1 ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The World Health Organization (WHO) estimates a shortage of 12.9 million healthcare professionals by the year 2035 (WHO 2013:online). One of the contributing factors causing this severe shortage of healthcare professionals is attrition. The annual attrition rate among healthcare professionals in South Africa is reported at 25% with an additional 6% being added to this percentage due to retirement, death and change of profession. The attrition rate among newly qualified healthcare professionals alone is reported to be as high as 23% per annum (Human Resources for Health South Africa 2030 2011:9). The effect of high attrition and turnover rates on the healthcare environment includes a decrease in the quality of care rendered (Arena 2016:1; Human Resources for Health South Africa 2030 2011:10), low satisfaction levels among staff and patients (Arena 2016:1; Rajan 2013:16) and an increased workload on the remaining staff (Rajan 2013:16).

Nurses make up 50% of the worldwide shortage of healthcare professionals (WHO 2018:online) and the critical shortage of nurse practitioners has stressed the importance of retention and recruitment of Newly Qualified Professional Nurses (NQPNs) for the nursing profession (Kim, Lee, Eudey, Lounsbury & Wede 2015:51; Roziers, Kyriacos & Ramugondo 2014: 92; Rush, Adamack, Gordon, Lilly & Janke 2013:346; Human Resources for Health South Africa 2030 2011:8-9; Mokoka, Oosthuizen & Ehlers 2010:8). Statistics, however, still show a staggering turnover rate of between 17% and 50% among NQPNs worldwide (Mills, Chamberlain-Salaun, Harrison, Yates & O'Shea 2016:2), which leaves the future of nursing in dire straits.

Retention and recruitment of NQPNs in the South African context is equally important, especially since nurses make up 80% of the South African healthcare workforce (Human Resources for Health South Africa 2030 2011:9) and were dubbed the "*backbone*" of the healthcare system by the KwaZulu-Natal Member of the Executive Council for Health, Dr. Sibongiseni Dhlomo (KwaZulu-Natal Department of Health 2017:online). The reasons for high attrition and turnover rates among nurse practitioners in South Africa have been linked to poor working conditions in the government sector (Washeya 2018:53; Human Resources for Health South Africa 2030 2011:8; Mokoka *et al.* 2010:7), negative relationships existing among colleagues and with management (Human Resources for Health South Africa 2030 2011:24; Mokoka *et al*. 2010:7) and high, unmanageable workloads (Human Resources for Health South Africa 2030 2011:24). When looking into the experiences of NQPNs and why they leave the nursing profession, a main contributing factor seems to be not receiving adequate support during their transition from student nurse to professional nurse (Commission of Collegiate Nursing Education [CCNE] 2015:4).

After graduation, and upon entering clinical practice, NQPNs go through a transition period (Duchscher 2016:online) during which they require a positive learning experience in order to retain them for the nursing profession (Hansen 2013:158; Ulrich, Krozek, Early, Ashlock, Africa & Carman 2010:374; Goode, Lynn, Krsek, Bednash & Jannetti 2009:147). When learning takes place during the transition period and when support is received, NQPNs' competency and job satisfaction increase, each respectively leading to the rendering of high-quality care and increased retention and commitment to the nursing profession (CCNE 2015:4).

Internationally, the implementation of standardised nurse residency programmes have proven to provide this much-needed support to NQPNs and it has become an essential institution in healthcare institutions (Wood 2016:online; Rush *et al.* 2013:346; Kramer, Maguire, Schmalenberg, Halfer, Buding, Hall, Goodloe, Klaristenfeld, Teasley, Forsey & Lemke 2012b:583; Maxwell 2011:27). Nurse residency programmes support competency development (Kim *et al.* 2015:60; Niemi, McErlane, Vasseur & Bohl 2014:20; Remillard 2013:79) and aim to connect professional development to extended competencies other than basic and technical skills (Kim *et al.* 2015:60; Bleich 2012:[1]; National Council of State Boards of Nursing [n.d.]:2) while support is provided by competent, expert facilitators who are specifically qualified and appointed for this role (Brown, Poppe, Kaminetzky, Wipf & Woods 2015:151; CCNE 2015:9-12; Kim *et al.* 2015:51;60; Bratt 2013:103,105; Goode *et al.* 2013:74; Park & Jones 2010:147). In addition hereto, nurse residency programmes have proven to address problems such as staff retention and recruitment (Niemi *et al.* 2014:20; Bratt 2013:109), negative workplace cultures (Bratt 2013:109; Goode *et al.* 2013:78) and poor job satisfaction (Kramer, Maguire, Halfer, Budin, Hall, Goodloe, Klaristenfeld, Teasley, Forsey, & Lemke 2012a:166). It is therefore not surprising that Slate, Stavarski, Romig and Thacker (2018:97) refer to nurse residency programmes as the "*gold standard*".

According to Krsek and McElroy (2009:3), other important factors to consider when providing support are that support should be provided continuously throughout the transition period and that it should be personalised to build competency and retain NQPNs for the nursing profession. Personalisation of support is possible when facilitators use a person-centered approach to education (Bhatti & Ahmed 2015:S12; Parsons & Beauchamp 2012:9). Person-centered approaches have proven to assist learners with knowledge retention and effective transfer of knowledge and skills into practice (Attard, Di Lorio, Geven & Santa 2010:8; Dewing 2010:23), thereby addressing the theory-practice gap (Breit 2015:44). The spill-over effect of person-centered education lies there-in that learners, which in this case refers to NQPNs, may adopt a person-centered approach to their care practices (Stirk & Sanderson 2012:19) which leads to the rendering of person-centered care (see Section 2.8.2.2). Person-centered care has become a philosophy of healthcare systems (McCormack & McCance 2017:1) through its direct connotation with the rendering of high quality care (Institute for Healthcare Improvement [n.d]:online; Health Innovation Network [HIN] [n.d]:[2]).

1.2 BACKGROUND TO THE RESEARCH PROBLEM

The background to the research problem forms part of the policy- and professional contexts (see Section 2.4 and Section 2.5) of healthcare professions in South Africa, specifically pertaining to the nursing profession. Remunerated community service was first implemented in South Africa among medical doctors in 1998 and then extended to healthcare graduates from other disciplines over the years. In 2008, remunerated community service was implemented for the first time among nurse graduates qualifying under Regulation 425, as stipulated in section 40 of the Nursing Act, 2005 (Act No. 33 of 2005) (South African Nursing Council [SANC] 2007:1). During the remunerated community service year NQPNs are registered in the category "*community service"* with the SANC ([n.d.]a:online) and according to Regulation 765 (SANC 2007:1), may be placed in one of many types of designated public healthcare institutions such as primary healthcare clinics, 24-hour clinics and hospitals, each having different resources and facilities. Upon completion of the remunerated community service year, the head of the public healthcare institution completes a report for submission to the Provincial Community Service Coordinator. If the completion report is found to be satisfactory, it is then sent to the SANC where after the registration status of the NQPN is changed to "*professional nurse"* (SANC:[n.d.]a:online).

According to the Department of Health [DoH], the purpose of remunerated community service is to increase the competency levels of graduates and to develop their professional behaviour and critical thinking skills. At the same time the public also benefits through the increased access to quality healthcare as a result from the evenly distributed placement of healthcare practitioners to public healthcare institutions across South Africa (DoH 2006:[1]). The problem, however, experienced by the healthcare institutions in which NQPNs were placed was that no formalised programme or guidelines were provided by the DoH that could guide them on how to provide support to NQPNs, nor on how facilitation or monitoring of the professional development of these NQPNs should take place. Subsequently, a request for guidelines was sent by nursing service managers to the DoH. The Provincial Department of Health, in collaboration with community service coordinators from each province, released Circular minutes 127 of 2007, *Guidelines for the presentation of orientation and support programmes for community service professional nurses* (see Annexure B1). The guidelines were developed to help nursing service managers, with assistance from senior professional nurses, to orientate and support NQPNs during their remunerated community service year with the aim of enhancing patient safety and increasing staff satisfaction. The DoH further stated in the guidelines, that the orientation and support programme should act as a means to "*refresh knowledge*" and not to "*teach*" NQPNs again.

The programme consists of an initial orientation programme, which is followed by various staff development programmes that must be attended throughout the year. The importance of supervision is highlighted as well as that NQPNs should receive support, mentoring and coaching from all other nursing staff. The suggested content of the orientation and support programme includes: "*general information regarding the institution"*; "*general information on*

remunerated community service"; "*aspects of ward management",* and "*general nursing care with discipline-specific nursing skills"*. The programme content and time frame in which the orientation and support programme is to be implemented is adaptable according to the needs, requirements and services rendered at the healthcare institution, but the guidelines do suggest that orientation concerning general nursing care should comprise 50% of the time allocated to the programme. The guidelines further instruct the nursing service managers to ensure that written information is available in the ward to serve as a reference for NQPNs and that the contact details of senior professional nurses should be made available to NQPNs if they should need to contact them if unsure of anything.

NQPNs receive a letter written by the clinical department of the tertiary hospital at the beginning of the remunerated community service year which explains the proceedings of the year (see Annexure B2). Newly Qualified Professional Nurses attend an eight-day orientation programme during their first week in practice which consists of lectures on twenty-four (24) topics chosen by the hospital. The topics range from human resource aspects to patient care and procurement (see Annexure B3). The first two sections of the guidelines "*General information regarding the institution*" and "*General information on remunerated community service*" are signed off by a Clinical Facilitator of the hospital after the initial orientation programme. Newly Qualified Professional Nurses receive skill/competency documents on management aspects and nursing skills specific to the discipline in which they work that need to be signed off by professional nurses in the ward during the year. Quarterly reports are written on each NQPN that is then submitted to the Department of Personnel Development and the SANC to update their registration to that of "*professional nurse*". The NQPNs receive the opportunity to evaluate the orientation programme by completing a small survey where after they proceed to work in clinical practice.

1.3 PROBLEM STATEMENT

Despite the knowledge acquired from the comprehensive curriculum followed during training, NQPNs feel and are being perceived as incompetent and unprepared when entering clinical practice (Faraz 2016:1539; Magano 2016:41; Hansen-Salie & Martin 2014:550; Lekhuleni, Khoza & Amusa 2014:384; Mthembu & Zakwe 2010:13). The WHO (2007:6) blames the tertiary education system for the lack of competency in skills such as communication, ethics and interpersonal relationships since technical skills have been the focus during training.

Although orientation and support programmes have been developed, it has only been implemented in some healthcare institutions (Makua 2016:250). Numerous South African studies conducted after the release of these guidelines in 2007 still report on the lack of competency of NQPNs and the lack of support and challenges they experience (Govender, Brysiewicz & Bhengu 2017:17-20; Makua 2016:245-278; Tsotetsi 2012:67; Andrén & Hammami 2011:11-19). Challenges include not having adequate skills, experiencing an increased workload (Sönmez & Yildirim 2016:107) and working under immense time pressures (Bjerknes & Bjørk 2012:6). These challenges have a major impact on the

transition process from student nurse to professional nurse (Duchscher 2016:online; Duchscher 2009:1105-1107), patient care and job satisfaction (CCNE 2015:4; Burger, Parker, Cason, Hauck, Kaetzel, O'Nan & White 2013:498; Mokoka *et al.* 2012:1;8; Welding 2011:37) as well as staff retention (CCNE 2015:4; Burger *et al.* 2013:498; Tastan, Unver & Hatipoglu 2013:410; Mokoka *et al*. 2012:1;8; Welding 2011:37) and further exacerbates the already existing nursing shortage.

Multiple problems can be identified with the existing orientation and support programme implemented in the tertiary healthcare institution involved in this study. Instead of facilitating the professional development of NQPNs, especially on extended competencies, the programme focusses mainly on aspects such as orientation to the institution and development of technical skills. Another problem identified with the initial orientation part of the programme is that it is lecture-based and offers no formalised continuous support system through precepting, mentoring or facilitating (see Annexure B1). Both these factors are what differentiates orientation programmes from standardised nurse residency programmes (see Section 3.5). Similar problems were identified in a mixed-methods design study by Makua (2016:127;178; 247) where the induction and orientation programmes from twelve South African healthcare institutions across four (4) provinces, and the provincial guidelines of two (2) provinces, were evaluated and were also found to lack structure and formalisation and did not support the professional development of NQPNs. Another problem identified in an E-mail interview with Mrs. M. Mildenhall on 24 July 2018, former member of the Department of Health and Social Development, who was actively involved with the content development of the guidelines for the support and orientation programme, is that the orientation and support programme was developed using a "*top-down"* approach and did not involve the input of ground-level stakeholders. Although a "*top-down*" approach is the traditional way of developing a curriculum (Nagabhushana & Hegde 2016:[8]; McCarthy 2008:586), literature does strongly advocate for the use of the unconventional, more effective, "*bottom-up"* approach where different levels of stakeholders are involved (Nagabhushana & Hegde 2016:[8]; Bratt 2013:103-105; McCarthy 2008:586) to ensure programme buy-in and successful implementation (Bratt 2013:108).

In addition to the aforementioned issues, the competency and willingness of staff that are supposed to support NQPNs during their remunerated community service year is problematic. According to the Gauteng Department of Health, the responsibility of supervising, supporting, mentoring and coaching NQPNs primarily lies with nursing service managers, with some assistance from senior professional nurses (see Annexure B1). However, in the letter addressed to community service staff from the Hospital's Clinical Department, it is stated that it is the responsibility of "*all persons in charge of the ward*" to ensure that NQPNs are exposed to learning opportunities and that they receive adequate information regarding their skills development. At the same time, the letter also states that all staff are requested to take responsibility for this (see Annexure B2). Information such as this causes confusion as there is no clear explanation as to who is responsible. *"All persons in charge of the ward"* may refer to the Nursing Manager in the ward, the Deputy

Nursing Manager in the ward (also known as the "*second-in-charge*") as well as shift leaders, who are essentially senior professional nurses that act as leaders and take control of the staff on the shift while the Nursing Manager may or may not be on duty. Responsibility can therefore easily be shifted and even result in no one providing support to NQPNs. Another issue that arises is that not all staff members are willing to act in these supporting roles (Parker, Giles, Lantry & McMillan 2012:154) and even if they are willing, they may not have the required educational qualifications or skills to do so effectively (Panzavecchia & Pearce 2014:1120; Botma, Jeggels & Uys 2012:[2]) as they do not have any experience as educators or clinical facilitators. To enable nursing managers and senior professional nurses to effectively support NQPNs and to fulfil their role successfully, they should be supported by the organisation and receive training in facilitation- and communication skills as well as on how to use a person-centered approach to education (RCN Mentorship Project 2015:16). No nurse residency programme currently exists in South Africa to support NQPNs in remunerated community service (Govender, Brysiewicz & Bhengu 2015:478). Furthermore, according to Bratt (2013:104), when developing a nurse residency programme, it should be context-specific to enhance buy-in, which subsequently may lead to successful implementation. It was therefore evident that an international nurse residency programme cannot simply be implemented in South Africa and that there was a need to develop a Person-centered Nurse Residency Programme specifically for the unique South African context.

1.4 EMERGENT NATURE OF THE STUDY

The initial aim of the study, on which ethical approval was obtained (see Annexure A1), was to co-construct a nurse residency programme for Newly Qualified Professional Nurses in remunerated community service specifically for the South African context.

To achieve the aim of the study, the objectives were to:

Objective 1: Identify the needs of Newly Qualified Professional Nurses to be included in a Person-centered Nurse Residency Programme as perceived by different levels of stakeholders.

Objective 2: Co-construct a Person-centered Nurse Residency Programme for Newly Qualified Professional Nurses in remunerated community service.

Objective 3: Evaluate and validate the Person-centered Nurse Residency Programme and determine the outcomes of the process of co-constructing the nurse residency programme.

However, during the programme development phase (Phase 2), the study emerged (see Section 4.4.1.7), which is congruent with the nature of qualitative studies (Polit & Beck 2017:463). Objective 3 was amended while the first and second objective remained the same. The changes made to the objective led to a change in the aim and the research question, as supported by Morgan (2008:246) and Appleton and King (1997:17) as well as the study title. Ethical

approval was amended and approved on 28 September 2017 (see Annexure A2). The final research question, aim and objectives are provided in Section 1.5 and Section 1.6.

Note:

All Annexures still hold the original study title and the initial aim and objectives as the documents were used and signed prior to the study emerging in Phase 2 (see Section 4.4.1.7).

1.5 RESEARCH QUESTION

Based on the problem statement of this study, the research question is:

What are the competencies required of a facilitator to support Newly Qualified Professional Nurses in a Person-centered Nurse Residency Programme?

1.6 AIM AND OBJECTIVES

The aim of the study was to co-construct competencies of facilitators supporting Newly Qualified Professional Nurses to meet the outcomes of a Person-centered Nurse Residency Programme.

To achieve the aim of the study, the objectives were to:

PHASE 1

NEEDS ASSESSMENT

Objective 1: Identify the needs of Newly Qualified Professional Nurses to be included in a Person-centered Nurse Residency Programme as perceived by different levels of stakeholders.

PHASE 2

PROGRAMME DEVELOPMENT

Objective 2: Co-construct a Person-centered Nurse Residency Programme for Newly Qualified Professional Nurses in remunerated community service.

Objective 3: Co-construct the competencies of facilitators supporting Newly Qualified Professional Nurses to meet the outcomes of a Person-centered Nurse Residency Programme.

1.7 INTRODUCTION TO THE CONTEXT

I drew on Plowright's (2011:246) *Frameworks for an Integrated Methodology* to discuss five relevant contexts in this study namely: the national-, policy-, professional- organisational- and theoretical contexts as well as the impact thereof on this study. Additional contextual aspects are discussed from my constructivist lens, which, according to Hunt (2009:1285), is aligned with the interpretive description approach used in the methodology (see Section 4.2.2). Constructivism was applied as: (1) a philosophical paradigm (Guba & Lincoln 1994:109) and (2) as a self-directed theory of learning, where it describes how learners construct knowledge (Hershberg 2014:182). As a self-directed theory of learning, constructivism is synonymous with applying a person-centered approach to education. The person-centered approach to education was initially developed and applied in the field of Psychology by Carl Rogers (1951) before it was adopted to other disciplines (Kirschenbaum [n.d.]:online; New World Encyclopedia 2017:online). The application of the person-centered approach in the care context led to the development of the Person-Centered Practice Framework (McCormack & McCance 2017:39) (see Figure 2.3) which was used as the theoretical framework in this study. A comprehensive discussion of the context and the theoretical framework is presented in Chapter 2.

1.8 CONCEPT CLARIFICATION

The following concepts are key concepts in the study and provide the reader with a consistent and clear understanding of each term and how it is applied throughout this study. In keeping with the person-centered approach, the definitions were rewritten to incorporate the principles thereof (where relevant).

1.8.1 Co-construct

According to Your Dictionary ([n.d.]:online), co-construct means: "*to construct together*". When referring to the Department of Health Ethics in Health Research: Principles, Processes and Structures (2015:53) the definition of the term "*co-construct*" as stipulated above can be integrated with their description of "*collaborative research*" which states that it "*involves co-operation of researchers, institutions, organizations or communities, each contributing distinct expertise, characterized by respectful relationships".*

For the purpose of this study, co-construct refers to the person-centered, collaborative, inclusive and participatory approach between me and the different levels of stakeholders, who each contributed their distinct expertise to develop the Person-centered Nurse Residency Programme and to co-construct the competencies of facilitators.

1.8.2 Competencies

The term "*competencies*" forms the plural of the noun "*competence*". Competence is a requirement for registration as professional nurse and midwife with the SANC and is defined in the Nursing Act 2005, (Act No. 33 of 2005) as the "*ability of a practitioner to integrate the professional attributes including, but not limited to, knowledge, skills, judgement, values and beliefs required to perform as a professional nurse or midwife in all situations and practice settings*". Botma and Hugo (2017:24) describe competence as the ability to think critically and integrate theory into practice, which requires foundational knowledge, conditional knowledge, functional knowledge and metacognitive knowledge.

For the purpose of this study, both these definitions are accepted. Competence will, therefore, be defined as the collection of knowledge, skills, judgement, person-centered values- beliefs- and attitude required by the healthcare practitioner to perform as a professional nurse or midwife in all situations and practice settings. When referring to the facilitator specifically, this definition is also applicable, but further includes additional competencies required to effectively facilitate learning using a person-centered approach.

1.8.3 Facilitation

Facilitation is defined as: "*a technique by which one person makes things easier for others*" (Kitson, Harvey & McCormack 1998:152). According to Kirk and Broussine (2000:13) facilitation aims to create and maintain an environment in which learning is created. Harvey Loftus-Hills, Rycroft-Malone, Titchen, Kitson, McCormack and Seers (2002:579;586) specifically refer to making the implementation of evidence into practice easier in their definition of facilitation and state that the purpose thereof can be as simple as facilitating a task-focused activity that requires support and guidance or alternatively, can involve a more holistic process of enabling individuals, teams and organisations to bring about change. Facilitation is synonymous with a person-centered approach to education, and specifically adult learning theory, where the teacher no longer acts as an instructor, but rather a facilitator of learning (Rogers 1951 as cited in Zucconi 2016:16; Smith 2012:[5]).

For the purpose of this study, facilitation refers to the creation of an environment conducive to learning where the facilitator offers person-centered support- and guidance to the NQPN to meet his/her individualised learning needs. It enables the professional development of the NQPN and narrows the theory-practice gap.

1.8.4 Facilitator

A facilitator is defined in the Merriam-Webster Dictionary ([n.d.]a:online) as: "*someone who helps to bring about an outcome (such as learning, productivity, or communication) by providing indirect or unobtrusive assistance, guidance, or supervision*". The role of the facilitator, according to Dogherty, Harrison and Graham (2010:80-81) is to monitor and provide support to individuals and groups through a process of goal-orientated transformation that takes place over an extended period. Facilitators should be competent (Gueorguieva, Chang, Fleming-Carroll, Breen-Reid, Douglas & Parekh 2016:428; Kinnair 2015:4; Botma *et al*. 2012:[2];[8]) and Kinnair (2015:4) further states that well-trained and motivated facilitators will assist in the development of competent nurse practitioners that render quality care. The supportive function of facilitators is confirmed by Bratt (2013:104). In keeping with the central theme of support in this study, other role titles that share the function of support with the facilitator is that of mentor (Royal College of Nursing 2017:7; Mazerolle, Barrett, Eason & Nottingham 2017:75) and preceptor (Botma *et al*. 2012:[3];[8]; Nursing Mentoring Toolkit 2009:[1]).

For the purpose of this study the terms facilitator, mentor and preceptor were considered synonymous and is collectively referred to as "*facilitator*". A facilitator is a senior professional nurse who is categorised into the "*proficient*" or "*expert*" stage in his/her field as described in Benner's *Novice to Expert Theory* (1982:405) (see Section 3.3.1). Although the "*expert*" nurse usually has a post-graduate qualification in a clinical discipline, this was not an essential requirement in this study. The central role of the facilitator is to provide support to the NQPN, facilitate learning and create an environment conducive to learning. The facilitator assists in the professional socialisation of the NQPN upon joining the organisation and acts as a friend during the transition period. The facilitator is a competent senior professional nurse that has the necessary prerequisites (see Section 5.3.4) and characteristics required to be a facilitator, may or may not have a post-graduate qualification in education and/or a clinical discipline and has obtained foundational knowledge in person-centeredness and the facilitation of learning (see Section 5.3.5). The facilitator is recognised, respected and trusted as a person and treats others the same.

1.8.5 Nurse residency programme

A nurse residency programme is defined as: "*a postgraduate experience designed to support the development of competency in nursing practice*" (Remillard 2013:79). Nurse residency programmes consist of structured experiences that allow the NQPN to comprehend the importance of his/her responsibilities in the nursing environment (Olson-Sitki, Wendler & Forbes 2012:156) and generally includes components of education, formal or informal preceptorships, mentorships, supernumerary shifts and orientation relevant to the ward (Rush *et al.* 2013:346). Interchangeable terms used in literature include: "*Transition-to-Practice programme*" (CCNE 2015:5); *graduate nurse programmes* (Cubit & Ryan 2011:65); *new graduate transition-to-practice programmes* (Rush *et al*. 2013:346); *professional socialisation programmes* (Kramer, Maguire, Halfer, Brewer & Schmalenberg 2011b:460); *mentoring programmes* (Halfer, Graf &

Sullivan 2008:243); *preceptorship programmes* (Lewis & McGowan 2015:40) and *orientation programmes* (Tastan *et al*. 2013:408; Riegel 2013:463).

For the purpose of this study, a nurse residency programme refers to any type of post-graduate programme implemented with assistance of a facilitator, that develops NQPNs' competence, provides support during their transition from student nurse to professional nurse and facilitates their integration into clinical practice.

1.8.6 Newly Qualified Professional Nurse

A NQPN is a nursing graduate who has successfully completed the four-year education programme as general, psychiatric and community nurse and midwife (R425 of February 1985) and is registered with the South African Nursing Council in the capacity "*community service*" awaiting registration as "*professional nurse*".

For the purpose of this study, the NQPN is a nurse in his/her remunerated community service year, is autonomous, capable of educating himself/herself with no direct instruction from an educator and is recognised, respected and trusted as a person. Simultaneously the NQPN also treats and responds to others in a similar manner. To generate more data (Polit & Beck 2017:497), inclusion criteria were applied, classifying NQPNs as nurses that graduated between 2013 and 2016 (see Section 4.3.2).

1.8.7 Person-centeredness

Person-centeredness is defined by McCormack and McCance (2017:20) as: *"an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development".* This definition is accepted in this study.

1.8.8 Person-centered Nurse Residency Programme

From the definitions of the terms presented in this concept clarification, I established a new definition for a Person-centered Nurse Residency Programme as applied in this study. A Person-centered Nurse Residency Programme is a post-graduate experience for NQPNs in remunerated community service where a healthful, supportive and respectful two-way relationship is established with a competent, expert facilitator. The Person-centered Nurse Residency programme aims to meet the individual needs of the NQPN, supports his/her transition from student nurse to professional nurse and facilitates his/her integration into clinical practice. The ultimate purpose of the Person-centered Nurse Residency Programme is to achieve human flourishing for both the NQPN and the facilitator.

1.8.9 Support

The Cambridge Dictionary ([n.d.]:online) defines support as "*to help someone emotionally or in a practical way*".

For the purpose of this study, support refers to the person-centered support the facilitator provides to the NQPN, based on his/her identified individualised emotional- and practical needs.

1.9 SUMMARY OF THE RESEARCH METHODOLOGY

Methodology, according to Holloway and Wheeler (2002:287), refers to the framework of theories and principles on which design and methods are based. I regarded methodology in this study as comprising of the research design, research approach and research methods.

This study had a qualitative design with an interpretive description approach using multiple methods to collect- and analyse data. The research design was emergent (see Section 4.4.1.7), which is significant to qualitative studies (Polit & Beck 2017:463). I drew on the working principles of practice development by applying the principles of Collaboration, Inclusion and Participation (CIP) in the methodology and thereby working in a person-centered way (Manley, Titchen and McCormack 2013b:58-62). The study was conducted across two Phases. In Phase 1, data was collected by conducting a needs assessment. The methods consisted of a focus group meeting and two self-administered qualitative open-ended questionnaires. In Phase 2, participatory data analysis took place during a workshop, using a combined inductive/deductive approach to co-construct the person-centered nurse residency programme. The population and sampling remained the same throughout the study, however different samples were involved in each phase that consisted of different levels of stakeholders.

I ensured rigour by combining criteria for ensuring credibility in interpretive description studies as provided by Thorne (2016:117) and combined it with the framework for trustworthiness by Guba and Lincoln (1994) as cited in Polit and Beck (2017:559). The four criteria according to Thorne (2016:117) that judges research to be theoretically, epistemologically and technically sound in interpretive description studies are referred to as epistemological integrity, representative credibility, analytic logic and interpretive authority. Guba and Lincoln's (1994) framework consists of measures to ensure credibility, dependability, confirmability and transferability. I also considered authenticity as this study was conducted in the constructivism paradigm (Polit & Beck 2017:559). Rigour, and how it was ensured in each Phase, is discussed comprehensively in Section 4.5.

1.10 SIGNIFICANCE OF THE STUDY

As stated in Section 1.3, programme- and curriculum development traditionally follows an ineffective "*top-down"* approach. I, therefore, used a "*bottom-up*", person-centered approach and adopted the practice-development methodology principles of CIP by including different levels of stakeholders' perceptions on NQPNs' needs for inclusion in the Person-centered Nurse Residency Programme. Different levels of stakeholders also participated in co-constructing the Person-centered Nurse Residency Programme (see Section 4.2.3.1, Section 4.3.2, Table 4.4). Stakeholders included NQPNs, senior professional nurses, clinical facilitators, managers, educators and representatives from the SANC, the Gauteng DoH and the Nursing Education Association (NEA). When including different levels of stakeholders in the development phase of a nurse residency programme, buy-in may be enhanced (Bratt 2013:108), which may essentially lead to a more successful implementation phase, although this did not form part of the scope of this study.

The emergent nature of the study led to workshop participants also co-constructing competencies of facilitators based on the needs identified during the needs assessment to meet the outcomes of the Person-centered Nurse Residency Programme. A similar approach was used by Gueorgueiva et al. (2016:428) where organisation-specific facilitator competencies were developed as a foundation for facilitator practice. The competencies that were co-constructed in this study included prerequisites, which can be used to identify senior professional nurses that can potentially act as facilitators. Senior professional nurses that have the necessary prerequisites can then be trained accordingly to ensure that they are competent in the use of a person-centered approach, facilitation of learning and the rest of the content of the Person-centered Nurse Residency Programme. By doing so, effective support can be given to NQPNs during their remunerated community service year during their transition from student nurse to professional nurse, thereby facilitating their integration into clinical practice. By instilling person-centered practices in the facilitator, support can be offered to NQPNs on a psychosocial- and educational level. Not only does the Person-centered Nurse Residency Programme lead to the professional development of NQPNs, but it also contributes to the professional development of the senior professional nurse fulfilling the role of facilitator and thereby lays the groundwork for human flourishing.

Although the implementation of the Person-centered Nurse Residency Programme was not part of this study, it can be expected that if it is implemented, it may lead to equally beneficial results in the South African context, as it has proven to do internationally (see Section 1.1, Section 3.5.2). Consequently, when the facilitator uses a person-centered approach, NQPNs may adopt its principles beliefs and values and apply the approach to their own practice as nurse practitioners. The advantages thereof will be evident in the rendering of high-quality person-centered care, and the establishment of positive interpersonal relationships with fellow staff members, thereby creating a positive workplace culture.

1.11 THE ROLE OF THE RESEARCHER

I had multiple roles throughout the duration of the study. Each is discussed shortly.

Academic role: I was responsible for compiling a research proposal, obtaining ethical approval from the institutions involved and writing the thesis.

Instrument for data collection: A combination of my epistemological positioning together with declaring my biases and assumptions (see Section 2.5.1, Section 2.7.2), as well as my ability to conduct the study (Simon 2011:[1]) (see Section 2.5.1), made it possible for me to act as an instrument for data collection (Greenbank 2003 as cited in Simon 2011:[1]). I was personally involved in this study as I recruited participants for the focus group meeting (see Section 4.3.3.1) and the workshop (see Section 4.4.1.4), compiled the questionnaires, distributed and collected questionnaires, acted as a note taker during the focus group meeting (see Section 4.3.3.1) and the workshop (see Section 4.4.1.7) and transcribed the focus group meeting myself (see Section 4.3.3.1). According to Thorne (2016:154). meaning is created by providing in-depth and detailed descriptions together with interpretation through reflection on the possible meaning of the data and according to interpretive description, the researcher plays a role therein. Creating meaning was part of my role in the steps involving the preparation of the data for analysis (see Section 4.3.3.2, Section 4.3.3.3, Annexure F6.1, F6.2, F6.3, F6.4) and by decluttering the data generated in the workshop. However, because a person-centered approach was used and CIP principles were applied, the role of meaning-making and interpretation was shared with the participants involved in the workshop through participatory data analysis (see Section 4.4.1.7).

Role model: I, in my way of interacting with the participants in the workshop, role modelled the principles and values of person-centeredness as described in Section 2.8.2. A role model is described in the Collins English Dictionary (2014:online) and in the American Heritage Stedman's Medical Dictionary (2002:online) as someone who's behavioural role or social role serves as an example to others and which is subsequently adopted by others if the behaviour and its associated outcome is valued by the learner.

1.12 CONTRIBUTIONS

According to Baptista, Frick, Holley, Remmik, Tesch and Âkerlind (2015:online) a Doctoral thesis has to contribute to disciplinary knowledge. In Table 1.1, I will provide a summary of the contributions of this study to nursing knowledge pertaining to its theoretical contributions, methodological contributions and contributions to nursing practice.

Table 1.1 Summary of the contributions of the study

Theoretical contributions	**Evidence**
Understanding the experiences and challenges of NQPNs in remunerated community service in South Africa as perceived by different levels of stakeholders.	Table 3.2, Annexure F6.1, Annexure F6.2 Section 7.3.1, Section 7.5.1
The use of a "*bottom-up"*, person-centered approach in programme development.	Section 4.3, Section 4.4, Section 7.5.1
Development of a conceptual framework for the Person-centered Nurse Residency Programme.	Chapter 6, Figure 6.1, Section 7.4, Section 7.5.1
Methodological contributions	**Evidence**
Use and application of a relatively unknown approach in qualitative methodology, interpretive description.	Section 4.3.3.2, Section 4.3.3.3, Section 4.4.1.7, Section 7.5.2
Innovative way in combining interpretative description and the person-centered approach.	Section 4.4.1.7, Section 7.5.2
Combined use of a an inductive/deductive approach to data analysis.	Section 4.4.1.7, Section 7.5.2
Nursing practice	**Evidence**
Co-constructing a Person-centered Nurse Residency Programme for NQPNs in remunerated community service for the South African context.	Section 4.4, Chapter 5, Section 7.5.3
Outcomes to be met by NQPNs on completion of the Person-centered Nurse Residency Programme were established, corresponding outcome statements were written and associated Knowledge, Skills and Attitudes (KSAs) were established.	Section 5.3.1, Section 7.3.3, Section 7.5.3
Competencies that are required of facilitators to support NQPNs in the nurse residency programme were co-constructed, based on the identified needs of various levels of stakeholders. Outcome statements were written and associated KSAs were established.	Section 5.3.4, Section 5.3.5, Section 5.3.6, Section 5.3.7, Section 7.5.3

A summary of the contributions of the study is provided in Table 1.1. For a detailed description of the contributions made by this study please view Section 7.5.

1.13 ETHICAL CONSIDERATIONS

The Ethical Committee of the University of Pretoria, as well as the hospital in which the study was conducted, was asked to approve the research proposal before commencing the study. The chronological steps followed to obtain ethical approval is discussed in Section 4.2.3.2 as part of gaining entrée to the research site.

Significant thought was given to the ethical considerations described by Polit and Beck (2017:139-148), the Belmont Report (1979) quoted in Polit and Hungler (1993:355-371), the SANC Code of Ethics (2013:online) and the Ethics in Health Research: Principles, Processes and Structures (2015) as established by the National Health Research Ethics Council in terms of Section 72 of the National Health Act. The principles of ethics are also supported by Bandman and Bandman (1988:67), Holloway and Wheeler (2002:47-66) and Burns and Grove (2010:107). The Belmont Report highlights three principles of ethical conduct namely beneficence, respect for human dignity and justice (Polit & Beck

2017:139-142). Each relevant principle is discussed separately as applied in this study. All individuals that took part in this study will be referred to as *"participants*" as supported by Thorne (2016:108).

1.13.1 Beneficence

Beneficence involves the duty of the researcher to *"minimize harm and maximize benefits"* (Polit & Beck 2017:139; DoH 2015:14). Beneficence is discussed under: (1) the right to freedom from harm and discomfort; and (2) the right to protection from exploitation.

1.13.1.1 The right to freedom from harm and discomfort

The data collection process was conducted in accordance with the rules and requirements of the University of Pretoria and the rules of the selected hospital in which the study was primarily conducted. According to Polit and Beck (2017:139) harm can be physical, emotional or financial. This study did not impose any physical harm on the participants, but the participants of both the focus group meeting and the workshop incurred some financial harm as a result of the travelling costs involved in travelling to the respective venues. The possibility of emotional harm existed during the focus group meeting when participants were asked to reflect on their year as NQPN as this may have been a traumatic time for them. To minimise emotional harm, the focus group meeting was conducted in a safe environment that was allocated specifically for that purpose, and I ensured that participants were comfortable and did not feel threatened in any way. The facilitator and I approached the focus group meeting with sensitivity by incorporating our person-centered beliefs and values in the way we worked with the participants (see Section 4.3.3.1).

1.13.1.2 The right to protection from exploitation

I adhered to the principle of protecting participants from exploitation as stipulated in Polit and Beck (2017:139) by not holding any information given by them against them, and only using the information for the purpose of the development of the Person-centered Nurse Residency Programme and, consequently, for co-constructing competencies of facilitators. The relationship between myself and the participants of the focus group meeting and workshop was highly valued throughout the study as relationships also form a central part of the person-centered approach and the constructivist paradigm (see Section 2.7.2.2, Section 2.8.2).

1.13.2 Respect for human dignity

Respect for human dignity is described under the right to self-determination and the right to full disclosure (Polit & Beck 2017:140; DoH 2015:14).

1.13.2.1 The right to self-determination

The right to self-determination states that individuals have a right to decide voluntarily if they would like to participate in a study. Participants also have a right to ask questions, refuse to disclose information or to withdraw from the study at any given time without being penalised (Polit & Beck 2017:140). Participation in this study was voluntary and no participants were penalised in any way if they decided not to participate. Mutual respect, dignity and kindness between myself, the facilitators involved in the focus group meeting and the workshop, and the participants were maintained throughout the study by following a person-centered approach and adhering to the values thereof. Values synonymous with the person-centered approach include: "…*respect for persons (personhood), individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development*" (McCormack & McCance 2017:3).

1.13.2.2 The right to full disclosure

The right to full disclosure involves the individual's right to make informed, voluntary decisions regarding participation in the study, which can only be made if full disclosure of the study is provided (Polit & Beck 2017:140). I provided participants with a comprehensive explanation of the study in the respective Participant Information and Informed Consent Documents (PICDs) that were handed out to them prior to giving informed consent to participate (see Annexures C1, D3, E2, F3). All information was accessible to participants for the duration of the study and no information was withheld.

❖ **Informed consent and participant authorisation**

Collectively, the right to self-determination and the right to full disclosure is closely related to obtaining informed consent when conducting research. Informed consent involves providing individuals with adequate information regarding the study and their power of free choice to participate. I compiled PICDs (see Annexures C1, D3, E2, F3) for each respective activity in which participants took part, ensuring that the documents complied with the guidelines provided in Polit and Beck (2017:143-145) and by the DoH (2015:21).

Interpretive description relies on the ongoing moral obligation of the researcher to obtain ongoing informed consent due to the emergent nature of qualitative studies (Thorne 2016:126). Ongoing informed consent is supported by Polit and Beck (2017:144) and the DoH (2015:15). I therefore compiled the PICDs to the best of my knowledge as to what I could "predict" for data collection during the focus group meeting and participatory data analysis during the workshop.

Where informed consent deviated from the original PICDs, which was the case in the workshop, I obtained verbal informed consent to ensure that participants were comfortable with providing extra information and to take part in additional activities (see Section 4.4.1.7). Polit and Beck (2017:144) refer to this type of "*transactional*" informed consent as "*process consent*".

1.13.3 Justice

Justice is discussed under two sections, namely the right to fair treatment and the right to privacy (Polit & Beck 2017:141).

1.13.3.1 The right to fair treatment

The selection of participants was conducted in a fair manner based on how they all related to the problem statement (Polit & Beck 2017:141; DoH 2015:15). I gave all participants who complied with the respective inclusion criteria in each step (see Section 4.3.2) a fair opportunity to participate in the study, should they have wished to do so. No individual was treated unfairly if they refused to participate in the study. Some participants who indicated that they would attend the workshop did not do so, but no one withdrew from the study who had already started. Along with the facilitators I used for the focus group meeting and the workshop, I was constantly sensitive and respectful to participants from other backgrounds and cultures by applying a person-centered approach. I was always easily accessible and gave my personal contact details on the PICDs (see Annexures C1, D3, E2, F3) in case of any uncertainties arising.

1.13.3.2 The right to privacy

Privacy was ensured by not imposing on participants' lives more than what was necessary for the study and by keeping data confidential as suggested by Polit and Beck (2017:141). The right to privacy was ensured by means of anonymity and confidentiality procedures as stipulated in Polit and Beck (2017:147) and is addressed under anonymity and confidentiality in the absence of anonymity.

❖ **Anonymity**

Anonymity refers to protecting confidentiality (Polit & Beck 2017:147). I did not have any means of connecting the participants of the questionnaires to the data collected (with exception of the questionnaires returned via E-mail) (see Section 4.3.3.2, Section 4.3.3.3). Anonymity of the names of the participants in the focus group meeting was ensured by not stating their names on the transcription document. Names were replaced with pseudonyms such as "*Participant A*" and "*Participant B*" etc. (see Annexure D5). The demographic data sheets accompanying the questionnaires (see Annexures C6, E4) did not require the participants to enter any personal details which may have led to me identifying who they were. The questionnaires were self-administered and returned in a sealed envelope to either a sealed box in the Deputy Nursing Manager's office or was collected by the gatekeeper and handed over to me, which further ensured

anonymity (Polit & Beck 2017:275) (see Section 4.3.3.2). The Datasheets that I compiled from the focus group meeting and the questionnaires and gave to the workshop participants for analysis did not display any of their personal details (see Annexure F6.1; F6.2). Anonymity of the tertiary hospital involved in this study was also maintained as its name was not disclosed anywhere in the study, as suggested by Thorne (2016:136).

❖ **Confidentiality in the absence of anonymity**

When anonymity is impossible, as in this case of group activities such as the focus group meeting and the workshop, confidentiality measures should be implemented (Polit & Beck 2017:147; DoH 2015:20). A paragraph was inserted into the PICDs (see Annexures D3, F3) to encourage the focus group meeting- and workshop participants not to disclose information discussed during any time, but at the same time informed them that confidentiality could not be guaranteed. Privacy and anonymity in the E-mailed questionnaires in Phase 1, Step 1 and Step 2 (see Section 4.3.3.2, Section 4.3.3.3) could not be assured as the participants' E-mail addresses were visible to me when they returned the questionnaire via E-mail, even though they were not asked to provide their name and surname in the demographic data sheets (see Annexures D4, E4). I kept the personal information of these participants, together with the personal information of the rest of the participants in the focus group meeting, confidential and did not disclose it to anyone else. The workshop participants, however, gave verbal informed consent to have their picture taken and their names included in this Thesis.

1.13.4 Key norms and standards

Additional key norms and standards to which research must comply have been provided by the DoH (2015:14). The norms and standards that were not yet discussed as part of the ethical considerations and that were relevant in this study were:

- stating the relevance and value of the study (see Section 1.10);
- showing scientific integrity through a sound methodology (see Chapter 4);
- role player engagement through various stages of the study to improve quality and rigour (see Section 4.3, Section 4.4) and
- acknowledging researcher competence and expertise and arranging alternative options for tasks in which the researcher isn't competent (see Section 2.5.1).

1.14 LAYOUT OF THE STUDY

The study comprises of 7 Chapters. The layout of the Chapters is supported by the emergent design consistent with qualitative research as stipulated in Polit and Beck (2017:58). An outline of the study is presented in Table 1.2.

Table 1.2: Outline of the study

Chapter	Description
Chapter 1 Orientation to the study	This chapter provides a general introduction to the study and the study's rationale. The research question, aim and objectives are set out and an introduction to the context is provided. A summary of the research methodology is provided, and the significance and contributions of the study are explained.
Chapter 2 Context	This chapter discusses the context in which this study was conducted. A discussion is presented on the additional contextual aspects, which includes the paradigm and the person-centered approach.
Chapter 3 Theoretical context	An in-depth discussion of the literature is presented, which frames the theoretical context of this study. The discussion of the existing literature includes competency and skill development, the transition period from student nurse to professional nurse, the importance of providing support to NQPNs during the transition period and the role of nurse residency programmes in the provision of support. This chapter also describes the experiences and competence of NQPNs in South Africa and internationally.
Chapter 4 Research methodology	This chapter discusses the qualitative research methodology which includes the research design, research approach and research methods. The research methods are discussed as applied across the two phases of the study. Phase 1 involves data collection by conducting a needs assessment. Phase 2 involves participatory data analysis and co-constructing the Person-centered Nurse Residency Programme. It was in Phase 2 that the study emerged, which resulted in a change in the aim and objectives, the research question and the study title. The rest of the chapter discusses the proceedings of the workshop based on the new objective of co-constructing competencies of facilitators supporting NQPNs to meet the outcomes of a Person-centered Nurse Residency Programme.
Chapter 5 Research findings and discussion	I return to the objectives of the study and discuss and interpret the results. The discussions are supported by literature.
Chapter 6 Conceptual framework Person-centered Nurse Residency Programme	In this chapter the Person-centered Nurse Residency Programme is presented.
Chapter 7 Conclusions, contributions, implications for practice, and limitations	This chapter concludes the study and discusses the contributions, implications for practice and limitations.

1.15 SUMMARY

In Chapter 1, I provided an orientation to the study. I presented the background to the research problem and the problem statement was formulated from the given background. A rationale for the study was provided along with a clear description of how the study's aim, objectives and title emerged. An introduction to the context and additional contextual aspects was given. A summary of the research methodology was provided, and the significance and contributions of the study were explained. The ethical considerations as applied in this study were also discussed. I lastly presented the layout of the subsequent chapters to reveal the flow of the study. In Chapter 2, I will discuss the context in which this study was conducted.