programmes that produce graduates who are work ready to remain profitable, effective and efficient (Bradshaw & Merriman, 2008; Hofler & Thomas, 2016). The stresses of the working environment have compelled nurse leaders in practice to shorten the orientation periods for the new workforce and move them rapidly to acceptance of professional roles and responsibility (Dyess & Sherman, 2009). A study conducted in Norway reported that newly qualified nurses enter into the professional world with a lot of enthusiasm but that suddenly disappears because of the experienced nurses neither respect nor inspire them. As a result, they are forced to learn and cope on their own (Bjerknes & Bjørk, 2012; Meleis & Price, 1988).

Studies conducted in South Africa reported a variety of factors that affect the newly qualified nurses in the working environment. These included inadequate orientation and supervision by senior personnel, lack of teamwork, shortage of human resources, deficiency of equipment, heavy workloads, high patient acuity and negative staff attitudes (Govender et al., 2017; Roziers et al., 2014; Thopola et al., 2013).

Sönmez & Yıldırım (2015) revealed that newly qualified nurses encounter two types of factors that influence their levels of stress in the working environment. Chandler (2012) and Feng & Tsai (2012) grouped these elements as professional and organisational factors. Professional components consist of role ambiguity, inadequate knowledge and skills, demanding responsibilities, and awareness of professional accountabilities. Regulatory factors comprise of time pressure when caring for patients, narrowed job description, nursing staff shortage, heavy workload, task-oriented operations rather than patient-oriented activities, shift work, high expectation for competency, limited peer support, difficulties in communicating with physicians and a shortage of material resources. Furthermore, workplace bullying, lack of access to mentors and coaches as well as generational diversity are other issues that negatively impact on the newly qualified nurse's experience in the working environment (Hofler & Thomas, 2016).

Workplace bullying is a destructive force in human relations, affect work performance (Vogelpohl, Rice, Edwards, & Bork, 2013) and hinders workplace socialisation of newly qualified nurses (Hofler & Thomas, 2016). Victims experience an inferiority syndrome, which progresses to noticeable psychological effects such as insomnia, diminished self-confidence, isolation, poor work ethics, absenteeism reflected by the excessive use of sick leave (Longo & Sherman, 2007; Wilson, 2016). However, the education of nurse managers and staff enables recognition of workplace bullying, and this might help in preventing harmful acts from happening (Vogelpohl et al., 2013).

The lack of a conducive working environment causes enormous stress to all nursing professionals. Work stress causes detachment and burnout which results in reduced work performance thus compromising patient safety and care (Hofler & Thomas, 2016). However, a variety of factors have led to the health sector inability to retain experienced nurses who will assist the newly qualified nurses to adjust seamlessly to practice; these include retirement, increased workloads, lack of career advancement, availability of flexible work opportunities and scarcity of resources (Hofler & Thomas, 2016).

2.6 CONCLUSION

The literature surrounding practice readiness of newly qualified nurses during their transition period was discussed. In the next chapter, a detailed research process and methodology used in the study will be explained.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This section discusses the research design, research setting, sampling process, data collection, data analysis, trustworthiness, and the ethical considerations.

3.2 RESEARCH DESIGN

A research design is a systematic plan used by a researcher to solve the research problem. It entails the logical steps, which guide the research process (Polit & Beck, 2010). The study aimed at exploring the perceptions of the newly qualified nurses of their readiness to practice in an academic hospital. A qualitative, exploratory research design was deemed adequate for achieving the objectives of this study. An explanation of why this research design is ideal follows.

3.2.1 Qualitative Research

The selection of a particular research method finds its basis on the nature of the research question (Brink, Van der Walt, & Van Rensburg, 2012). In this study, the researcher wanted to find out the perceptions of the newly qualified nurses of their readiness to practice in an academic hospital. The study of human experiences, feelings and subjective views is associated with qualitative research studies (Brink et al., 2012; Gray, Grove, & Sutherland, 2011; Polit & Beck, 2010).

Qualitative research is a systematic approach that allows the researcher to interact with individuals or groups to study their life experiences and to infer meaning from them (Gray et al., 2011). The use of a qualitative research approach enabled the researcher to engage with the participants gathering information about their perceptions of their readiness to practice as qualified nurses.

Another critical characteristic feature of this design is that it allows the use of words instead of numbers. Researchers who intend to provide an in-depth understanding of human experiences from the participants' point of view would find it challenging to quantify this type of data (Brink et al., 2012). Conclusions drawn from the data gathered from the verbal information provided by the participants were presented in a word form instead of a numerical format to delineate an in-depth narrative view of their perceptions.

3.2.2 Exploratory Research

The adoption of an exploratory research design shades light on the different ways in which a particular problem can manifest (Polit & Beck, 2010). Botma et al. (2010) stated that exploratory research design adoption occurs when there is limited information known about the problem under study. As already indicated in the research problem, the literature search has yielded fewer research works that have explored the perceptions of newly qualified nurses of their readiness to practice in an academic hospital in the South African context. Thus, the exploratory research approach is suitable for addressing the problem under investigation in this study.

3.3 RESEARCH SETTING

The research setting is a specific location where data are collected (Brink et al., 2012). Choosing a research site depends on the nature of the problem under investigation and the type of the data required for solving the problem (Brink et al., 2012). In qualitative studies, data collection occurs in a natural setting where the experiences are lived (Botma et al., 2010). A natural setting, for research purposes, is an environment free of alterations (Brink et al., 2012).

An academic hospital in Johannesburg was the research site for this study. The hospital was purposefully selected because it is one of the largest accredited public health academic hospitals used for the placement of newly qualified nurses for community service. This site was chosen for its convenience to the researcher regarding accessibility.

3.3.1 The Context of the Research

The context of the research is another important aspect of qualitative research. According to (Brink et al., 2012) background information about the research context is essential in qualitative research because it informs the readers about the uniqueness of the research setting.

The research setting is an academic hospital used by various faculties of health science for clinical teaching and research.

3.4 THE SAMPLING PROCESS

The sampling process entails selecting the appropriate group of objects, subjects or events from which the research answers or information are sourced (Brink et al., 2012). Hence, the need for the researcher to define his or her population and sample (Brink et al., 2012).

3.4.1 Population

A population is a targeted group for the study (Polit & Beck, 2010). The study population was the newly qualified nurses who were doing their compulsory community service. The population consisted of all newly qualified nurses (N=65) who were working in the academic hospital during the time of the study. The population consisted mainly of new graduate nurses from two nursing education colleges and three universities in the Gauteng province.

3.4.2 Sampling

In qualitative research, sampling continues until data saturation is reached because the total number of participants to be included is not known in advance (Brink et al., 2012). Sampling is the process of selecting a representative subset of the entire population (Polit & Beck, 2010). A commonly used sampling method in qualitative research is purposive sampling.

3.4.3 Purposive sampling

Purposive sampling permits the investigator to select participants who have been through a particular experience and are conversant with the subject matter (Brink et al., 2012; Polit & Beck, 2010). Purposive sampling is also known as a 'judgmental' or 'selective' sampling because participants have to fall within a predetermined sampling criterion of the study (Gray et al., 2011).

The participants were purposefully sampled from the departments of Medicine, Surgery, Obstetrics and Gynaecology, and Paediatrics and Child Health. These departments were selected because the educational preparation of undergraduate nursing students focuses mainly on these areas of practice. Therefore, newly qualified nurses placed in these units would be able to provide in-depth knowledge about the

research problem. Table 3.1 below presents the departments and the specific units in which the participants were sampled.

Table 3.1: Departments and Units where Participants were sampled

Name of Departments	Wards/units
Medicine	• Pulmonary ward • Dermatology ward • Cardio & endocrine ward
Surgery	• Cardiothoracic surgery • Otorhinolaryngology surgery • Orthopaedics
Obstetrics & Gynaecology	• Labour ward • Neonatal ward
Paediatrics & Child Health	• Medical paediatrics ward

3.3.4 Inclusion and exclusion criteria

The inclusion and exclusion criteria enable the researcher to decide whether an individual or an object can be classified as a member of a study population (Brink et al., 2012).

Included in the study were:

- Professional nurses who completed their training in 2016.
- Professional nurses who were engaged in community service at the academic hospital.

Excluded were all:

- Newly qualified nurses who were working in intensive care units (ICUs) and other highly specialised units because they spend little time during training in these units hence their knowledge would be limited.

3.3.5 Sample size

In qualitative studies, the sample size is not known in advance, but it is established when saturation of information is reached in the area of study (Brink et al., 2012; Gray et al., 2011). Data saturation is the point whereby there is no new information, ideas, and views gathered from the participants when collecting the data (Brink et al., 2012; Gray et al., 2011; Polit & Beck, 2010). The purpose of using data saturation is to get thick (quantity) and rich (quality) data from the population of interest (Fusch & Ness, 2015).

In this study, a minimum of three participants was selected within the sampling framework until data saturation was reached at a sample of 16 (n=16) participants. The sample comprised of three males and thirteen females.

The following aspects enabled the researcher to reach and determine data saturation; asking the participants similar questions, using open-ended questions, probing for more information and using a data saturation matrix. A data saturation matrix facilitates easy identification of recurring concepts or themes across the dataset (Fusch & Ness, 2015). The figure (3.1) below is a sample of the data saturation matrix designed and used by the researcher in this research.

Table 3.2: Saturation Matrix Sample

Interview Questions	**Participant's responses (themes)**						
	P 01	P 02	P03	P05	P 06	P 07	P 08
Q1							
Q2							
Q3							
Q4							
Q5							

KEY: **Q-** Stands for the question; **P:** Stands for a participant

3.5 DATA COLLECTION

3.5.1 Data Collection Method

A semi-structured face-to-face interview was the data collection method used in this study. Semi-structured interviews allow the researcher to prepare in advance a set of questions or topics that need to be covered during the interview (Polit & Beck, 2010). Therefore, an interview guide was used to guide the researcher when conducting the interviews.

3.5.1.1 Data collection tool

In qualitative research, the researcher is instrumental in gathering the data (Gray et al., 2011; Polit & Beck, 2010). Moreover, an interview guide helps the researcher to focus the interview on the specific objectives of the study and encourages the participant to give more in-depth information freely (Polit & Beck, 2010).

3.5.1.2 Interview guide

The researcher designed an interview guide with the help of the research supervisor who refined and validated the questions before being pretested. The interview questions were pretested to determine their validity and reliability among three participants. The pretesting of the tool also gave the researcher an opportunity to improve her interview skills, refine the questions and estimate the time for completing an interview session. The pretest results were not included in the primary study.

The interview guide (Annexure 1) comprised of five open-ended questions that were accompanied by a list of probes to assist in eliciting more in-depth information. Additional probes were generated during the interviews as guided by the participant responses.

3.5.2 The process of data collection

During the time of requesting permission to conduct the study, the researcher met the head of departments of the selected departments and asked for permission to interview the newly qualified nurses who were under their management. The head of departments provided the researcher with either a list of all the newly qualified nurses and or a list of the names of the operational managers and units in which the study

participants were stationed. Also, the researcher met with some of the operational managers in one departmental meeting and presented a brief overview of the research proposal. All of these measures facilitated access to the newly qualified nurses.

3.5.2.1 Gaining access to the participants

- In all the units, the researcher introduced herself to the operational manager and asked for permission to have access to the newly qualified nurses. Most of the in-charge nurses were very welcoming and assisted in directing the researcher to the potential participant.

- The prospective participant was approached. Firstly, the researcher introduced herself, gave a verbal explanation of the purpose of the study and invited the individual to participate in the study. An information sheet (Annexure: 2) was presented to all candidates who showed interest in the research. Questions that arose about the purpose and the study processes were answered to the satisfaction of the participants.

3.5.2.2 During the interview

- Before the commencement of the interview, a consent form for participating in the study (Annexure: 3) and consent for digital recording (Annexure: 4) was issued and voluntarily signed by every participant.

- All interviews were held in locations that were chosen by the participant and at a time that was suitable for him or her. The majority of the participants preferred to be interviewed at their workstations, during less hectic days like Fridays and the weekend and less busy hours such as lunchtime and in the afternoon. Fewer participants preferred off days and or after working hours. The most commonly used venues for the interviews were, the staff kitchen, operational manager's office, and doctors call room, an empty ward, and the nursing residence or nursing home.
- The exact time or preferred time for conducting the interview sessions were not decided during the first contact due to the nature of the job. The

times were communicated via WhatsApp or by continuing to revisit the ward at the various times that were proposed by the participants.

- The duration of the interviews varied from person to person. The minimum time spent on each session was 24 minutes and the maximum time was 43 minutes.

3.5.2.3 Challenges encountered in some units:

- It was difficult to find a room that had low levels of noise
- Controlling the up and down movement of staff members was difficult.

However, such disruptions were resolved by pausing the recorder for a while, shutting the door, and asking the other staff members to lower their voices and requesting for fewer visits to the interview site.

- At the end of the interview session, the researcher thanked the participant for voluntarily participating in the study and offered him or her two candies as a token of appreciation.

3.6 DATA ANALYSIS

The purpose of data analysis is to organise, provide structure and to draw meaning from the data (Polit & Beck, 2010). In qualitative research, data analysis is carried out concurrently with data collection.

In this research, the data were analysed using Braun and Clarke's phases of thematic analysis; transcription, reading and familiarisation, coding, searching for themes, reviewing themes, defining and naming themes and report writing (Braun & Clarke, 2006).

3.6.1 Braun & Clarke's Phases of Thematic Analysis

Thematic analysis is a method for categorising, analysing, and reporting patterns within the dataset (Braun & Clarke, 2006). The authors further contended that it is a comprehensible and theoretically flexible method of analysing qualitative data.

3.6.1.1 Data transcription

Data transcription refers to turning audio information into text notes by writing verbatim what the participant said during the interview (Braun & Clarke, 2006). All the interviews were recorded using a digital voice tape recorder to capture the exact words or phrases reported by the participants. The information shared by each participant was saved using a number that was allocated by the researcher for identity purposes. The researcher transcribed all the interviews verbatim herself. A sample of a transcript can be found as (Annexure: 5). All the data transcripts were checked for completeness and accuracy by concurrently listening and reading all the written scripts before they were further analysed. Transcribing the interviews also helped with data familiarisation.

3.6.1.2 Reading and familiarisation

During this phase of data analysis, the researcher immerses himself or herself to be familiar with the data by reading the scripts (Braun & Clarke, 2006). The data scripts were repeatedly read while listening to the voice recordings to gain the sense of the data and to be familiar with the content. The researcher was also able to search for meanings and patterns of the entire data for easy categorisation.

3.6.1.3 Coding

Coding is a process of identifying concepts of interest within the data that can be assessed in a more meaningful way concerning the research problem (Braun & Clarke, 2006). The research question and the objectives were then reviewed. Illuminating ideas that contained related information were highlighted using the same colour font and pasted into a table for easy identification and categorisation of the coded data. A long list of codes was produced from the dataset.

3.6.1.4 Identification of themes

The coded data were analysed and sorted in preparation for theme identification. The sorted data were presented in a table to help to group the codes into themes. Potential themes were deduced, and relevant coded data extracts were unified under the identified themes to establish theme categories.

3.6.1.5 Reviewing themes

Reviewing themes is about determining whether candidate themes fit well with the coded data (Braun & Clarke, 2006). In this phase, the themes were examined to verify if they were coherent with the coded data. The researcher also checked if they were enough data segments that supported the major themes. Finally, a thorough data check was undertaken to validate if the themes were an accurate reflection of the perceptions of the participants using a thematic map. Information that was not analogous was reshuffled and or redefined until there were no new discrepancies noted.

3.6.1.6 Defining and naming themes

Defining and naming themes refers to theme refinement. Themes are refined to ensure that they provide a comprehensive description of the data content (Braun & Clarke, 2006). The themes were refined to ensure that they broadly define the scope and content of the data provided by the participants. The refinement of the themes was achieved by reviewing and evaluating the collated data extracts with the analysis drawn by the researcher. The analysis was presented to the research supervisor who, together with the researcher, examined the whole analysis process, refined the work and confirmed the relevance of the themes to the data context.

3.6.1.7 Report writing

Report writing is the final phase of the qualitative thematic analysis phase. This phase is the write-up of the research report (Braun & Clarke, 2006). In the write-up, an analytic review of the study findings was presented, which included capturing data extracts to substantiate the credentials of the themes. A detailed report of the above information will be presented in the subsequent chapters.

3.7 TRUSTWORTHINESS

According to (Lincoln & Guba, 1985), the primary focus of qualitative research is trustworthiness. It helps in evaluating the consistency and quality of the methods used when conducting the study. Trustworthiness has four evaluative criteria, which are credibility, dependability, confirmability, and transferability.

3.7.1 Credibility

Credibility means confidence in the veracity of the data and the meanings attached to them (Polit & Beck, 2010). The following criteria were satisfied to ensure the credibility of the research findings: prolonged engagement, member checking and peer-debriefing.

3.7.1.1 Prolonged engagement

Prolonged engagement allows the participants to get accustomed to the researcher (Braun & Clarke, 2006). The interviews did not all take off immediately in the first contact. Arrangements were made, and during that period rapport was established with the participants. As a result, the participants were comfortable to share their personal feelings and experiences encountered during their first year of professional practice.

Another aspect, which encouraged openness was emphasising that all their inputs, would be kept confidentially and that there were no right or wrong answers to the questions that would be asked during the interview.

3.7.1.2 Member checking

Member checking refers to the sharing of the data interpretation with the participants to determine its accuracy (Brink et al., 2012). Member checking can be done informally or formally, that is during the interview session or after the data analysis respectively (Polit & Beck, 2010). In this study, member checking was carried out during the interview session. The researcher frequently analysed the participant's responses and asked for comments to ascertain if the conclusions drawn reflect their perspectives.

3.7.1.3 Iterative questioning

Specific strategies should be incorporated to discover false information (Shenton, 2004). Data quality was ensured by the use of probes, rephrasing questions and returning to previously discussed extracts to elicit more detailed information, which also helped in detecting any emerging discrepancies.

3.7.1.4 Researcher's credentials

In qualitative research, the researcher becomes the data collection 'instrument' and plays a major role in the analysis of the data (Polit & Beck, 2010). Therefore, the

researchers' knowledge, skills, and experience are essential in establishing the reliability of the data (Polit & Beck, 2010).

The researcher completed a workshop on research methodology and qualitative data analysis; therefore, she is knowledgeable about the processes, procedures and the systematic undertakings of this research approach.

Also, the research supervisor is highly knowledgeable about the processes and procedures of this type of research. The supervisor actively monitored the entire research proceedings to ensure adherence to the methodology or principles of this research.

3.7.1.5 Debriefing sessions between the researcher and the supervisor

Debriefing refers to the process whereby the researcher's data analysis is subjected to external validation (Polit & Beck, 2010). The researcher frequently met with the supervisor who cautiously monitored the data analysis process. The supervisor brought to light any flaws or gaps within the researcher's interpretations and provided constructive guidance to achieving data accuracy.

3.7.2 Dependability

Dependability refers to the sustainability of the data when repeated over time and under similar circumstances (Polit & Beck, 2010). This criterion was achieved by providing a full description of the research processes and methods to enable other researchers who may be interested in using similar procedures to have a clear understanding of how the data were collected and analysed to reach the conclusions presented in the study.

The research supervisor also served as an external auditor:

- Provided guidance and ensured that the researcher was adhering to the research plan.
- Provided constructive feedback regarding the data analysis to ensure better interpretation of the findings.
- Evaluated the content of the interviews for quality and adequacy.
- Assessed and confirmed the results of the study.

3.7.3 Confirmability

Confirmability means that the conclusions drawn from the study accurately reflect the subjective opinions of the participants rather than the researcher's underlying assumptions (Brink et al., 2012; Polit & Beck, 2010). The following measures created an audit trail:

- The interviews were digitally recorded to capture all information given by the participants and they were transcribed verbatim
- All the raw data were held securely and would be kept safely for two years after publication and six years without publication.

3.7.4 Transferability

Transferability refers to the generalisability of the research findings in other settings and samples (Brink et al., 2012; Polit & Beck, 2010). The results cannot be transferred due to some limitations that would be discussed in chapter six. However, the research methodology could be used in other similar settings. A thick description of the research methodology is provided so that it could assist other interested investigators to make their judgements when applying the processes and procedures used in this study.

3.8 ETHICAL CONSIDERATIONS

Research that involves humans and animals is obliged to address ethical issues (Polit & Beck, 2010). It is also imperative that the researcher submit his or her research proposal to the appropriate research review committees who are also responsible for granting permission to conduct the study (Brink et al., 2012).

3.8.1 Permission to conduct the study

Permission to do the research was sought and granted by the following committees:

- The Human Research Ethics Committee (Medical) of the University of Witwatersrand and granted the ethical clearance certificate, protocol number: M170483 on the 21 June 2017 (Annexure: 6).
- Research site approval was sought from the Chief Executive Officer and the Nursing Director of the Academic Hospital. The permission was granted on

the 16 August 2017, research proposal number: GP_2017RP29_955, (Annexure: 7).

- The University of the Witwatersrand Postgraduate Committee granted the title approval on the 19 July 2017(Annexure 8).

3.8.2 INFORMED CONSENT

Informed consent is one of the procedures used to preserve and protect participants' right to self-determination. The informed consent should contain comprehensive information to inform the participant about the research. The information given to the participant plays a role in signing the consent form (Polit & Beck, 2010).

An information sheet (Annexure: 2), written in the English language was given to all participants. The English language was chosen because it is the medium of instruction in all academic institutions in the country, which means all persons at this educational level commonly understand it. The following aspects were contained in the information sheet:

- the purpose of the study, potential benefits, and risks associated with participating in the study,
- time commitment and explaining the process and procedures,
- anonymity and confidentiality were discussed,
- Also included was emphasising that participation was entirely voluntary, and that withdrawal would not lead to any prejudices.

An opportunity to ask questions was given to the participants before the signing of the two consent forms; for participating in the study form (Annexure 3) and for digital voice recording form (Annexure 4).

3.8.3 The principle of respect for persons

This principle entails the right to self-determination and full disclosure (Polit & Beck, 2010). Respect for persons can be violated by withholding information and misinforming the participants about the purpose of the study as well as the use of threats to get their consent (Brink et al., 2012; Gray et al., 2011; Polit & Beck, 2010).

The following conditions were met to fulfil the participant's right to self-determination and full disclosure:

- The participants were informed that participation in the study is purely voluntary.
- The right to withdraw at any time from the study was communicated to the participants.
- The participants were told about the purpose of the study.
- Participants were encouraged to ask questions for clarification about the research.
- Participants were treated with respect throughout the study.
- There were no benefits or rewards promised to the participants for them to be part of the study.

3.8.4 The principle of beneficence

The principle of beneficence is about protecting the participant from harm and discomfort during the study (Polit & Beck, 2010).

- Participants were told that information they shared in the study would not be used against them or shared with the members of the staff in the ward.
- Participants were informed that participating in the study would not result in any form of discomfort or harm.

3.8.5 The principle of justice

The principle of justice refers to the right to fair treatment and fairness in the selection of participants (Brink et al., 2012).

- Participants were selected based on the inclusion and exclusion criteria of the study.
- All Participants received the same treatment, for example, they were all asked similar questions.

3.8.6 Anonymity and confidentiality

Anonymity and confidentiality are about respecting the participants' right to privacy. Anonymity is the act of ensuring that information provided during the study could not

be traced back to the participants while confidentiality is the act of not disclosing the information shared during the investigation (Gray et al., 2011; Polit & Beck, 2010).

- Numbers instead of the participants' names or personal identifiers were used to differentiate the raw data. The same numbers were also used in the research report.
- Access to the data was limited to the researcher and the research supervisor.
- To avoid breaching confidentiality, the researcher transcribed the data.
- All raw data would be kept in a lockable locker at the University for a minimum of two years after publication, or six years in the absence of publication.

3.9 CONCLUSION

In this chapter, the research design and the methods were discussed. In the next section, the findings of the study will be outlined.

CHAPTER FOUR: RESULTS

4.1 INTRODUCTION

In this chapter, the results of the study are presented. A content analysis of the interviews conducted with newly qualified nurses was done according to Braun & Clarke's Seven Stages of Thematic Analysis, namely transcription, reading and familiarisation, coding, searching for themes, reviewing themes, defining and naming themes and report writing (Craver, 2014). Four themes were deduced during this process namely 1. The transition from education to practice, 2. Support, 3. Working environment and 4. Settling in as shown in table 4.1 below. Twelve categories emerged from the four themes.

Table 4.1 Themes and categories

Themes	Categories
1. The transition from education to practice	1.1 Formal preparation for practice
	1.2 Absence of deliberate practice
	1.3. Exposure to specialist conditions
2. Support	2.1. Orientation programme
	2.2. Operational manager
	2.3. Peer support
3. Working environment	3.1. Resources
	3.2. Patients
	3.3. People or staff dynamics
4. Settling in	4.1. Overwhelmed
	4.2. Acceptance
	4.3. Growth

4.2 DESCRIPTION OF THE THEMES

4.2.1 Theme 1: Transition from education to practice

The transition from education to practice refers to the changes that occur between leaving the relatively safe role of a student nurse to an employee of a health service, where the newly qualified nurse (NQN) has her first experience of working as a full-time nurse with patient responsibilities. The theme has three categories, namely formal preparation for practice, deliberate practice, and exposure to specialist conditions.

4.2.1.1 Formal preparation for practice

Formal training for practice refers to the preparation the participants received in their respective nursing education institutions during their undergraduate studies. Participants indicated that the curriculum influences their ability to transition from education to practice.

The newly qualified nurses, who participated in the study irrespective of the nursing education institution they had attended, felt that the educational programme concentrated more on theoretical knowledge than practical knowledge. As a result, they thought they were not ready for practice and expressed an inability to handle their professional responsibilities.

Participant 5 stated, "*I was ready in a theoretical sense… because the theory behind what I was meant to be doing, I knew. Ah, but the practicality of it…I wasn't very comfortable with it…"*

This sentiment was echoed by participant 11, *"I wasn't sure whether I was ready or not when I came here, because you know at university, you learn a lot (more) of theory than practice. So, as much as you think that you might be ready and all of that. At the same time, you are scared because you don't know what you are going to do when taking the responsibilities as a professional. Being a student and becoming a professional nurse, is not very easy."*

Another issue raised by participants was that during their training, they had limited time to consolidate information. The nursing programme was viewed as good, but it did not adequately prepare the NQNs to become competent practitioners because it consists of various fields, and is very full. As a result, they do not get enough time to consolidate and integrate their knowledge into practice. Both the college-trained nurses (diploma nurses) and university-trained nurses (degree nurses) expressed similar sentiments.

One of the participants (6) who came from a nursing college explained that "*the tutors are pushing us to do our assignments and write tests like you don't fully understand because we cram to pass. You don't get to learn to understand because all you want is to pass and be done with D4 (four-year diploma). So, it does not fully prepare us for practice; it just works overload."*

A participant (3), who followed a university course said, *"I think maybe, the university must find a balance. But, I do understand, Universities are theory based… sort of. The course is quite challenging, and there is a lot of things to coordinate; different faculties and different departments to fit into the course or curriculum for that particular year. So, I do understand the trouble, the challenges that they face. But, aaa, I do think that college nurses or graduates have the upper hand practically compared to University students."*

There was concern about the time available for clinical experience in both the university and the college courses.

Participant 5, who is a university graduate, said, *"I think if we had more nursing time, more nursing class time because our programme was long and big and full because of other subjects that were not. I wouldn't say they were not nursing related, but they were not under the nursing department. So, your anatomies, physiologies, sociologies, psychologies all those things, they were not taught on the nursing side of things. They were taught as this is psychology and we are teaching psychology. This is anatomy; there is anatomy for nurses, yes, but it still seems the anatomy that the medics (medical students) are doing, it still seems the psychology that the psychologies are doing and also share classes with the same people. So, as much as they would say it's the allied subjects or subject content it still felt like you were studying that subject as the main core subject. We never really had much nursing core time."*

Participant 9 expressed a similar idea: *"I think we don't have enough time for clinical practice, we don't spend enough time in the wards between our rotations. I think we spend a week or two in a certain unit. So, as soon as you are getting more comfortable in a unit you are out already. So, in a unit, when you are getting to know the staff, and you actually start to learn things you are moved out of that environment, and you are put to another one, and you basically have to start over again in that other unit. So, maybe if the rotations could be longer and perhaps maybe the clinical hours that you spend in a hospital physical could be longer instead of once or twice a week."*

The problem of preparing nurses for practice during the formal education course is not only caused by a lack of time as indicated by the participants above, but also by the sequence of the possible placement and the timing of these practical placements.

Participant 6 explains: *"we are not fully prepared because in the fourth year we only go to psych (psychiatric) wards, so, it's only community and psych (psychiatric nursing) so we don't go to surgical or medical wards, and we end up forgetting things. So, the fourth year does not prepare us for com serve (community service) in a hospital because we only go to clinics, community, psych (psychiatric) and we sometimes go to wards for psychiatric nursing. But psychiatry is different from medical and surgical wards."*

All speciality placements seem to be problematic as participants referred to midwifery placements and stated*, "…when it is midwifery block, you will spend two days in labour ward, two days in postnatal, two days in antenatal, maybe two days in admissions. And it's like a rotation. By the time you finish all those two days, you find that two weeks is over, and your block was only two weeks. And you haven't adapted or learned the routine properly in each department so, you just know a bit of everything, and you don't know everything concretely."*

During the formal training period, clinical skills are taught related to the objectives or outcomes of the curriculum and are often taught and demonstrated at a time disconnected to clinical placements. The focus is on the objectives rather than what is happening in the ward. This focus results in fragmentation of learning, which further detracts from the ability to apply theory to practice confidently, once they are qualified as some skills have never been taught or practised while in training.

Participant 10 indicated that, if it is not in the objectives, you are not taught that skill. She said*, "When you are a student, they don't allow you to insert an NG (nasogastric) tube, you just feed a baby that has an NG (nasogastric) tube."*

The consequences of such an approach were explained by participant 6 who said, *"… We went to practice only for our formative and summative exams. We were not like, fully… concentrating on the things that were done in the ward. But now, it affects us because we don't even know what to do if there is a resuscitation in the ward. You just want to run away whereas …, when you were training you could see that there is a resusci(tation) but you didn't care because it was not part of your objectives. But now, reality, you find that there is a resusci(tation) and they are not going to say that you are a com serve (community service nurse), you are a sister. They expect you to know certain things."*

The nursing education institutions have a responsibility to provide clinical supervision and adequate exposure to practice. However, the student nurses are often placed in the wards without the accompaniment of either a clinical preceptor or a facilitator. As a result, they rely on the ward staff who may have priorities other than supervision of students. The participants expressed concerns about both the quality and the quantity of the clinical accompaniment from the nursing education institutions about their transition to practice.

Participant 10 said that *"some of the tutors were diligent in doing their jobs. We will go to the wards and treat a patient with them, and they will show you exactly what this is, like, 'if you are in such a ward, this is what you should focus on.' But some of them, they just dumped us to the sisters in the wards and the sisters have their work, they have to do their other functions, so they felt overwhelmed. So, sometimes we felt like we were a burden to some of them."*

Participant 5, who reflected a great deal on the quality and the quantity of the accompaniment stated that *"the lecturers did come, but it would be like, 'okay guys, I am here to check if you are fine, are you well, do you have any problems?' 'No.' Then they will be like, 'okay, sharp.' Done, gone, that it's, 'we will see you next week when you are in a different ward.' You understand. It wasn't a consistency thing, to say ok, maybe every second day, whatever, or there was someone you can literally run to because as students, when you get to the ward, sometimes you are even scared to ask the permanent staff because they seem so busy. And some would say, 'you are just a student, just sit down and do whatever you have been taught by your lecturers.' Then you would wish the lecturers were there. Sometimes you would voice these things out, 'in the wards they are not helping us,' and all of that. The lecturers would come, but still would be there for about ten, twenty minutes and then would leave. Still, they would come in with that sense, of saying, ok; 'where are you having trouble in.' At that time, if I am not having any trouble, I would say, 'no, I am not.' Then she would be gone for the rest of the day and the other days when I am experiencing difficulty. All I am saying is that the opportunity should be there to go to the lecturers and ask and all of that. But the hands-on type of stuff they were not really there, in my experience."*

4.2.1.2 The absence of deliberate practice

Deliberate practice is defined as “repetitive performance of a motor or cognitive skills combined with an assessment of those skills and specific instructional feedback” (Ericsson et al., 2015, p. 535). The newly qualified nurses indicated that they were taught skills during their training, but they did not get enough time to practice those skills under the supervision or guidance of their tutors until they were confident to perform them accurately, before exposure to clinical practice.

Participant 5 stated that they were never given much time to practice the skills they have learned under supervision and guidance until they were competent in doing them. He said, *“It was one session in class, practice on him and practice on her, and that was it, now go to the wards you are ready.”*

The sequence of clinical placement and the amount of time spent in clinical practice was another issue that inhibited deliberate practice. Both the diploma and the degree students attributed their lack of confidence to the lack of time spent practising the skills in the clinical setting.

Participant 1 who trained from a college said, *“even though you were taught, but you don’t know the practical part of it because D4 (four years diploma) students, we only stay like two weeks in a ward. So, you don’t get to practice and be perfect for doing something.”*

The importance of skills training and the implications of the lack of deliberate practice was raised by participant 14. He said*, “I feel like if you are in a certain area for three weeks, you get to master how things are being done and your practical confidence becomes more feasible. Whereas… I would go to practical’s for three days, learn how to take a BP and then the following week I would go to school haven’t mastered how exactly practical to take a BP. So, that’s the thing; you end up forgetting the skill but knowing more theory of how to do the thing because most of the time you spend in class.”*

Insufficient time to practice the skills due to the sequence of the clinical practice was not the only problem that led to short deliberate practice time. The participants felt there was a lack of continuity of learning between the two areas of learning (nursing

education institution and clinical setting) contributing to their lack of confidence in delivering care to the patients.

During training, the newly qualified nurses did not gain real-life experiences because there is no communication between their tutors and those who are in practice.

Participant 14 explains the discrepancies, *"…you find that I've learned how to take BP (blood pressure), but when you come here (clinical setting), they show me how to take the temperature. So, there is no continuity of learning. So, the system is like "A and C." So, I think there should be proper communication between the clinical facilitators and the lecturers to say, ok, this week we are dealing with this, then they will know what they must focus on when we get to the hospital. So, there is just that discontinuation of learning."*

Participant 1 supported this concern: *"I was placed in a neurology ward. And when I went for accompaniment we were taught how to remove staples, other things, you see, which is not relevant to what I am placed in. … we could not practice the procedures we learned in class."*

Another issue that inhibited deliberate practice was the variation between the skills that are taught by nurse educators and what they experience in practice. Some participants felt what they have learned in class from their lecturers is not commensurate with what is happening in practice.

Participant 9 stated the variation, *"…what we're taught in varsities, or at school, it is not necessarily how we do it in the wards."*

Participant 7 expressed how she felt when could not practice what she was taught at school during the clinical placement*, "you get disoriented at times. You feel like lost. Sometimes you feel like you don't know anything because …it is not the same things you did at school."*

4.2.1.3 Exposure to specialist conditions

The newly qualified nurses, in this study, were placed in an academic hospital. An academic hospital is a level three hospital that deals with diseases that need special care and management. Most of the participants were not exposed to this type of hospital during their training. As a result, they felt unprepared for practice.

Participant 1 said, *"…I was not ready to be honest because it's a speciality ward. I did three years at (hospital name) hospital, which is a level two hospital and (a) lot of these things (conditions) are not there… so, many of these things (conditions) I haven't seen them with my naked eyes."*

Participant 12 also indicated the lack of exposure to an academic hospital: *"… the thing is, coming from the hospital where I trained, we didn't have specialised units like medical was just medical. Everything goes into the same place, and now I found myself into this huge training hospital, and then I was like, OK, specific for whatever organs in the body. So, I found myself in an infectious disease ward; It was scary. …if I had trained in this institution, it would have been in line with my training. But in the institution where I trained, it did not prepare me to work in such a hospital."*

Participant 16 said*, "…some of the conditions in this ward, I didn't know about them. And I never knew about them from the hospital I was practising. So, I've learned them here in the ward."*

4.2.2 Theme 2: Support

Support refers to the assistance given to the newly qualified nurse during the transition period. Newly qualified nurses require support to adjust seamlessly to the new working environment. Without help, they feel neglected, unwelcomed and stressed. Therefore, it is the responsibility of a healthcare institution to ensure that newly qualified nurses receive support during the transition period. This theme discusses the support system available in the academic hospital, under the following categories; orientation programme, support from the operational manager and support from peers or friends.

4.2.2.1 Orientation programme

An orientation programme is one strategy that is used to ensure that newly qualified people learn about the requirements of their roles and are socialised to the new environment (Business Dictionary, 2017). The operational manager and other experienced nursing staff are responsible for orienting the newly qualified nurses. An orientation, should be structured, comprehensive, ongoing and be done by an individual who is knowledgeable about the duties of the person who is being oriented to ensure that they acquire all the knowledge and skills required to perform the duties.

All the newly qualified nurses attended an orientation programme offered by the hospital administration, which was mainly about the policies and human resources issues. All the participants were happy with the orientation given by the hospital administration because it was more in-depth when compared to the orientation they received in their respective wards. They claim that it was too short, unstructured and it only focused on the physical layout of the ward instead of equipping them with knowledge on how to deliver nursing care to the patients. As a result, they were afraid of taking on their responsibilities.

Participant 1 commented about the orientation. She said, *"…it was a short orientation. It was about the geography, like, this is the sluice room and what, what, but they couldn't fully orientate us."*

Participant 15 shares the impact of an inadequate orientation*, "…you are sort of afraid that you will make mistakes because you didn't go deep into the orientation."*

The depth of the orientation was not the only thing that made the newly qualified nurses to be scared of taking their responsibilities but also the lack of a structured orientation plan was a concern. As a result, some of their expectations and learning needs were not covered.

Participant 13 who expressed that there was not much guidance from the staff, said, *"there wasn't a particular structure (formal orientation), to say, on Monday we will be learning about this so that you are oriented. We were just joining into the routine of whatever they were doing. And then, along the way, you were learning. I don't know if it's a perception that you are registered, you have graduated, you must know, or they somehow assume you know what to do somehow, and then you will learn whatever else along the way."*

Other newly qualified nurses felt that they were thrown in at the deep end due to the shortage of staff; therefore, they had to struggle on their own as explained by;

Participant 5, *"…you kind of jump into the deep end in the ward, because, unfortunately for us here, as the (ward number) staff, we were short staffed, so they couldn't really take their time into orienting us…. So, we were thrown in at the deep end, but somehow we managed to swim our way out basically."*

Contrary to the above sentiments, some participants were satisfied with the orientation they received from the ward staff. All the participants in this study were doing their one-year community service, which is a mandated service for all nurses who studied to be registered as professional nurses. One of the principles of community service is that newly qualified nurses should work under supervision to gain and develop their nursing skills. However, some organisational issues hinder that goal as already seen above.

Participants who were pleased with the orientation were those who had an opportunity to shadow members of staff for one month and received some positive feedback about their progress from the operational managers. However, even those who did not shadow anyone in the ward were hoping that the work processes would be explained or shown to them rather than being left on their own.

Participant 2 stated, *"…you have about one month of orientation, you are basically shadowing other people in the ward. It is quite sufficient because during that shadowing you don't practice on your own. And it's not like at the end of the orientation you are just thrown in at the deep end. "*

Participant 4 who was satisfied with the orientation said*, "…our operational manager regularly has feedback sessions with us, and will discuss how we feel. And we write the things that we still lack and in the next session they would ask if we have achieved the objectives that we set for ourselves at the previous meeting."*

4.2.2.2 Support from the operational manager

The operational manager is a registered nurse who is in charge of the workstation or the ward and his or her role influences how the newly qualified nurse would adapt to the new environment. Newly qualified nurses possess the theoretical knowledge, and they require support from the health care practitioners to develop their clinical skills. Some participants were miserable in their wards because the operational managers were not supportive and they relied on the ward sisters for support.

Participant 8 who could not cope in the ward because of inadequate support from the operational manager, she said*, "…my operational manager is just something else, I don't understand her…Right now, we are having patients who are falling, serious adverse events. It's very hard in the ward. You will tell her (the operational manager); this is what is happening in the ward. She will be like, 'ah, why don't you handle it."*

Some participants felt that they were not supported while others felt that both the operational managers and the ward sisters played a significant role during the transition process. The operational managers and the ward sisters provided guidance, feedback and monitored their progress until they felt confident to work independently.

Participant 2 explains how the operational manager supported her: *"…the operational manager was quite efficient because you know as a new staff (member) you try and find out how are the reviews, what's the feedback and if you are doing a good job so that you can actually grow as an individual. So, she actually did do that, she provided feedback whenever necessary, compliments all the time. And if she feels I need a bit of guidance, she will pair me with somebody, or she would sometimes provide the guidance herself."*

Participant 1 who received support from the ward staff said*, "…if I was all by myself, and there was an emergency, I would probably be at SANC (South African Nursing Council) by now because I wouldn't know what to do."*

4.2.2.3 Support from peers

Peer support refers to the support that the newly qualified nurses received from those they studied with and from other newly qualified nurses. Newly qualified nurses valued peer support during the transition period.

All the newly qualified nurses who participated in the study valued peer support because it made them aware that everyone is overwhelmed and frustrated by the new role. Thus, it reduced their anxieties.

Participant 3 said, *"I do have one particular friend that I talk to, we exchange experiences, and yeah, in that way you really debrief. I guess it feels good to know that someone else is in the same boat and is frustrated as you are about work."*

Participant 6 echoed the same view *"having peers to talk too helps because it makes one aware that there are problems everywhere. They are also not happy where they are. So, it consoles me in a way."*

The peers did not only help each other to cope with the emotional stress that comes with being a newly qualified nurse, but they shared clinical knowledge and skills that assisted them to solve clinical and personal problems.

Participant 5 stated, *"my peers, I would say, they still influence the way I do things because you know, sometimes aah, human error and mistakes happen, and you forget things…they are always willing to help. Yeah, aam we are still in touch the majority of us. We still help each other, we go and visit each other in the wards just to see how they are doing and stuff like that. It does add value, aah in a sense that because you know not all of us are in the same ward, so we experience different things and when you go to them to ask their opinion regarding work stuff, and you always get a vast variety of ways of doing things."*

Participant 8 said, *"we have a WhatsApp group with my friends, whereby we sometimes chat about the challenges that we encounter day by day. And then they will tell you how to handle such issues, like what needs to done and not to do."*

4.2.3 Theme 3: Working environment

Working environment refers to the circumstances that the newly qualified nurses face during the adaption period. The majority of the nurses were shocked at the amount of work they were expected to do with limited resources and were also traumatised by the demands and the behaviours of the patients towards them as new nurses. In this theme, the perceptions of the newly qualified nurses about the working environment will be further discussed under the following headings: resources (material and human), the patients, and people/staff dynamics.

4.2.3.1 Resources

Resources include both human and material (equipment and drugs) resources, and they are all essential for quality delivery of healthcare services. The newly qualified nurses verbalised concerns about the resources because they believed it compromised the standard of quality care.

Many indicated that there is a shortage of staff and it was marked as the primary contributor of heavy workloads in the working environment; as a result, they expressed feelings of burnout and distress.

"Shortages of staff!" exclaimed participant 14 as he explained how it feels to work under such circumstances: *"Experiencing that, it's like you can go crazy. We have fewer nurses than patients, putting more burden on those who are available, causing us to be much more tired than we are supposed to be."*

Participant 8, who commented on the issue of staff shortage said, *"they are expecting you to give quality care, but you are having 32 patients with five nurses. So you are nursing eight patients as one nurse…they are expecting everything to be perfect. …it is very hard; it's very hard."*

The shortage of staff and increased workloads were not the only problems that frustrated the newly qualified nurses but also the quality and the quantity of the material resources. The newly qualified nurses felt that the status of the resources compromised the delivery of quality care to the patients. They end up providing substandard care to ensure that they do something for the patients. That situation troubled the participants as in some cases they were compelled to do such practices because doctors would blame them if particular care were not given to the patients.

Participant 9 expressed her distress about the status of the material resources. She said, *"…with resources, sometimes they are here (available), sometimes they are not here (available). Some of the equipment is old, or they are about to break. So, it's worrying because sometimes you need that specific instrument or that resource that you don't have. And you end up cutting corners, so, you end up doing the wrong things sometimes."*

Participant 6 who was asked to comment on the impact of limited resources, said, *"It affects us during doctors' rounds, like a lot because if the vital signs of the patient are not written, yooh! They will be saying, "sister, why, why, why this is not done," as if it is our fault."*

4.2.3.2 The patients

Patients refer to individuals who are being provided care by nurses in the hospital. To some of the newly qualified nurses who were part of this study, the patients were part of the support system that was available for them during the transition period. Some found the patients supportive others did not.

The newly qualified nurses who felt that the patients were not supportive expressed shock about the patients' conduct and that stimulated anger towards the patients. That anger suggested that they were not prepared to handle such behaviour during their training.

Participant 5 narrated his circumstances*: "Patient is a 50-50 type of thing…. Some days you don't even know what happened, patients are angry, shouting, they are this and that. Yeah, to some extent it does influence aaa the way, honestly the way I feel towards them."*

Participant 8 who showed great emotion when narrating a story of a patient who was complaining about their service, she said*, "…I was angry towards the patient because I was the one who was running the shift. I tried to make some means, to get bread and make some tea for her but she threw it back on me."*

Participant 12 also related her encounter with a patient*, "The working environment can be stressful at sometimes … A patient hit me, and this made me not be anywhere near a crazy patient."*

The above extracts show the negative experiences. Some participants had positive encounters with the patients, and that motivated them to continue to work regardless of the difficulties they were facing in the working environment.

Participant 9 said*, "the patients are amazing. I think that's my motivation amongst all the nonsense in the ward."*

Participant 11 shared a similar sentiment. She said, *"Patients are cool. I think I get along with patients than the staff."*

Participants 14 said*, "there are times when I feel like I don't want to go to work but then I just think of the patients, you know what, these people make me happy … if it weren't for them (patients) I would say the shift is not so nice; I am staying at home.*

4.2.3.3 People / staff dynamics

All the members of the staff have a significant role when it comes to socialising newly qualified nurses as they venture into the professional world. Staff dynamics refers to various unprofessional conducts and personalities of the staff members.

The newly qualified nurse found it hard to work with other members of the staff. They belittled them because they are young and lacked sound clinical skills and knowledge. The participants' feedbacks revealed some aspects of bullying in the workplace. They

were oppressed; assigned enormous responsibilities and the staff withheld information about the work they were supposed to do.

Participant 1 relates the experience: "*During delegation, they (staff) will delegate you to do tachy (tracheostomy) care for instance. Even though the step-by-step procedure on what needs to be done, was not given to us. So, I was afraid when I was allocated to do those things (responsibilities). I was afraid that I wouldn't be able to do them, and it's the very same people who are unapproachable. …even if I approach them, they have that attitude, 'you are a sister, you should know, you should know'."*

Some participants felt that there is little teamwork because some of the staff members would be busy with their phones on Facebook during work time and would refuse to do the work that was assigned to them - especially those who are in the lower ranks.

Participant 9 said, *"there is more resistance in the lower ranks, but in the senior RNs (registered nurses), there are one or two. They just refuse point blank. So, I end up doing that job myself."*

Participant 8 who found it hard to work with junior staff said, *"it is tiring because we are being bullied by people who had been working years and years here.…when you tell them, do this, they will be like; 'who are you to tell me what to do. You don't know anything; you have been in this ward for three months. I've shown you how things are done here not long ago, why don't you just take this time and practice those skills. 'The sad thing is that you can't reprimand them because you are scared and you are still going to ask for assistance from them. They will also tell you that they have been in this ward for 20 years and you have just come here, who are you to come in and try to change things."*

4.2.4 Theme 4: Settling in

Transition into practice can be exciting before exposure to the realities of professional practice. This theme is about the experiences of the newly qualified nurses upon entry to professional practice. The initial period entails a gradual process of acquiring professional skills and knowledge until the new nurse has gained self-confidence in handling the roles and responsibilities of professional practice. The following categories were deduced from the participant interviews: overwhelmed, acceptance and growth.

4.2.4.1 Overwhelmed

Being overwhelmed is a feeling that can be brought by a new experience. Newly qualified nurses had to leave their student status and adopt a professional status in a new environment and in the presence of other professionals who might have different expectations than those held by the newly graduated nurse.

The newly qualified nurses expressed feelings of being overwhelmed because they lacked confidence in their skills and being exposed in an unfamiliar environment. They were also worried if they will be able to handle their professional duties with the knowledge they had acquired during their training.

Participant 2 stated that *"I was overwhelmed, I was stressed, because, this is not the hospital that I trained in (sic). So, I had to learn the new trends and how they do things here... as well as the medication."*

A participant (14) who appeared to be engulfed with self-doubt said*, "…the transition from a student to being a qualified professional nurse is such a big gap to fill. So, you are filled with indecisive ideas of whatever I've learnt at school; is it going to be enough? Will I be accountable? Will I be responsible enough? Will I be able to put the theory that I've practised at school, aaa, will it be enough to be practised here in the hospital? And another thing is that the time when you were a student, it was easy to make mistakes while knowing very well that someone will cover you. But now, as a qualified professional you have to be responsible and accountable for what you are doing. So, all of those feelings and fears, they just become overwhelming."*

4.2.3.2 Acceptance

The transition into practice for some newly qualified nurses began with negative views of self-worthless, poor self-confidence and uncertainty about their capabilities regarding the requirements of their role. However, with time, they accepted their professional duties and viewed themselves as accountable and responsible leaders of the profession.

Participant 7 said *"… I have outgrown some of the things that made me feel like I am disoriented, I am useless, such things. So, I can say, I have adapted a lot… now I am a professional nurse; I have to be responsible… I can't run away from that. So, I have*

to fly no matter how hard it can be, yes, I may struggle somewhere somehow, but obviously I have to consult and ask for help."

4.2.4.2 Growth

Initially, the newly qualified nurses were overwhelmed and lacked confidence in handling their professional duties; they eventually experienced growth and felt more comfortable.

The newly qualified nurses stated that after they had worked for some time, they developed some skills. As a result, they were less overwhelmed by the new environment and regarding handling their professional roles and responsibilities.

Participant 14 excitedly stated *that "…by mid-March that's when I got comfortable and I started gaining confidence in what I know and aaa, feeling less overwhelmed. Because all the expectations that aaa, I had to achieve, I kind of excelled, yeah."*

Participant 13 who was enjoying her achievement said, *"At the moment (early August), I have found my feet, I am no more anxious, and I'm more confident. …and when you are leading with confidence, I think it also rubs off on other people. You tend to be even more happy and motivated to do more. So, in running shifts, it's not as hard now, because I can lead."*

Participant 3 stated that *"I think I have, I would say I've grown and learned definitely, and just developed a better of a sense of what a nurse does in a ward typically, on a day to day basis."*

4.3 CONCLUSION

This chapter presented the findings of the study under four themes and twelve categories, which emerged from the data analysis of the interviews gathered from the participants. In the next chapter, the findings of this research will be discussed based on the literature.

CHAPTER FIVE: DISCUSSION

5.1 INTRODUCTION

In the previous chapter, the results of the study were outlined. This chapter discusses the findings in relation to the literature under the four themes that emerged from the participants' interviews namely; 1. The transition from education to practice, 2. Support, 3. Working environment and 4. Settling in.

5.2 COMPARISON OF THE FINDINGS OF THE STUDY WITH THE LITERATURE

5.1.1 The transition from education to practice

In a 2011 nursing summit, challenges that influence the nursing profession were addressed (Department of Health, 2012; The Nursing Education Stakeholders (NES)-Group, 2012). The challenges addressed included the continuous reports about the lack of competence of newly qualified nurses coupled with poor clinical practice management. As a result, a new clinical model for nursing education, training and practice were proposed (The Nursing Education Stakeholders (NES)-Group, 2012). However, the challenges are still unresolved as the majority of the study participants reported that they were not ready for independent practice upon placement. The results of this study confirm the perception that newly qualified nurses are not 'work ready'(Brown & Crookes, 2016; Dlamini et al., 2014; Edward et al., 2017; Wolff et al., 2010).

In a study by Armstrong & Rispel (2015) the lack of practice readiness was attributed to the inadequacies of the nursing curricula. A similar view became apparent in this study. The study participants felt that their programme did not prepare them for the realities of nursing practice because it concentrated more on theoretical knowledge than practical learning. Inadequacies associated with the curricula found in the literature, include failure to integrate theory with practice during the instructional time (Dale, 1994) and insufficient time for clinical practice (Walker et al., 2017). Similar findings were reported in this study.

Furthermore, the curriculum was perceived as big and full of none nursing courses, which took some of the nursing time. In this regard, the participants suggested the restructuring of the nursing programme so that more time would be spent developing

nursing skills because nursing is more practical than theory. The views of the participants are in line with the propositions made in the new clinical model, training and practice regarding the amount of time that should be spent in clinical practice (70%) and theory (30%) (The Nursing Education Stakeholders (NES)-Group, 2012).

Other issues that impeded on the practice-readiness of newly qualified nurses during their educational preparation include poor quality of the clinical placement settings, lack of supervision during clinical practice time and limited resources; this is similar to the findings reported in (Armstrong & Rispel, 2015). Moreover, Dlamini et al. (2014) revealed that less attention is given to the practical component as opposed to the classroom lessons. Similarly, to the findings of this study, but the participants also revealed that there was insufficient time for theory either because they were overloaded with theory, thus forced to cram.

Matters associated with content overload reported in this study consists of studying to pass assignments, tests, and exams rather than achieving meaningful learning. The highlighted issues reiterate the view the administration of the curricular content is one of the significant challenges in the education of health professionals (Giddens & Brady, 2007). The adoption of a concept-based curriculum has been proposed as a solution that can rescue the nursing education profession from content saturation (Giddens & Brady, 2007).

Results from the study also indicated that the newly qualified nurses had low levels of confidence because of the absence of deliberate practice. The findings are supported in the nursing literature by (Gonzalez & Sole, 2014) who contend that the application of deliberate practice has not been fully incorporated despite the evidence, which suggests that retention of fundamental skills is bound to be lost without constant practice. In their study, results showed that undergraduate nursing graduates were unable to accurately, perform specific procedures after not practising for about 4 to 6 weeks. (Kardong-Edgren & Mulcock, 2016) affirmed this and revealed that 12 out of 13 students who had been taught and practised how to do a urinary catheterisation, failed to adhere to the procedural steps without the guidance of the clinical instructor after six weeks of not practising. In this research, spending little time between ward rotations and the lack of continuity of learning hindered the aspect of deliberate practice; hence, there was no mastery of skills.

However, delays in the uptake of deliberate practice during training have been linked to the belief that nurses would learn and master their professional roles and responsibilities when they enter the workplace (Barsuk, Cohen, Mcgaghie, & Wayne, 2010). The participants in the study had the same view as they were disappointed by the reactions of other staff members who were reluctant to assist them to learn about the activities of their roles. The participant's reactions concur with findings presented in Parker, Giles, Lantry, & McMillan (2014), who stated that participants in their study were disappointed when the assistance promised to them did not happen.

On the other hand, the reluctance of the experienced nursing staff to assist NQNs may indicate their lack of understanding and appreciation of the levels of nurses' skill acquisition as outlined in Benner's theory, 'From Novice to Expert'. The theorist articulated that skills develop with time through repeated exposure to a similar situation that requires the application of similar knowledge (Benner, 1982). Benner's work also revealed that a newly qualified nurse is at the level of an advanced beginner, whom she described as an individual who has been taught a variety of situations and objective information but lacks experiential knowledge and clinical judgement (Benner, 1982). Similarly, Del Bueno (2005) concluded that newly qualified nurses lack clinical skills, and sound clinical judgement required to provide safe patient care competently.

The lack of exposure to an academic hospital during the educational preparation was another concern, which the participants of this study believed resulted in their lack of readiness for practice. They were seeing the management and some the conditions for the first time thus; they struggled to provide direct patient care. The findings of this study are in line with that of (Edward et al., 2017)who concluded that limited exposure to practice during the educational preparation period compromises the work readiness of newly qualified nurses. However, the type of clinical settings was not specified unlike in this research. In addition, Gohery & Meaney (2013) indicated that their study participants felt ill-prepared and incompetent to work in a critical care setting due to inadequate education and support.

5.1.2 Support

Despite having completed an accredited nursing programme newly qualified nurses require assistance from experienced personnel to effectively handle their professional

roles and responsibilities in diverse health care settings (Moore & Cagle, 2012; Edward et al., 2017). Evidence drawn from this study revealed the lack of formal support structures in the workplace such as mentoring, coaching, supervision and orientation programmes hindered their smooth transition to practice.

On the other hand, the study participants shared divergent views about the amount and quality of support they received during the transition period in their various units. There was also some variation with the application of the support system within the same facility in the different departments (Morrell & Ridgway, 2014; Thopola et al., 2013; Parker et al., 2014)

Negative feelings about the support emerged from the nursing staff shortages. Also linked to similar feelings is the lack of mentors or supervisors, failure to meet the new graduate nurses learning needs and expectations as well as short or the unavailability orientations (Bisholt, 2012; Gardiner and Sheen, 2016; Thopola et al., 2013; Walker et al., 2017). The identified support issues contribute to the development of frustration and low self-confidence (Govender et al., 2015; Thopola et al., 2013). Wolff et al. (2010) and Dlamini et al. (2014) added that the lack of support has the potential of compromising patient outcomes. Of concern to some of the study participants is that the ward orientation was about the geography of the hospital and the work routine other than the conduction of the nursing duties. However, participants who viewed the transition support positively were those who received support from experienced nurse practitioners

The participants' comments about the content of the orientation they received in their workstations are similar to the findings by Kellett et al. (2015) who revealed that newly qualified doctors wanted their orientation to focus more on practical skills required for fulfilling their professional responsibilities. Whitehead et al. (2013) stressed the importance of providing comprehensive support to newly graduated nurses even though they may display some degree of competency because they lack the confidence to assume independent practice.

Despite the existence of evidence about the professional abilities of new graduates, the study participants continued to experience unfair treatment as they stated that they learned to 'swim' on their own through trial and error. However, through peer support as indicated in Whitehead et al. (2013), the self-confidence of the participants improved

when they discovered that everyone is faced with similar circumstances. High levels of satisfaction with peer support were also reported in Govender et al. (2015) as reflected in the responses of the participants of this study. Edward et al. (2017) stressed that positive partnerships with experienced peers and mentors could significantly improve the work readiness of newly qualified nurses during the transition period. However, more research still needs to be done regarding peer support because not a great deal of information was found in the literature.

5.1.3 Working environment

Participants of the study could not cope with the weight of the workloads, which were aggravated by low levels of teamwork between them and the lower nursing categories. Evidence from the literature indicates that newly qualified nurses encounter challenges in the working environment upon placement (Thopola et al., 2013; Roziers et al., 2014).

Several instances of bullying behaviour were raised during the interviews including withholding of information, gossiping, being ignored, being shouted at and, humiliated, being given unmanageable workloads and having allegations made against the participants. The bullying behaviours found in this study were similar to findings reported in (Wilson, 2016; Hofler & Thomas, 2016; Vogelpohl et al., 2013). The majority of the participants were exposed to all three aspects of bullying as outlined in (Vogelpohl et al., 2013), which are work-related bullying acts, person-related bullying and physical intimidation bullying. Organisations that are unresponsive to the issues of bullying are encouraging unethical behaviours (Hofler & Thomas, 2016). The authors further stated that these harmful acts should not be ignored because they affect the personal life of the new professional and impede on the quality of care given to the patients.

When asked about actions they had taken about the cases of bullying behaviour they had experienced, participants revealed a fear of victimisation and further intimidation because everybody was aware of such instances but nothing had been done to address them. On the other hand, other participants stated that they had already applied to be transferred to other wards because that is how everybody new had responded to the situation. However, the responses of the participants are incongruent to the evidence presented in the literature about the implications of bullying, which include leaving the job or changing profession (Wilson 2016; Hofler and Thomas 2016;

Vogelpohl et al. 2013). The response of the study participants might probably be driven by the fact that they are obliged to complete one year of community service in a designated hospital and possibly require money to pay for their study loans.

Another concern linked to the challenges that newly qualified nurses' face in the working environment is the issue of nursing role confusion associated with role ambiguity (Govender et al., 2017; Parker et al., 2014). Duchscher (2009) and Feng & Tsai (2012) described such circumstances as "reality shock."

5.1.4 Settling in

Participants of the study had mixed emotions. They were full of excitement about their achievements, but those feelings were quickly dispelled as they learned about the professional responsibilities ascribed to their role. As a result, they expressed feelings of being overwhelmed. Several studies in the literature reported similar findings in the first few months of employment (Govender et al. 2017; Bjerknes & Bjørk 2012; Hart & Bowen 2016; Duchscher 2008). The study participants focused their attention on learning their professional duties and familiarising themselves with the new environment. Findings from Kumaran & Carney (2014) concurred with the study findings. Also, in their study, the newly qualified nurses were worried about the number of responsibilities and degree of accountability required by their new role.

Professional roles come with professional accountability. Many of the participants expressed fear of making mistakes because they were now accountable for their errors and omissions unlike when they were students. Similarly, participants in a study by Kumaran & Carney (2014) were anxious because of the loss of the student status which comes with security and support from licensed practitioners. Hofler & Thomas (2016) termed such experiences 'anxiety performance'.

Some of the participants did not have full access to support. However, they gradually accepted their professional responsibilities and finally overcame the feelings of being overwhelmed and experienced professional growth after repeated exposure to the same working environment. These findings are consistent with Kumaran & Carney (2014) who reported that initially, the newly qualified nurses viewed the duties as a considerable burden, but eventually accepted that it was part of their professional requirements.

Evidence from the literature suggests that the views shared by the participants in this study about their transition experience are not new. Bradshaw & Merriman (2008) reported that, since the transformation of the nursing profession from the 'training model' to the 'education model,' newly qualified nurses felt unprepared and lacked the confidence to practice independently upon employment. During the transformation period, any views, which implied that the new system was not fulfilling, were dispelled and justified with either, the 'lack of understanding' of the new nursing education training systems, or with a shortage of resources (Elkan & Robinson, 1993). According to Neary (1997), that was the possible reason nurse educators, clinical practitioners and the students had challenges in meeting the educational goals of the profession.

5.2 CONCLUSION

The findings of this research were discussed in relation to the literature. The next chapter is the final chapter of this research report. The summary, main findings, limitations, recommendations and conclusions drawn from this study will be presented.

CHAPTER SIX: SUMMARY, MAIN FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

In the previous chapter, the findings of the study were discussed in relation to the existing literature. This section is the final chapter of the research report; the summary and the main findings drawn from the study will be presented. The limitations of the research and the recommendations towards nursing education, nursing practice and nursing research will be outlined.

6.2 SUMMARY

The purpose of the study was to explore the perceptions of the newly qualified nurses of their readiness to practice in an academic hospital in Gauteng. Four objectives enabled the researcher to achieve the outcomes of the study. The first objective explored the readiness of the newly qualified nurses for practice. The second objective explored the educational preparation the newly qualified nurses received from their nursing education institution, and the third objective explored the perceptions of the newly qualified nurses about the possible formal support structures in the hospital and lastly, their perceptions about the working environment.

The research design was found to be appropriate for the study because it enabled the researcher to meet the purpose and the objectives of the study. In this study, sixteen in-depth semi-structured interviews supported by an interview guide were conducted with newly qualified nurses working in the academic hospital. From the interviews, four themes emerged with twelve categories. The four themes that emerged from the study are the transition from education to practice; support; working environment and settling in. The main findings of the study will be highlighted below.

6.3 MAIN FINDINGS

The transition from education to practice: The findings of the study revealed that the participants were not ready to practice independently immediately upon placement. The participants felt that the formal educational preparation they received from their nursing education institutions concentrated more on theoretical knowledge than practical knowledge. The highlighted concern was exacerbated by limited time to

consolidate the information they had learnt in class. Their responses also revealed that some clinical skills were taught in class, but they never had an opportunity to practice them while they were students. This limitation is intertwined with the aspect of the absence of deliberate practice during their educational preparation. They had limited exposure to clinical practice and inadequate time to practice clinical skills until they had mastered them.

Lastly, the participants revealed that clinical skills were taught based on the curriculum objectives and were demonstrated at a time disconnected to clinical placement. The discrepancy resulted in the fragmentation and discontinuation of learning which gave rise to a failure to apply theory confidently to practice.

Support: The newly qualified nurses struggled with acquiring and developing the necessary skills for their professional role. The primary constraint which led to this situation was the unavailability of support systems in the hospital to help them to transition seamlessly to practice. The on-the-job orientation was too short, the duration varied from ward to ward, and it had a minimum of one day and a maximum of six weeks. The operational managers were always busy, and the newly qualified nurses depended on the ward staff who had no time for teaching them because of other commitments and the belief that being qualified means the individual can handle the professional responsibilities independently. Peer support was found to be helpful, and all the participants valued it.

Working environment: The findings of the study also revealed that the newly qualified nurses found it stressful and challenging to adjust to the working environment. The following issues were perceived as the factors that strained their transition to practice; heavy workloads, shortage of human resources and equipment, bullying and poor teamwork.

Settling in: The theme settling in explains the transition experiences. In this study, the first stage of the transition period began with feelings of being overwhelmed. The newly qualified nurses upon entry to practice were overwhelmed because they lacked confidence in their professional capabilities, compounded with the loss of the student status and the fear of the unknown. However, as they got familiar with the new professional environment, they began to accept their professional accountabilities and responsibilities. They eventually experienced growth.

6.4 LIMITATIONS

- The study was limited to one specific academic institution, and some of the participants had no previous exposure to the similar facility. The lack of prior knowledge and skills made the transition period more challenging for these participants than their counterparts. Thus, created a variation in their responses.

- The sample was confined to one academic hospital; therefore, the findings cannot be generalised to all newly qualified nurses in the Gauteng province or nationally, nor may they be generalizable to the district and regional hospitals.

- The participants were sampled from several different wards that are managed by operational managers who possess diverse managerial skills and levels of professionalism. The lack of uniformity in the professional conduct, skills and attitudes of the operational managers influenced the quality of the data because each participant shared experiences based on their ward circumstances. Some participants had fewer challenges because their managers were said to possess sound managerial skills.

- The data were collected during one specific month, eight months into the community service year of the participants. It is possible that newly qualified nurses would have responded differently at the end of their community service year when they had more experience.

- Research setting was limited by the fact that the site was chosen for convenience of the researcher.

6.5 RECOMMENDATIONS

6.5.1 Recommendations for nursing education

- The purpose of a nursing education institution is to equip student nurses with knowledge and skills required to deliver nursing care competently upon qualification. The researcher suggests that students should be better prepared for community service. Appropriate preparation for service could be achieved by placing the students in general wards in their fourth year of study to revive their medical and surgical nursing knowledge and skills.

- Targeted funding should be made available to implement the proposed clinical and training model for nursing education so that the issues of students being placed in clinical areas unsupervised, unmonitored during experiential learning would be eliminated, thus increasing effective learning in both areas of teaching and practice. Implementing the clinical model will ensure that students have time to develop their nursing skills during role taking, thus facilitating the aspect of deliberate practice.

- It is recommended that concept based curricula be adopted in nursing education institutions to prevent theory overload, which is currently the situation whereby more theoretical information is given with little meaning and application to practice. The adoption of a concept-based framework will enable the educators to have time to provide teaching and learning in a meaningful manner and give students time to internalise the information for easy application to practice.

- Both theory and practical learning should be given equal value to avoid over prioritisation of one educational aspect over the other to ensure adequate acquisition of expertise in both aspects of the nursing programme.

- The nursing education institution should ensure that nursing students are exposed to all levels of care because once a nurse is qualified they can be deployed in any area of practice.

- Students should be taught practical skills on assertiveness to reinforce problem-solving skills and enable them to handle matters surrounding workplace bullying and other work conflicts professionally.

6.5.2 Recommendations for clinical practice

- Newly qualified nurses face many challenges, which are linked to the fear of handling professional roles and responsibilities within the first six months of placement. Therefore, it is suggested that clinical practice should collaborate with the clinical preceptors from the local nursing education institution to extend the period of support given by preceptors to at least six months into their community service placements. This will facilitate a smooth transition from education to practice once the proposed clinical and training model has been implemented. Preceptorship refers to “the process through which existing nurses and midwives provide sup- port to newly qualified nurses and midwives” (Whitehead et al., 2013).

- The hospital should introduce a peer-support group association to provide support for newly qualified nurses as they adapt to their new role.

- The hospital management should create awareness among the staff about bullying. Any person who is reported or seen performing such conduct should be subjected to disciplinary action to promote a positive working environment.

- It is recommended that the hospital should ensure that newly qualified nurses’ especially those who have no previous exposure to an academic hospital be given extra support so that they can quickly develop the nursing skills required in that level of practice.

6.5.3 Recommendations for research

- A workload analysis should be conducted for both the newly qualified nurses and the professional nurses to determine an equitable amount of work each category can manage. In most cases, newly qualified nurses tend to say that they are given too much work to do and that the professional nurses do not have

time to supervise them during placement because of heavy workloads. Therefore, there is a need to find out how much each category can manage.

- It is also suggested that the study is replicated at the national level to improve planning of community service.

6.6 CONCLUSION

The study explored the perceptions of the newly qualified nurses of their readiness for practice. The study-generated findings that will create awareness and understanding of the factors that promote and hinder practice readiness during educational preparation. Therefore, it will enable educators, clinical experts and healthcare stakeholders to come up with meaningful ideas that will contribute positively to the development and improvement of both the academic and practical aspect of the nursing profession. Lastly, the findings will be able to guide clinical managers on how best they can assist the newly qualified nurses to transition with ease to practice so that they can quickly develop their professional skills in an environment that promote learning and increase job and professional satisfaction. Thus, prevent attrition rate among the newly qualified nurses.

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LIST OF ANNEXURES

ANNEXURE 1: AN INTERVIEW GUIDE

Section A Demographic data:

- Age
- Gender
- Unit/ward
- NEI.

Section B Questions:

1. **How readily did you feel to practice as a qualified nurse when you started working in this hospital?**

   Probe:

- Could you please tell me more about your level of preparedness to practice as a qualified nurse?

2. How has the academic program in your nursing education institution helped or hindered you to practice in the academic hospital?

Probes:

- Could you please discuss the formal education you received from your nursing education institution?

- Could you please tell me about the role of fellow students and nurse educators?

3. How do you believe the support structures have helped or hindered you to practice in the academic hospital?

Probes:

- Could you please tell me how the orientation program has helped you?

- Could you please talk more about the mentoring or supervision you received from other staff members?

- Could you please tell more about the influence of the following during the transition period:

✓ Unit manager.
✓ The hospital staff members.

- ✓ Nurse educators or clinical facilitators.
- ✓ Peers.
- ✓ Family members, i.e. parents.

4 How do you think the working environment assisted or hindered you to practice in the academic hospital?

Could you please tell me more about the working environment?

- What about the staff as a whole
- What about the patients.
- Could you please tell me more about the resources?
- Is there anything else you would like to add?

5. Is there anything else you think might have better prepared you to practice as a qualified nurse in the academic hospital?

ANNEXURE 2: INFORMATION SHEET

RESEARCH TITLE: The Perceptions of Newly Qualified Nurses of their readiness to practice in an Academic Hospital in Gauteng

Good day, my name is Sithembile Shongwe. I am an MSc Nursing student in the Department of Nursing Education. I am undertaking a research study entitled, "The perceptions of newly qualified nurses of their readiness to practice in an academic hospital in Gauteng."

I would like to invite you to participate in the research study. Before agreeing to participate, it is crucial that you read and understand the following information about the purpose of the study, the study process and procedures. This information sheet is meant to help you decide if you would like to participate. You need to understand everything before you agree to take part in this study.

The purpose of this study is to explore the perceptions of newly qualified nurses with the intention of gaining an understanding of their readiness to practice as qualified nurses. The results of the study will, in the future, enable educators and healthcare stakeholders to develop an orientation programme to prepare students who are in their final (fourth) year of study for community service. Participation in this study will not benefit you directly but the information obtained may benefit nurses in the future.

As far as I can tell, there should be no risks or discomfort to you in sharing your perceptions. Your participation will mean that you will meet with me once for a voice-recording interview lasting not more than an hour. You will be requested to sign a consent for digital-voice recording before the start of the interview, which will later be transcribed. Semi-structured interview questions will be used to assist in guiding the conversation towards the subject-matter.

I will keep a record of the people who have participated in this study, and I will keep the recordings of our interviews, together with a transcription of those tapes. Your name will not be included in the recording, transcription or the final publication of this research so that the data could not be traced back to you. Should quotations of your input be utilised in the report or publication, a code will be assigned to ensure anonymity. The data will be stored in a secure place, and access to the data will only be limited to the researcher and the research supervisor. All data, including tape recordings, will be stored securely in the Department of Nursing Education at the

University for a minimum of two years after publication, or six years in the absence of publication.

Participation in this study is entirely voluntary; you may withdraw your participation from the study at any time without any prejudice or negative consequences.

The study has been approved by the Human Research Ethics Committee (HREC) Medical of the University of the Witwatersrand.

Should you have any questions or concerns about any aspects of this study, please call me Sithembile Shongwe (researcher) at (+27) 0825947451 or email at thetwin.sithembile@gmail.com. You can also contact my supervisor, Dr Sue Armstrong at (+27) 11 717 1234 or email her at Sue.armstrong@wits.ac.za, during working hours.

For reporting of complaints or problems, please contact the Chairperson, HREC Medical Professor P. Cleaton-Jones, at +27(0)114883094 or please call Ms Zanele Ndlovu at +27(0)117171252 or email her at Zanele.ndlovu@wits.ac.za

Thank you.

ANNEXURE 3: CONSENT FORM

I at this moment confirm that I have been informed of the study by, Sithembile Siphiwe Shongwe, about the nature, conduct, benefits, and risks of her study entitled "The Perceptions of Newly Qualified Nurses of their readiness to practice in an Academic Hospital in Gauteng."

I have received, read and understood the written information sheet regarding the study.

I am aware that the results of the study will be anonymously processed into a study report and all information will remain confidential.

I may, at any stage, without prejudice, withdraw consent and participation in the study.

I have had sufficient opportunity to ask questions and of my free will, declare myself prepared to participate in the study.

…… ……

Signature Date

ANNEXURE 4: CONSENT TO DIGITAL RECORDING

I ……, consent to be interviewed, and I understand that this interview will be recorded for the sake of accuracy and reliability. I understand that the consent is voluntary and that once these records are completed for its use towards this research, they shall be destroyed. I further understand that if any of my comments made during the interview are used in the research report, the quote will be anonymous.

Participant Signature…….

Date……

ANNEXURE 5: SAMPLE OF DATA TRANSCRIPTS AND ANALYSIS: FORMULATION OF CATEGORIES

Participants verbatim responses	**Analysis: formulation of categories**
Q 1 How ready did you feel to practice as a qualified nurse when you started working in this hospital? ***P5*** *… the theory behind what I was meant to be doing I knew. Aah but the practicality of it due to time constraints and how the programme was, I wasn't very comfortable with it.* ***P1*** *I was not ready, to be honest, because it was a speciality ward and given that a speciality ward has so many complications…* ***P3*** *I don't think I was made ready while I was at varsity because nursing is a lot and sometimes is very generalised. There are things that you can only encounter while you are in practice, in the ward and not something that you can learn in textbooks.* ***P4*** *Theoretically, I felt like I was competent…but when I came to the practise setting, and I started working here practically, that's when the challenges began.* **Q 2: How has the academic program in your nursing education institution helped or hindered you to practice as a qualified nurse?** ***P1*** *The thing is we do a lot of theory. It does not help us with the 'how' part. Even though you were taught, but you don't know the practical part of it, because D4 (4-year diploma) students, we only stay like two weeks in a ward.* ***P4*** *…the work is not as clear as it is the theory of practice is not the same as theory. Yeah, because of that I needed a lot of assistance, especially with practical things.* ***P6*** *It did not fully prepare us because in a first and second year is general nursing, but we only do it for a few months and the other subjects, and there is just overwork of things*	**Formal preparation for practice:** -too much theory, *-limited time for practicals due to the programme structure*, *- not ready for professional practice,* *- a lot of time spent in theory,* *-lack of integration of theory with practice,* *-not made ready at university,* *-theoretical competent but lack practical knowledge and skills,* *-needed a lot of assistance,* *-overloaded with learning content,* *-poor programme structure)* -**The absence of deliberate practice** (*limited time for clinical practice*) -**Exposure to speciality conditions** (*complicated and unfamiliar conditions*)

ANNEXURE 6: ETHICS CLEARANCE CERTIFICATE

R14/49 Ms Sithembile Shongwe

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170483

NAME: (Principal Investigator)	Ms Sithembile Shongwe
DEPARTMENT:	Nursing Education Charlotte Maxeke Johannesburg Academic Hospital
PROJECT TITLE:	The Perceptions of Newly Qualified Nurses of their Readiness to Practice in an Academic Hospital in Gauteng
DATE CONSIDERED:	05/05/2017
DECISION:	Approved unconditionally
CONDITIONS:	Title Change (19/07/2017)
SUPERVISOR:	Dr Sue Armstrong
APPROVED BY:	Professor P. Cleaton-Jones Chairperson, HREC (Medical)
DATE OF APPROVAL:	21/06/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004,10th floor, Senate House/3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially review April and will therefore be due in the month of April each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

ANNEXURE 7: PERMISSION TO CONDUCT THE STUDY FROM CMJAH

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Enquiries:
Ms. G. Ngwenya
Office of the Nursing Director
Tell: (011): 488-4558
Fax: (011): 488-3786
11 AUGUST 2017

Ms. Sithembile Shongwe
University of the Witwatersrand

Dear. Ms. S. Shongwe

RE: "The Perceptions of Newly Qualified Nurses of their Readiness to Practice in an Academic Hospital in Gauteng"

RESEARCH PROPOSAL DETAILS: GP_2017RP29_955

Permission is granted for you to conduct the above recruitment activities as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic hospital will not in anyway incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Supported / ~~not supported~~

Ms. M.M Pule
Nursing Director
Date: 2017/08/14

Approved / not approved

Ms. G. Bogoshi
Chief Executive Officer
Date: 16.08.2017

ANNEXURE 8: POSTGRADUATE RESEARCH COMMITTEE APPROVAL

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

10 January 2018
Person No: 1044231
PAG

Mrs SS Shongwe
P O Box 46
Piggs Peak
Hhohho
H108
Swaziland

Dear Mrs Shongwe

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled *The perceptions of newly qualified nurses of their readiness to practice in an academic hospital in Gauteng* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences