3 THEORETICAL CONTEXT

3.1 INTRODUCTION

In Chapter 2, I discussed the context in which this study was conducted. In Chapter 3, I will discuss various findings from relevant literature sources that were reviewed to describe how competency develops and how NQPNs transition from student nurse to professional nurse and integrate into clinical practice. I will further illustrate the needs and challenges of NQPNs and specifically focus on their need for support during the transition period and the use of nurse residency programmes as a means thereto.

3.2 MOTIVATION

According to Polit and Beck (2017:60) a literature review provides context to a study. Based on Plowright's (2011:246) *Frameworks for an Integrated Methodology* (see Section 2.2), which I applied in this study, the literature review specifically refers to the theoretical context. Much debate exists as to when, and if at all, a literature review should be conducted in qualitative studies and the answer is usually determined by the paradigm (Polit & Beck 2017:87). It is, however, argued by Thorne, Kirkham & O'Flynn-Magee (2004:9) that when using an interpretive description approach, it should be acknowledged that there is existing theoretical knowledge, clinical patterns and a scientific basis for the existence of a phenomenon. Later, Thorne (2016:64) identified literature reviews as a fundamental part of the theoretical scaffolding of an interpretive description study, which essentially refers to the intellectual positioning of the researcher (Thorne 2016:64).

The literature review in this study allowed me to come to know and draw conclusions on the "*state of science*" (Thorne 2016:64). I first looked at the important scholarly knowledge that exists about competency and skill development and the transition period. It helped me to understand the reported and perceived incompetence and unpreparedness of NQPNs better, as well as their need for support. The role of nurse residency programmes as an effective support measure and how they are developed and implemented internationally was also explored.

In staying true to the interpretive description approach, I did not limit the literature review to the use of keywords, databases or dates as it limited the body of knowledge that could be accessed (Thorne 2016:65:67). Knowledge of central ideas in this study was also borrowed from other disciplines, non-traditional sources - also known as "*grey literature*" - and collateral sources such as policy documents, white papers, dissertations, lay autobiographical accounts and public media sources as these data sources do provide valuable data, despite their limitations (Thorne 2016:64-69;95-97:221). In addition to the abovementioned non-traditional data sources, I also included Weblogs

written by nurses as supported by Hookway (2008:91-113). Polit and Beck (2017:88) also supports the use of non-traditional data sources but at the same time state that it does not serve as evidence of a research problem but that it should rather be used to broaden the researcher's understanding thereof. By using the abovementioned aspects in the literature review, as well as in other chapters in this study, I had authoritative confidence in my extensive knowledge of what was being studied (Thorne 2016:66). In Section 3.6 and Section 3.7, however, I conducted a structured literature review by looking at studies conducted on national- and international level (see Table 3.2 and Table 3.3) that reported on the experiences and challenges of NQPN in their first year of clinical practice and compared the findings.

3.3 COMPETENCY AND SKILL DEVELOPMENT

The Department of Health *Strategic Plan for Nursing Education, Training and Practice* 2012/13 -2016/17 (2011:14) acknowledges South Africa's need for competent nurse practitioners to manage South Africa's disease profile and healthcare needs and to render safe patient care. In this report, the emphasis was placed specifically on the nursing profession, due to nurses making up the largest part of the healthcare professions (see Section 1.1). Competence is a requirement for registration as professional nurse and midwife with the SANC (Nursing Act No 3 of 2005) and was defined in Section 1.8.2. Although competence is a requirement for registration, literature proves otherwise, with numerous studies reporting on the incompetence of South African NQPNs (see Table 3.2). The incompetence of healthcare professionals is a leading factor of the poor healthcare system in South Africa (Medical Brief 2016:online). A quantitative study by Hansen-Salie and Martin (2014:550) conducted among experienced professional nurses using a descriptive survey to establish their perception on factors that influence NQPNs' competency included: experience gained in nursing; learning opportunities provided; environmental factors such as staff shortages and resources; motivation; level of confidence; high expectations placed on NQPNs by themselves and others; knowledge supporting actions; effective facilitation where they experience both support and challenge and being accepted into the healthcare team in the ward. The vast evidence that exists on NQPNs' incompetence is concerning as they are often expected to function independently due to the existing critical nursing shortages (Hansen-Salie & Martin 2014:538; *Strategic Plan for Nursing Education, Training and Practice* 2012/13 -2016/17 2011:22), leaving them to make important decisions with limited to no guidance, and at the same time compromising the safety of patients. In contradiction to the belief that NQPNs are expected to be competent upon registration, numerous authors argue that this is an unrealistic expectation as competency develops over time, after entering the work environment as a professional (Hofler & Thomas 2016:135; Magano 2016:41; Goode *et al.* 2009:143; Krsek & McElroy 2009:1).

Botma and Uys (2017:24) describe competence as the ability of the learner to think critically and integrate theory into practice. Competence is further described at the hand of the different types of knowledge and thinking processes that the learner uses to solve problems in practice, also referred to as cognitive thinking skills. The basic knowledge learnt

of a discipline is referred to as foundational knowledge and consists of declarative knowledge (knowledge learnt from literature) and procedural knowledge (knowledge of how to do a task or practice a skill). When the learner can link various sciences and understand how it relates to each other, critical thinking is demonstrated. When applying context to a situation, conditional knowledge is required which refers to the ability of the learner to apply foundational knowledge, also known as clinical reasoning. After obtaining foundational- and conditional knowledge, functional knowledge guides performance. Functional knowledge is the ability of the learner to know when to do what and how to do it. Functional knowledge is also referred to as clinical judgement and decision-making. After decisions are made and implemented, metacognitive knowledge is applied, which directs person-centered learning. Metacognition refers to the reflection on the thinking processes to establish if any errors were made during clinical reasoning; to determine how similar errors can be avoided in future and to choose a more effective strategy to apply in future practice. New knowledge is then constructed (see Figure 3.1).

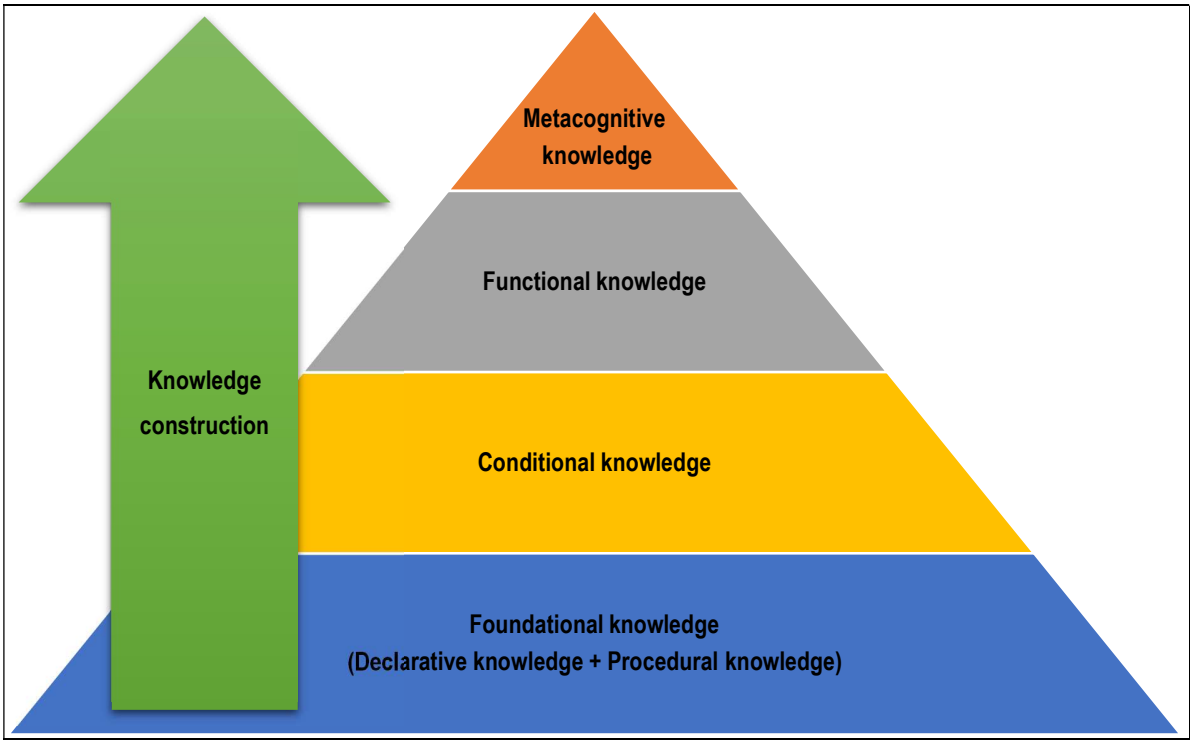

Figure 3.1: Knowledge construction *Source: Botma and Uys (2017:24)*

Figure 3.1 illustrates how knowledge is constructed starting from the bottom with foundational knowledge, developing upwards to metacognitive knowledge, where new knowledge is constructed. As knowledge develops, so competence increases.

Irrespective of what definition of competence is provided, it is evident that the core aspects on which competence is based is Knowledge, Skills and Attitude (KSA). The KSA approach is an educational framework of learning objectives as identified in Taxonomy of Learning Domains by Bloom et al. (1956) as cited in Mizbani & Chalak (2017:14). Knowledge and skills were discussed comprehensively earlier in this section. With regard to attitude, Baartman and de Bruijn (2011:131) sate that attitudes are a result of a socialisation process, which is determined by both the social environment and the learner's individual characteristics.

3.3.1 Benner's Novice to Expert Theory

How skills and competency develop throughout the nurse practitioner's career is described in literature at the hand of Patricia Benner's *Novice to Expert Theory* (1982). Benner's theory is based on the Dreyfus model of skill acquisition, which states that knowledge is obtained through experience and that it is situational, therefore placing the theory in the constructivist paradigm (see Section 2.7.2.2). Benner adopted the Dreyfus model and applied it to the context of nursing after conducting interviews with fifty-one (51) experienced professional nurses, eleven (11) NQPNs and five (5) senior nursing students in six (6) hospitals to establish if this was, in fact, practical and to determine the characteristics of the nurse's performance at each stage. Benner's theory maintains that nurses move through five consecutive stages of learning known as "*novice", "advanced beginner", "competent", "proficient" and "expert"* (Benner 1982:402) (see Figure 3.2).

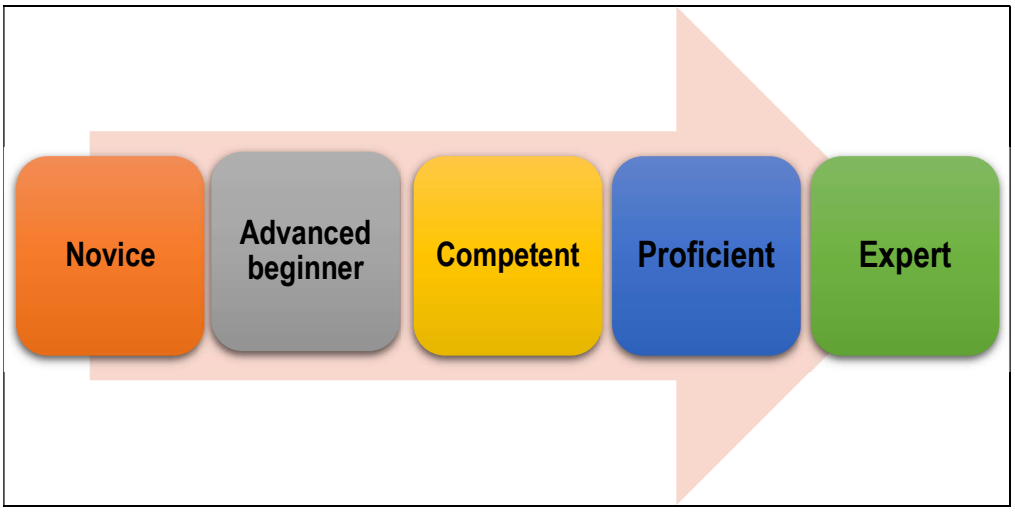

Figure 3.2: Benner's Novice to Expert Theory *Source: Benner (1982:403-407)*

Figure 3.2 illustrates the five stages of learning; "*novice", "beginner", "competent", "proficient"* and *"expert"* as formulated by Benner (1982:403-407). Each of these five stages will now be explained in short.

3.3.1.1 Stage 1: Novice

According to Benner, the novice refers to the student nurse with no experience. The novice uses general rules that are uncontextualized to perform tasks without having the necessary experience. The novice can, however, not use these rules to decide which action is the most appropriate or when an exception can be made to the rule. Novices lack discretion when making decisions and do not have knowledge on policies, procedures and protocols involved with rendering patient care. Tasks performed include monitoring intake and output, assessment of weight and measuring vital signs (Coble 2016:online; Nursing Theories 2011:online; Nematollahi & Isaac 2011:196; Polifko 2009:507; Benner 1982:403).

3.3.1.2 Stage 2: Advanced beginner

The advanced beginner refers to the nurse who has obtained some knowledge through experience. The advanced beginner can detect meaningful components of a situation (referred to as "*aspects*") but is unable to prioritise them. Work performance is acceptable in this stage and the advanced beginner can now start formulating principles based on experience to guide his/her actions. Self-confidence and good communication skills are, however, lacking and direction and support from competent nurses, are still needed (Coble 2016:online; Hopkins 2014:20:22; Nursing Theories 2011:online; Nematollahi & Isaac 2011:196; Polifko 2009:507; Benner 1982:403). The CCNE (2015:5) categorises NQPNs as advanced beginners.

3.3.1.3 Stage 3: Competent

After two (2) to three (3) years' experience in practice, the nurse reaches the competent stage. At this stage, the nurse understands his/her actions in terms of long-term goals. The competent nurse can plan his/her own actions and think critically, which builds competence and organisational skills. The competent professional nurse works according to a plan, is goal orientated, copes well with challenges, works efficiently and can distinguish between relevant and irrelevant aspects. When compared to a proficient nurse, the competent nurse lacks flexibility and speed (Coble 2016:online; Hopkins 2014:20; Nursing Theories 2011:online; Benner 1982:404).

3.3.1.4 Stage 4: Proficient

Benner did not place a timeframe on the experience of the proficient professional nurse but according to Cruise (2013:22) he/she has three (3) to four (4) years' experience in clinical practice. The proficient nurse has a holistic view of situations that enables him/her to make better decisions when unforeseen situations present itself. The proficient nurse has mastered numerous skills and has a deep understanding of situations, which assists him/her in distinguishing between aspects that are important and those that are not as important in a certain situation (Coble 2016:online; Hopkins 2014:20; Nursing Theories 2011:online; Polifko 2009:507; Benner 1982:405).

3.3.1.5 Stage 5: Expert

The experience required to be considered an expert is equal to five (5) years according to Cruise (2013:22). Benner (1982:406) states that, in order to reach the expert stage, the professional nurse should have received formal education and should have acquired extensive experience. The expert professional nurse does not depend on principles, rules or guidelines and has a lot of experience that allows him/her to almost immediately and accurately identify the source of a problem. The expert's performance is fluent, flexible and very proficient with excellent intuition. Expert nurses, however, have difficulty in articulating all the mental steps taken when making quick assessments, but others learn from them by observing what they do and from what their attitude is (Bowen & Prentice 2016:144; Coble 2016:online; Nursing Theories 2011:online; Polifko 2009:507; Benner 1982:405). Benner (1982:407) argues that expert nurses should be retained for the profession to improve the quality of care rendered to patients and further states that they should be recognised and rewarded for their expertise.The description of the expert nurse assisted me to establish the recommended inclusion criteria required for acting as a "*facilitator*" for NQPNs in the Person-centered Nurse Residency Programme and to establish an appropriate definition for the term (see Section 1.8.4, Section 2.8.3).

Benner's Novice to Expert Theory is not without critique. Hargreaves and Lane (2011) argue that skill acquisition is not a linear process that is linked to time and context and that prior experience, expertise, motivation and the person himself/herself has an influence thereon. I agree with this critique from my person-centered perspective and agree that individuals cannot be contained into a time frame linked to a specific stage as everyone is unique and can develop according to different timeframes. In addition, hereto, a further point to make is that Benner's theory was developed internationally in countries where nursing students' training and clinical exposure differs from that of South African students. As mentioned in Section 2.5, nursing students must spend 4000 hours in clinical practice during their training which is spread across the four disciplines. The SANC *Nursing Education and Training Standards* also state that at least 60% of training must be done in the clinical environment and that the last eight (8) weeks of the four-year programme should consist of uninterrupted clinical training to allow for integration into the clinical environment (SANC 2016:online). On the other hand, universities in Australia, for example, offer a selection of nursing programmes where learners can either study over a period of three (3) years to obtain a Bachelors degree in general nursing, which requires 1000 hours in clinical practice (University of South Australia: online) or they may choose to study a double Bachelors degree in general nursing and midwifery that runs over four (4) years and consists of 840 hours in general clinical practice; 640 midwifery hours and an additional 200 midwifery hours where students are responsible for monitoring women throughout their whole pregnancy (Edith Cowan University Nursing and Midwifery Course Guide 2020). In the UK, training as a general nurse care stretches over three (3) years of study, consisting of 4,600 hours combined theoretical and clinical training, of which clinical training should be at least 2300 hours (Nursing & Midwifery Council 2018:13). It is evident from these findings that South African nurses spend more time in clinical practice as part of their training, which results in increased exposure and may lead to increased competency based on experiential

learning. It is therefore understandable that international NQPNs are categorised as *advanced beginners* and not *competent* nurse practitioners. On the other hand, in South Africa, NQPNs should at least have reached the *competent* stage of Benner's Theory but the vast evidence on incompetence (see Table 3.2) indicates that this is not the case and therefore, for the purpose of this study, I also consider NQPNs as *advanced beginners.*

Gobet and Chassy (2006:129;137) also delivered critique on the over-simplified explanation of expert intuition in Benner's theory and her research being based on phenomenology, which is not considered as "*standard research*". I do not agree with this view as I myself have undertaken a "*non-standard*" approach in this study by using interpretive description, which cannot be validated with numbers and closely relates to Benner's interpretive approach used in her study. I acknowledge and agree with these authors that there are developed scientific explanations for expert intuition, but that Benner's explanation thereof can be motivated for from her own epistemological stance as a nurse and is therefore considered to be true.

3.4 THE TRANSITION PERIOD

For NQPNs to transition into competent professional nurses, a transition period is necessary (Kramer 1991 as cited in Goode *et al*. 2009:143). The transition period is filled with challenges (Bjerknes & Bjørk 2012:6) that can be categorised as "*physical", "intellectual", "emotional", "socio-cultural" and "socio developmental* (Duchscher 2016:online). Examples of challenges include the lack of skills and an increased workload (Sönmez & Yildirim 2016:107) as well as working under immense time pressures (Bjerknes & Bjørk 2012:6) and not receiving adequate support (CCNE 2015:4; Bjerknes & Bjørk 2012:6). In order to overcome the challenges that NQPNs face they require support (Bvumbwe & Mtshali 2018:71; CCNE 2015:4), not just during the initial period of clinical orientation, but throughout the year of transition (Bjerknes & Bjørk 2012:6). The transition period leads to the identity reconstruction of NQPNs based on their new roles and responsibilities as professionals (Meleis 2010:79). When the transition period is experienced positively and NQPNs are well supported, there is an increase in professional competence and job satisfaction as well as a decrease in stress levels, which ultimately lead to the increased retention of nurses for the healthcare institution and for the profession itself (Hansen 2013:158). However, if the transition period, especially during the first few months, is experienced negatively and support is not provided, NQPNs experience what is known as "*reality shock*" (Duchscher 2016:online) which I will discuss in Section 3.4.2.

3.4.1 Professional socialisation

A prominent theory used for describing the transition period is Merton's *Three Stage Theory of Professional Socialization* (see Figure 3.3). Merton, Reader and Kendall (1957) as cited in Kramer et al. (2011b:461) defines professional socialisation as the acquisition of knowledge, norms, values, skill, attitudes and behaviour of a profession to enable individuals to be socialised into that specific profession. Merton's theory divides the transition period into

three stages namely the "*academic*"-, *"transition"*- and *"integration"* stages (Kramer *et al.* 2011b:462). The definition of professional socialistion provided by Merton et al. (1957) as cited in Kramer et al. (2011b:461) agrees with the definition of competency as provided by the SANC (see Section 1.8.2) which implies that neither professional socialisation, nor competency, are stand-alone concepts. This essentially means that one cannot be considered competent without going through the stages of professional socialisation. This view is also shared by Kramer et al. (2012b:568) where the authors state that competency increases as NQPNs move through the three stages to become independent, competent nurse practitioners.

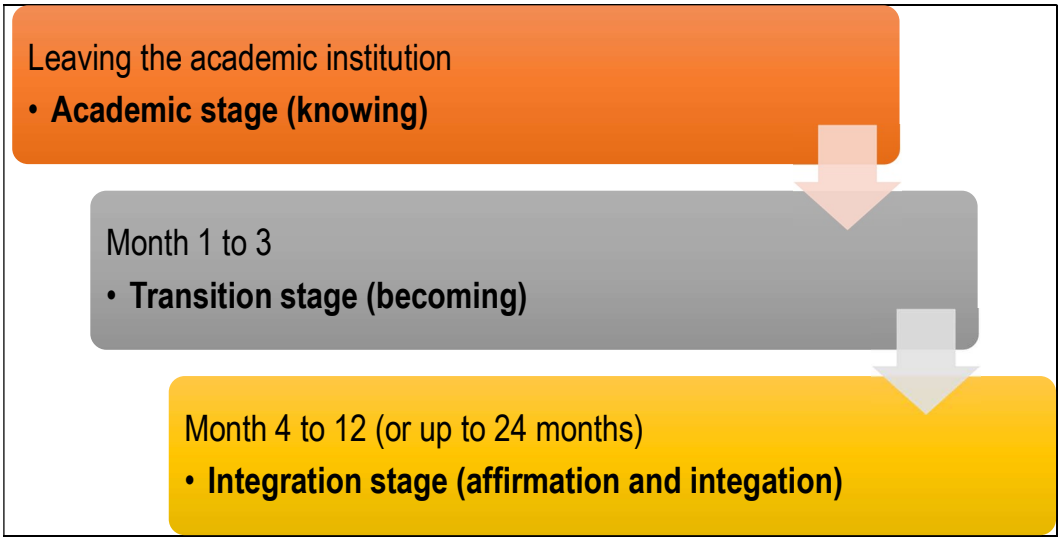

Figure 3.3: Merton's Three-stage Theory of Professional Socialization *Source: Kramer et al. (2012b:568)*

Figure 3.3 illustrates *Merton's Three-stage Theory of Professional Socialization* with relevant time frames for each stage (Kramer *et al*. 2012b:568). Merton's theory has been used regularly in the development of nurse residency programmes since the recognition of nursing as a professional occupation (Duchscher 2016:online; CCNE 2015:5; Kramer *et al*. 2012b:568; Kramer *et al.* 2011b:460;485). The three stages will now be discussed shortly.

3.4.1.1 Academic stage

The academic stage carries the theme of "*knowing"* and refers to the period where the NQPN separates from a tertiary institution. This stage is not discussed in detail as it is not relevant in this study.

3.4.1.2 Transition stage

The transition stage of Merton's theory focuses on the theme of "*becoming"* a professional nurse and represents the first three (3) months after entering clinical practice as a NQPN. During the transition stage the NQPN works closely with a preceptor for guidance (Kramer *et al*. 2011b:485) and the aim of this stage is to narrow the theory-practice gap (CCNE 2015:5).

3.4.1.3 Integration stage

The integration phase carries the theme of "*affirmation"* (Kramer *et al.* 2011b:462) and takes place between four (4) months and one (1) year after entering clinical practice as a professional nurse (Kramer *et al.* 2012b:568). During the integration phase, the professional identity of the NQPN is formed by accepting the values and norms of the nursing profession (CCNE 2015:5). Kramer et al. (2011b:464;475) state that the goal of the integration stage is for NQPNs to assume the role of the professional nurse by being able to deliver competent care to multiple patients simultaneously, function independently, manage clinical situations and to be accountable for their actions. Secondary roles of NQPNs during the integration stage include conducting research and educating junior staff. The role of the preceptor is now taken over by expert professional nurses who act as coaches and mentors in the ward and merely advise NQPNs. A strong focus is placed on the development of non-technical competencies such as conflict management, autonomous decision making, delegation, integration into the workgroup, professional development and role clarification. In the study by Kramer et al. (2011b), literature on the goals of each stage (see Section 3.4.1.1, Section 3.4.1.2, Section 3.4.1.3), themes, components and strategies of the professional socialisation process was reviewed and staff from thirty-four (34) Magnet hospitals were interviewed to determine if their nurse residency programmes reflected the professional socialisation process. The results showed that nurse residency programmes especially supported the transition stage of professional socialisation, and that more than half of the participating hospitals' programmes also supported the integration stage. The most valuable components identified included: facilitated experience; acquisition of skills; reflective practice sessions; management projects that are evidence-based and clinical coaching-facilitation sessions. A possible reason for this study's finding on nurse residency programmes not always supporting the integration stage of professional socialisation, is the inclusion of goals such as research and educating junior staff as part of the integration phase, therefore measuring professional socialisation against achieving these goals.

In my opinion, expecting NQPNs to start doing research as part of the integration stage is unrealistic. Research requires creativity, judgment, communication, organisation, and persistence according to Showman, Cat, Cook, Holloway and Wittman (2013:16) and many of these skills are still being developed by the NQPN. Newly qualified professional nurses should rather be given enough time to focus on their own circumstances and new role as professionals and should not yet be preoccupied with aspects such as research. Research requires specific skills and is a time-consuming process

for which there isn't much time in the busy practice environment, especially when one is not yet a seasoned nurse practitioner.

3.4.2 Reality Shock

The challenges NQPNs face have a major impact on their transition from student nurse to professional nurse (Duchscher 2016:online; Duchscher 2009:1105-1107), patient care and job satisfaction (Burger *et al*. 2013:498) as well as staff retention (Tastan, Unver & Hatipoglu 2013:410). Kramer (1974) conducted a study on 400 NQPNs, exploring their experiences over the first eight (8) months of their professional careers and found that they experienced a similar cyclical experience where they had trouble finding the balance in rendering the quality patient care required by the patient, combined with the challenges of working in the clinical environment, and defined this role-conflict theory as "*reality shock"* (as cited in Parker *et al.* 2012:151; Bratt 2013:102; Riegel 2013:461 & Duchscher 2009:1104). The cycle has four (4) phases namely: "*honeymoon"; "shock", "recovery"* and "*resolution"*. As described in Brunt ([n.d.]:20), the honeymoon phase reflects the excitement the NQPNs feel when starting his/her new career. However, as soon as he/she realises that what occurs in practice does not correlate with what was learnt during training, shock occurs with detrimental effects such as attrition and burn-out. During the recovery phase, the NQPN starts to outweigh the positive and negative aspects of his/her professional role and is more open-minded to what occurs. The final stage, resolution, is when the NQPN regains his/her positive outlook and sense of humour, seeing the "*bigger picture*". Another study by Kramer, Brewer and Maguire (2011a) found that a healthy work environment was the most significant variable on NQPNs' experience of environmental reality shock. A healthy work environment was described in this study as one that is supportive where NQPNs can work with other competent nurses, interprofessional collaboration takes place, adequate numbers of competent staff are available where skills can be developed and that is person-centered. Kramer's theory was further developed by Dr Judy Duchscher (2007) by focussing on the details of antecedents that influence the transition of the NQPN from student nurse to professional nurse. The antecedents included the roles, responsibilities, relationships and knowledge of the NQPN. Duchscher named her theory "*transition shock"* (Duchsher 2016:[6]; Kajander-Unkuri 2015:13).

In the Doctoral thesis of Dimitriadou (2008), 91.9% of nurses reported to have experienced reality shock due to the practice environment not correlating with what was learnt during training (as cited in Dimitriadou, Pizirtzidou & Lavdaniti 2013:316) and in South Africa, the case is no different. In a phenomenological study by Roziers et al. (2014:95;97), interviews were conducted with eight (8) NQPNs in their remunerated community service year to establish their lived experiences. The results showed that the participants experienced reality shock within the first six (6) weeks of clinical placement. These findings are not congruent with literature that states that reality shock starts at around three (3) to six (6) months after placement (Ciocco 2016:124). However, according to Duchscher (2012:20), transition shock is a

non-linear process as not all NQPNs experience it in the same way. How it is experienced is said to be dependent on the individual's coping mechanisms, personal issues that may exist, personal history and the support they receive.

3.5 PROVIDING SUPPORT TO THE NEWLY QUALIFIED PROFESSIONAL NURSE

The implementation of programmes to support NQPNs during the transition period is well noted in literature. The terms used to describe different Transition-to-Practice programmes were provided in Section 1.8.5. Although the term "*nurse residency programme"* is at times used interchangeably with an "*orientation programme"*, some authors argue that it is in fact not the same (Trepanier, Early, Ulrich & Cherry 2012:214). This argument is based on the fact that orientation programmes serve the purpose of orientating the individual to the physical environment, policies and procedures (Kramer *et al.* 2012b:584) and are implemented over a shorter period than a nurse residency programme (Bleich 2012:[1]). Nurse residency programmes complement traditional orientation and consist of structured experiences that allow NQPNs to understand the importance of their responsibilities in the nursing environment (Olson-Sitki *et al.* 2012:156) and to facilitate their professional development (Kramer *et al.* 2012b:584). Furthermore, preceptorship and mentorship are also incorporated into nurse residency programmes (CCNE 2015:19. I will now provide a background as to how nurse residency programmes are developed and implemented internationally.

3.5.1 Background to the development and implementation of international nurse residency programmes

Internationally, nurse residency programmes have become a valuable and essential institution in order to provide support to NQPNs (Wood 2016: online), build their confidence (University of Wisconsin 2018:online), develop their critical thinking skills (Maxwell 2011:30), improve the quality of care rendered (CCNE 2015:4) and, ultimately, decrease reality shock (Kramer *et al*. 2012b:568). The CCNE, who is the recognised accreditation agency of the Department of Education in the United States of America (USA) (CCNE 2015:2) states that nurse residency programmes support the "*professional role transition", "integration"* and *"socialisation"* of NQPNs, during which they can expect to:

- Transition from advanced beginner nurse to competent professional nurse with the ability to render safe, quality care (see Section 3.3.1).
- Improve decision-making skills associated with clinical judgement and performance.
- Develop clinical leadership skills in patient care.
- Work together as part of the inter-professional team.
- Develop strategies to implement evidence into practice.
- Devise a professional development plan for the NQPN that promotes commitment to the nursing profession (CCNE 2015:5).

The development of the first standardised nurse residency programme was initiated in 2000 in a partnership between the American Association of Colleges of Nursing [AACN], a representative body for baccalaureate and graduate nursing education in the USA and the University Health System Consortium, a healthcare performance improvement company in the USA (which is now known as Vizient) (Stringer 2016:online; AACN [n.d]a:online; Vizient [n.d]a:online). Since its implementation, the programme has become the largest nurse residency programme implemented across the USA (AACN [n.d.]b:online), with 250 organisations taking part and 60 000 NQPNs completing the programme up until 2016, according to Wood (2016:online). The Vizient/AACN nurse residency programme forms the basis of my discussion on nurse residency programmes as it is seen as "*the model of the industry*", according to The Joint Commission (2015) (Vizient [n.d]b:online). I believed that this specific nurse residency programme, due to its success in the nursing industry, would provide me with good background knowledge as to how nurse residency programmes are developed, and what typical content it includes – forming a possible guideline for the development of a South African nurse residency programme.

The Vizient/AACN nurse residency programme is based on the Dreyfus' Model of Skills Acquisition, which discusses the intellectual actions involved in directed skill attainment and Patricia Benner's *Novice to Expert Model* (1982) (Wood 2016:online; Danzil 2015:15; Maxwell 2011:28) (see Section 3.3.1). The development of the programme was based on numerous studies that investigated the competency of NQPNs from their own perspective, as well as from the perspectives of their employers (Goode *et al.* 2009:146), which reflects the use of a "*bottom-up*", person-centered approach. Stakeholders involved with the development of the programme included a group of chief nursing officers, deans and nurse educators from tertiary institutions and participating hospitals (Goode *et al.* 2013:2). It comprises of an evidence-based curriculum (Vizient [n.d]a:online), based on *the Essentials of Baccalaureate Education for Professional Nursing Practice* (Goode *et al.* 2013:74) and includes modules on *"leadership", "professional roles"* and *"quality outcomes"* and an evidence-based practice project that has to be completed (CCNE 2015:13; Vizient [n.d.]a:online). The curriculum is revised and updated on a three-yearly basis (Goode *et al.* 2013:74) and includes the following key modules on which accreditation is given: "*quality and safety"; "patient- and family centered care"; "management of patient care delivery"; "communication and conflict management"; "management of the changing patient condition"; "informatics and technology"; "professional development"; "ethical decision making"; "stress management"* and *"the business of healthcare"* (CCNE 2015:11-22). Monthly face-to-face seminars and group discussions form the basis on which the programme is implemented (Goode *et al.* 2013:74; Vizient [n.d]b:online), which are popular methods used in andragogy and person-centered approaches to education (Zucconi 2016:12:18; Kunze 2013:117; Attard *et al*. 2010:2). The programme furthermore makes use of an extensive staff complement consisting of preceptors, facilitators, programme coordinators and programme educators/faculty, each with their own specific function in the provision of support to NQPNs (CCNE 2015:24-26). The programme is implemented over a period of one (1) year (CCNE 2015:5), which agrees with the period of transition according to Kramer (1991) as cited in Goode

et al. (2009:143) and Merton's *Three Stage Theory of Professional Socialization* (see Section 3.4.1) and can be tailored to the specific hospital in which it is implemented (Maxwell 2011:30). The effectiveness of nurse residency programmes are based on the number of NQPNs that complete the programme, retention rates, evaluation of the performance of the NQPNs; measuring satisfaction of stakeholders and NQPNs (CCNE 2015:22), evaluating programme data and the receipt of complaints. Based on the results of these evaluations the nurse residency programme is continuously revised and improved (CCNE 2015:22).

Accreditation of newly developed nurse residency programmes is awarded based on its compliance with the Standards for Accreditation as compiled by the CCNE, which are "*programme delivery", "institutional commitment and resources", "curriculum"* and "*programme effectiveness"* (CCNE 2015:11-22; Goode *et al.* 2013:6). Although accreditation is not a compulsory requirement for nurse residency programmes, it serves the purpose of ensuring that programmes of a high standard are maintained, it assesses the effectiveness of the programme and provides an opportunity for feedback that assists with making improvements to the programme where needed (CCNE 2015:2-3; Krozek 2008:43). According to the University of Wisconsin Health (2018: online), there are currently twenty-five (25) nurse residency programmes accredited by the CCNE in the USA.

My critique on the Vizient/AACN programme is as follows: The fact that the programme is regarded as the "*Model of the industry*" self-explains its effectiveness in the international context. The development thereof follows a "*bottom-up*", person-centered approach which supports why it is so effective (see Section 1.3). The implementation period of one year is supported by Cochran (2017:54) and Goode et al. (2013:77), who also confirm that, in order for nurse residency programmes to be successful, it should be implemented over a minimum period of twelve (12) months or over an even longer period of 12-18 months as recommended by Bratt (2013:105). The extensive support staff complement used in this programme, however, is not feasible in the South African context as there are not enough human- and financial resources available to appoint support staff with different roles and functions related to the implementation of nurse residency programmes (see Section 1.1, Section 2.4, Section 2.4.1).

3.5.2 Advantages of implementing nurse residency programmes

According to the AACN (2017a:[2]), the implementation of nurse residency programmes does not only hold advantages for NQPNs, but also for the rest of the staff and the organisation. The effect on patient outcome has not been researched extensively as it is the most difficult to quantify (Hansen 2013:158). Studies evaluating and reporting on the evaluated advantages and disadvantages of implementing nurse residency programmes are summarised in Table 3.1.

Table 3.1: Advantages of implementing nurse residency programmes

Advantages	Source
Staff retention/decreased turnover	Warren, Perkins and Greene (2018:19); AACN (2017a:[1]); Olson-Sitki et al. (2012:159); Cubit and Ryan (2011:70); Goode et al. (2009:147)
Staff recruitment	Maxwell (2011:32)
Increased skills/competence – narrows theory-practice gap	AACN 2017a:[1]; Kim, Lee, Eudey, Lounsbury, & Wede (2015:60); Goode et al. (2013:78); Olson-Sitki et al. (2012:159); Ulrich, Krozek, Earl, Ashlock, Africa and Carman (2010:371); Goode et al. (2009:147)
Creates a better workplace environment/workplace culture	Goode et al. (2013:78)
Decreased stress	AACN 2017a:[1]; Goode et al. (2009:147)
Increased job satisfaction	AACN 2017a:[1]; Olson-Sitki et al. (2012:159)
Saving costs (when compared to traditional orientation of 24 months)	Trepanier, Early, Ulrich and Cherry (2012:214)

Table 3.1 illustrates various advantages of implementing nurse residency programmes. The large amount of literature indicating the positive effect nurse residency programmes have, especially on staff retention and competency development, which are areas for concern in the South African context with its current nursing shortages and high levels of incompetence (see Table 3.2), supports my argument as to why a nurse residency programme is a great need at present. The literature on staff retention does not necessarily provide a specific reason as to exactly what about a nurse residency programme contributes to staff retention. One can only accept that aspects such as reduced stress and increased job satisfaction are some of these reasons, and therefore further strengthens the motivation for such a programme. The only disadvantage I could identify in literature was that of additional costs as reported by Maxwell (2011:32). This claim, however, seems to be contradicted when the Institute of Medicine reported on various examples of organisations spending a large amount of money on the replacement of NQPNs who resign shortly after appointment and found that these replacement costs were higher than the implementation cost of a nurse residency programme, which could have prevented resignations in the first place (Hansen 2013:157; Maxwell 2011:27).

3.6 EXPERIENCES OF NEWLY QUALIFIED PROFESSIONAL NURSES IN SOUTH AFRICA

Although, as stated in Section 3.2, interpretive description studies do not normally apply limits to literature searches, I decided to apply limitations to this section. The reason, therefore, was because remunerated community service was only implemented among nurse graduates in 2008 and therefore studies conducted prior to that year would not consist of any information thereon. South African researchers have conducted numerous studies attempting to understand the

transition experiences of NQPNs when entering clinical practice. According to Duchscher (2016:online) and Bjerknes and Bjørk (2012:6), by understanding these transition experiences, we become conscious of the challenges new graduates face, which can then lead to identifying ways of improving experiences at ward-level. Challenges specific to the nursing environment in the South African context include poor working conditions in the government sector (Human Resources for Health South Africa 2030 2011:8; Mokoka *et al.* 2010:7), negative interpersonal relationships existing among colleagues and with management (Human Resources for Health South Africa 2030 2011:24; Mokoka *et al.* 2010:7) and high workloads (Human Resources for Health South Africa 2030 2011:24).

I conducted a literature search on NQPNs in South Africa using the search terms *newly qualified nurses/ newly graduated nurses/ novice nurses/ new nurses/ new graduate nurses/ pre-licensure* and *South Africa.* Databases included Africa-Wide Information, Cumulative Index to Nursing and Allied Health Literature (CINAHL), E-Journals, Medline Complete and Google. Searches were limited to articles written in the English language and specific to the years 2008-2017. Sixty-three (63) publications were identified after exact duplicates were removed. I read the abstracts of the publications to do the initial sorting. The remaining publications were read in totality. A total of fifty-eight (58) publications were excluded due to irrelevance. Thorne (2016:69) reiterates the importance of not just relying on reading an abstract of an article to identify relevant articles, but states that it can be used for initial sorting. Thereafter, reading the total paper is suggested. Four (4) relevant publications were identified. Literature reporting on competencies and experiences of NQPNs in specialty units and NQPNs, who completed bridging programmes, were excluded from this literature search as nurses who complete bridging programmes have already worked in clinical practice for a period as enrolled nurses and do not complete a period of remunerated community service (see Section 2.5). The type of support required and expected in specialty units may also differ from normal wards. Refining and expanding a literature review is significant in interpretive description (Thorne 2016:65) and therefore the search was supplemented using Google, which led to the identification of six (6) additional publications. A total of ten (10) publications were included. A schematic representation of the literature search is presented in Figure 3.4.

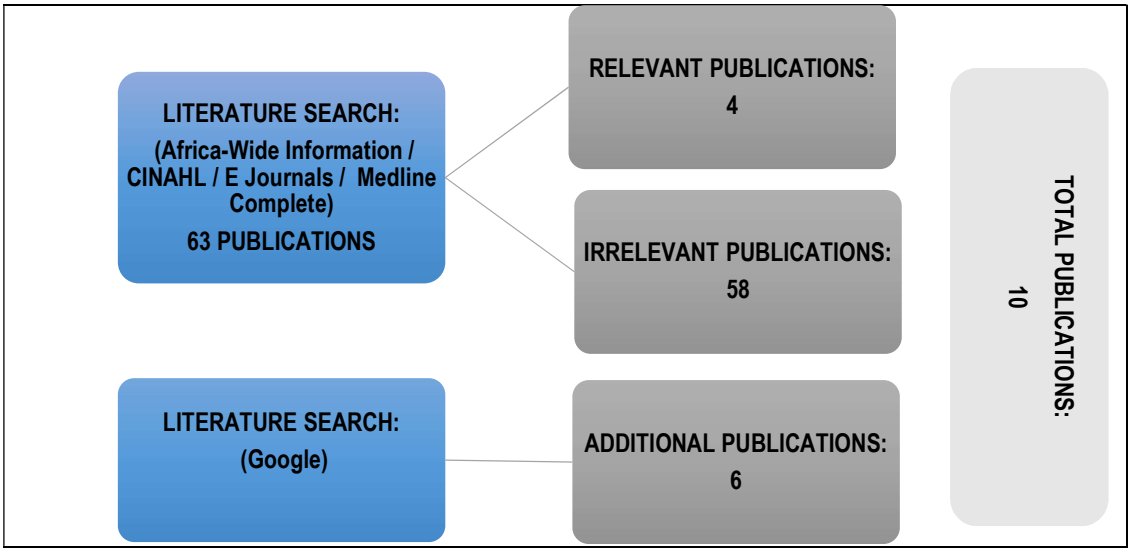

Figure 3.4: Schematic representation of the literature search conducted

Figure 3.4 Illustrates the literature search conducted on the experiences of NQPNs in remunerated community service in South Africa with the purpose of exploring their challenges and level of competency as perceived by themselves and by others. I decided to include both qualitative and quantitative papers as it created familiarity into the field in which I aimed to introduce new knowledge (Thorne 2016:69). The literature was analysed, and content categorised under positive- and negative experiences during remunerated community service as well as competencies and incompetencies. In the case where quantitative studies were conducted, I stated the percentages of the findings to accurately portray the results. I did not regard experiences and challenges of the lesser percentages insignificant as reality is subjective and therefore no single truth exists (see Section 2.7.2.2) and because reality shock is a non-linear process (see Section 3.4.2). The results of the studies and the recommendations made by the authors are also summarised in Table 3.2.

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Kwa-Zulu Natal	Quantitative descriptive design Questionnaire Coding	40 NQPNs Convenience sampling	Theory-practice integration (50%) NQPNs felt they were competent in skills (71%) Learnt active learning strategies	Theory-practice integration (50%) Lack of support (83%) Role ambiguity (55%)	This study revealed that the transition period remains stressful for some NQPNs because of the minimal support they receive.	Consider how NQPNs can be better prepared during student years NQPNs to have supernumerary status Implement preceptorship programme	Mthembu and Zakwe (2010:9;12-13)

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Limpopo	Qualitative exploratory, descriptive contextual design Individual Interviews Content analysis	7 NQPNs Undisclosed sampling method	Professional development Improved guidance	Lack of skills Weak introduction to community service Lack of supervision Lack of support High workload Poor communication Lack of teamwork Staff shortages Impact of a dual health system (Traditional healers vs. Western medicine) Low salary **INCOMPETENT IN:** Disease management Ward management	Identified factors causing stress to the NQPN leads to attrition and are mostly caused by a lack of financial resources provided by the South African government.	A better introduction to clinical practice Reconstruct tertiary education curriculum Develop guidelines to support NQPNs in remunerated community service	Andrén and Hammami (2011:11-19)

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Gauteng	Qualitative exploratory, descriptive contextual design Focus group interviews Analysis: Tesch's descriptive approach	42 NQPNs Purposive sampling	Adequate support Some NQPNs received mentorship	Role-conflict Staff shortages Environment not conducive to learning Negative staff attitude Adverse events Inconsistent support Low salary Lack of orientation Lack of coaching Inconsistent rotations Overwhelmed with responsibility Theory-practice gap Risk-taking Paired with incompetent seniors	Support received by NQPNs vary	Review curriculum annually Implement structured training programme for NQPNs Train and allocate mentors Call-centre Review placement of NQPNs quarterly Scope of practice for NQPNs to be established Pocket size policy and procedure manual for NQPNs to use for referral Workbook and standardised orientation programme Quarterly performance reviews Provincial guidelines for community service to be designed by head of department	Tsotetsi (2012:38-65)

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Limpopo	Qualitative exploratory, descriptive contextual design Phenomenology Semi-structured face-to-face interviews Analysis: Tesch's descriptive approach	8 NQPNs	Training received increased competence	Poor orientation Lack of supervision Lack of teamwork Low salary Staff shortages Shortage of material resources	NQPNs encountered challenges based on their subjective data and they require professional support.	Develop orientation programmes Review orientation programmes Provide in-service education, workshops and seminars Increased team spirit through provision of a forum for free exchange of ideas led by a facilitator Department of Health to address staff- and material shortages Revise remuneration policy	Thopola, Kgole and Mamogobo (2013:173-178)

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Western Cape	Qualitative Descriptive Phenomenology Semi-structured individual interviews	8 NQPNs Purposive sampling	Sense of achievement, confidence and excitement Eager to develop professionally Financial independence Spending time with family and not having to study Increased professionalism Receiving support Constructive feedback from unit managers	Role ambiguity Stress, anxiety Vulnerability Inadequately prepared Fear of victimisation Feel incompetent Unwelcoming staff Shock in response to unprofessional colleagues Experienced reality shock when caring for high acuity patients Orientation programme stopped due to staff shortages **INCOMPETENT IN:** Conflict management	Prior to placement NQPNs experience a sense of achievement and thereafter reality shock.	Use adult learning principles Evaluate NQPN competency to develop curriculum Implement preceptorship Supply guidelines for ethical and legal practice Host a welcoming function and implement an orientation programme Create a positive learning environment. Identify experienced professional nurses as clinical coaches Preceptorship programmes Implement nurse residency programmes Provide constructive feedback and regular evaluation of NQPNs	Roziers, Kyriacos and Ramugondo (2014:96-99)

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Limpopo	Qualitative Descriptive Phenomenology Focus group meeting	12 NQPN Purposive sampling		Inadequate orientation Conflicting values Poor interpersonal relationships **INCOMPETENT IN:** Communication skills	NQPNs experienced self-care deficiencies pertaining to the performance of specific competencies and difficulty in adapting to the workplace culture and healthcare culture.	Skills development for NQPNs related to required clinical competencies, adaptation and health and nursing practice culture Final year student nurses to take charge of units Improve interpersonal relationships Senior professional nurses to orientate and include NQPNs in activities Support development of communication skills and therapeutic relationships	Lekhuleni, Khoza and Amusa (2014:383-392)

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Kwa-Zulu Natal	Quantitative Cross-sectional descriptive survey	110 NQPNs Random sampling *not all participants answered all the questions	Adequately prepared (95.4%) Skill competency (100%) Felt at ease to seek help from seniors (96.3%) Received encouragement and feedback from ward manager (72.9%) Realistic job expectations (81.3%) Adequate support in ward (96.3%) Received orientation (75.7%) Orientation was useful (75.5%) Has enough knowledge (89.7%) Has a supportive mentor/preceptor (64.2%)	Inadequately prepared (3.7%) Did not feel at ease to seek help from seniors (3.7%) Did not receive encouragement and feedback from ward manager (27.1%) Unrealistic job expectations (19.8%) Lack of support in ward (3.7%) Did not receive orientation (24.3%) Orientation was not useful (25.5%) Lack of knowledge (10.2%) Did not have a supportive mentor/preceptor (38.3%)	NQPNs have a positive attitude towards remunerated community service and feel well prepared. Problems identified included a lack of support and orientation and interpersonal relationship problems with colleagues.	Develop standardised guidelines for orientation of NQPNs Develop a job description for NQPNs Implement a structured mentorship programme	Govender et al. (2015:4-8)

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
			Had a mentor to develop confidence (64.2%) Presence of role models (88.8%) Realistic responsibility and workload (49.5%) **COMPETENT IN:** Confidence in communicating with doctors (98.1%) Comfortable in delegating (90.6%) Prioritising patient needs (87.9%) Comfortable to make decisions for patients (97.2%)	No mentor to help develop confidence (35.8%) No role-models (11.2%) Overwhelmed by responsibility and workload (50.4%) Orientation < 1 week **INCOMPETENT IN:** Confidence in communicating with doctors (1.9%) Not comfortable to delegate (9.4%) Prioritising patient needs (12.2%) Uncomfortable to make decisions for patients (2.8%)			

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Gauteng Eastern Cape Western Cape Mpumalanga	Mixed methods Quantitative: Survey Qualitative: Descriptive phenomenology Interviews and Focus group meetings	Quantitative data – 350 NQPNs through systematic probability sampling Qualitative data – 208 operational nurse managers; community service coordinators and NQPNs	Felt welcome In-service training Good induction programmes Felt respected	Poor professional development support in orientation programmes Minimal support/ supervision Poor induction/orientation programmes Orientation programmes too short Inadequate learning opportunities Lack of supervision due to staff shortages Mentors are untrained and unsupported by organisation NQPNs not allowed to attend in-service training Seniors report NQPNs are not willing to learn Seniors report NQPNs are disrespectful, irresponsible and unprofessional, lack commitment	Lack of professional development support for NQPNs. Lack of skills, poor discipline and lack of professionalism.	Increased orientation time Relevant content to be included in orientation programmes Formalised induction programme Implement internship programme Formalise professional development support programme Formalise mentorship programme - supported by SANC and reinforced by Department of Health Balancing theory and clinical components of the curriculum Collaboration between educators and nurse managers in competency assessment Implement 3-6 monthly rotations	Makua (2016:245-278).

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
				Seniors unwilling to be mentors Too high expectations of NQPN Allocation and scheduling challenges Feel neglected Staff shortages Rescheduling of shifts No platform to lay grievances NQPNs report "*feeling competent*", but this is contradicted by seniors **INCOMPETENT IN:** Clinical skills Teamwork		Professional development programmes to be implemented	

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Western Cape	Qualitative exploratory, descriptive design Semi-structured interviews Inductive data analysis	6 NQPNs Purposive sampling	Transition was regarded as a positive experience The building of positive interpersonal relationships with staff Received support by senior staff Developed leadership skills Professional development Learnt to work autonomously, increasing confidence Developed responsibility to work under pressure	Adapting to increased responsibility No orientation High expectations of ward managers Theory-practice gap Transition was difficult Negative attitude from staff Felt incompetent Lack of supervision No mentorship Unsupported Staff shortages **INCOMPETENT IN:** Conflict management	Remunerated community service year was considered as difficult as it required putting knowledge into practice and taking more responsibility. The undergraduate programme was considered to be insufficient.	Academic staff and mentors are needed to prepare 4th year students for practice Develop guidelines for ethical/legal scope of practice of NQPN and how to support them Train NQPNs on conflict management, assertiveness, practical ethics Develop job description and file with guidelines In-service training, seminars and workshops for professional development Continuous support through a mentorship programme Revise orientation programmes	Zaayman (2016:40-67)

Table 3.2: Experiences and competencies of Newly Qualified Professional Nurses in remunerated community service in South Africa

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Kwa-Zulu Natal	Qualitative descriptive Semi-structured interview Tesch's content analysis	27 NQPNs Purposive sampling	Learnt "*ropes of the profession*" through increased responsibility and accountability Professional development Increased self-confidence	Felt overwhelmed by increased responsibility Lack of recognition Role confusion High expectations Low salaries Hindering of professional development by not being allowed to attend post-graduate programmes Delays in registration as professional nurse	Main categories identified in study: paying back the government or community, transition period for professional role, being thrown in the deep end, lack of role clarification, and frustrations with the remunerated community service policy.	Orientate nursing students on policy of remunerated community service Clarify role expectations Develop job description for NQPNs Develop structured orientation programme	Govender, Brysiewicz and Bhengu (2017:17-20)

Table 3.2 provides a summary of various South African studies that were conducted on the experiences and competence of NQPNs. These ten (10) studies were used to compile Datasheet 4, which was given to the workshop participants for interpretation and to extract findings that they considered relevant and valid for their own context (see Section 4.4.1.7, Annexure F6.4). Most of the studies were conducted in the KwaZulu-Natal province and Limpopo province each with three (3) studies. One (1) study was conducted in the Gauteng province and the Western Cape respectively and one study was conducted over multiple provinces (Gauteng, Eastern Cape, Western Cape and Mpumulanga). No studies were conducted in the Free State-, North West and Northern Cape provinces, which is interesting seeing as both the Free State- and North West provinces have universities that offer nursing. Four (4) studies showed that NQPNs felt that they were adequately supported, with the rest reporting a lack thereof. Some studies also reported on the specific competence and incompetence of NQPNs which varied across settings. The methodology, methods, sample size and sampling methods were also noted. Eight (8) studies were qualitative, one (1) quantitative and one (1) study used mixed methods. All studies were descriptive and recommended either the development of a type of transition-to-practice programme or guidelines on how to provide support to NQPNs. It is interesting to note that only one (1) study used a multi-level stakeholder sample. All other studies were conducted with NQPNs themselves. This is problematic seeing as studies by Katowa-Mukwato and Banda (2016:128), confirmed a negative correlation between the self-reported competence and objective competence of learners due to fear of judgement by others. This is also evident in the study by Makua (2016) in Table 3.2. Similarly, Kajandur-Unkuri (2015) reported that a needs assessment conducted on both NQPNs and their mentors in an attempt to establish what the NQPNs' learning needs were, delivered incongruent results, which again confirms NQPNs' inability to identify their true competence when asked to do so. The possibility therefore exists that if samples only consist of NQPNs, and the perspective of other levels of stakeholders is not obtained, the reported competence may be untrue.

3.7 EXPERIENCES OF NEWLY QUALIFIED PROFESSIONAL NURSES AT INTERNATIONAL LEVEL

Experiences of NQPNs at international level has been researched extensively. In this section, I repeated the literature review as described in Section 3.6, using the search terms *newly qualified nurses/ newly graduated nurses/ novice nurses/ new nurses/ new graduate nurses/ pre-licensure* but excluded the search term "South Africa". The same Databases and years were used, and the articles were limited to full text. I identified 1 956 studies. I conveniently sampled the first ten (10) relevant articles based on their titles and abstracts, to match the number of articles used for the datasheet on South African literature. Convenience sampling does not aim to obtain a representative sample but strives for diversity (Polit & Beck 2017:492). I also considered the literature review in each of these articles and included aspects reported on that were not included in the specific article's data. Additional articles from Google were also included.

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
USA	Qualitative Descriptive study Appreciative inquiry	36 NQPN	Received support Accomplishments were recognised Preceptorship Working with other NQPNs Culture where questions were welcomed Repetition of skills contributed to learning	Not welcomed Unsupported Felt humiliated Competitive culture Short orientation Felt unprepared Criticised and taunted by seniors Didn't ask questions to avoid feeling "stupid" Discouraging workplace environment Lack of encouragement **LITERATURE IN ARTICLE:** Role conflict Having an overwhelming sense of responsibility Fearful of physicians	The study found that welcoming nurses into an environment where questions are welcomed, where support is provided and where good interpersonal relationships exists is critical when working with NQPNs.		Chandler (2012:105-107)

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
				Difficulty in organising, prioritising and delegating Lack of a consistent facilitator Coping with high workload Struggles with dependence on others Feeling undervalued Limited orientation Overwhelming amount of decision making Experience of loss, doubt, confusion and disorientation Poor level of confidence in performing required skills Poor peer relationships Can't function independently			

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Iran	Qualitative Interviews Content analysis	18 senior professional nurses with >2yrs work experience Purposive sampling		Lack of knowledge Poor physical fitness Lack of support No self-esteem Lack of emotional readiness to work (Fear & anxiety) Poor coping skills (complex care environment) Cultural differences and lack of knowledge on hierarchy **INCOMPETENT IN:** Clinical skills Management skills Critical thinking Social skills Conflict management skills	Undergraduate curriculum should be reviewed, and support programmes should be developed in order to protect the well-being of new graduates and improve retention.	Eliminate sources of distress Develop support programme Implement orientation One-year long support programmes to be offered by mentors and preceptors	Ebrahimi, Hassankhani, Crowley, Negarandeh, Sadeghian and Azizi (2016)

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Turkey	Qualitative Semi-structured in-depth interviews Content analysis	NQPNs Unknown sample size Purposive sampling		Lack of knowledge leading to stress Increased workload **INCOMPETENT IN:** Communication skills Clinical skills	Experiences of NQPNs during first 6 months in clinical practice was identified under four categories, lack of communication skills, lack of clinical skills, lack of knowledge and increased workload	Unit-specific orientation NQPNs to be trained prior to first day of employment	Sönmez and Yildirim (2016:107)

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Norway	Qualitative Ethnography Observation, interviews, document analysis	13 NQPNs Purposive & convenience sampling		Lack of respect received from seniors More responsibility than what was expected Fragmentation of patient care Stressful interactions with colleagues Working under time pressures Not receiving adequate support	Lack of support in the work environment and lack of role models increased the NQPNs' experience and responsibility in their work situations. Coping skills were learnt "the hard way"	Adjust the nursing profession's expectation of NQPNs Implement support programmes	Bjerknes and Bjørk (2012:6)

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
USA	Mixed methods Descriptive design Survey Analysis: SPSS 11	62 Preceptors	**COMPETENT IN:** Basic technical skills (72%) Function independently and perform advanced technical skills (76%) Good physical assessment skills (50%) Communication skills (63%)	**INCOMPETENT IN:** Psychomotor skills Assessment skills Critical thinking Time-management Communication Teamwork		Develop a structured training programme Develop methods to identify learning needs and facilitate learning Ensure that sufficient administrative commitment and support is available i.e. staff and support Promote professional socialisation of NQPNs	Hickey (2009:38-40)

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
China	Qualitative Field Observation & informal discussions Semi-structured Interview Open coding in constant comparative analysis	52 NQPNs observed 25 NQPNs interviewed Convenience & snowball sampling		Low work status Incompetence High workload Lack of support Uncertain of career development	NQPNs experience numerous stressors including low work status, incompetence, high workload, lack of support and uncertainties of career development. These factors should be identified in an attempt to address the nurse shortage.	Development of support programme	Hu, Zhang, Shen, Wu, Wu and Malmedal (2017:190)

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Australia	Mixed methods Cross Sectional Online survey – Quantitative data analysis with SPSS & qualitative data analysis with coding Focus group meetings - coding	282 NQPNs	Recruitment processes were good Professional development opportunities	Negative workplace cultures Poor morale Lack of support Transition is stressful, draining, physically- and emotionally demanding, and personally challenging High workload Horisontal violence Felt like unsafe practitioners Too much responsibility placed on NQPNs	Key factors impacting on the transition experience are the workplace environment, the level and nature of support available, their tendency to learn and adapt to workplace cultures and to accommodate their own and others' expectations and not the amount of prior experience.	Develop and test evidenced based approaches that empower nurses (new graduates and experienced nurses) and implement approaches that allow stewardship of NQPNs into the profession	Parker, Giles, Lantry and McMillan (2014:150,155)

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Oman	Qualitative Case study Individual Interview Observation Focus group meeting Document analysis Thematic analysis Microsoft's Access database software Statistical analysis of demographic data	115 NQPNs 8 Student nurses 6 Preceptors 5 Clinical instructors 5 Head nurses 4 Managers Purposive sampling		Found that nursing is routine-and task orientated Theory-practice gap Conflict with peers & negative attitudes Feel insubordinate to doctors	Transition experience is affected by the work environment and the status of nursing in the country.	Nursing education institutions to partner with healthcare institutions to narrow the theory-practice gap.	Al Awaisi (2015:1723-1734).

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Iran	Qualitative Interviews Content Analysis	17 NQPNs 4 Nurse managers (2 supervisors and 2 experienced nurses) Purposive sampling		**INCOMPETENT IN:** Clinical skills Communication skills Management skills	The three categories collectively represented the inability of the NQPN to implement theory into practice	Implementation of orientation programmes	Hezaveh, Rafii and Seyedfatem (2014:222)

Table 3.3: Experiences and competencies of Newly Qualified Professional Nurses at international level

AREA	METHODOLOGY	SAMPLE	POSITIVE EXPERIENCES AND ADEQUATE COMPETENCIES	NEGATIVE EXPERIENCES AND INADEQUATE COMPETENCIES	RESULTS	RECOMMENDATIONS	SOURCE
Denmark	Qualitative Observation Interviews Analysis based on Malterud's systematic text condensation	4 NQPNs Purposive sampling		Lack of practical training Require more knowledge on anatomy, physiology, microbiology and pathology	NQPNs feel unprepared when entering clinical practice and cannot relate to nursing theories, as they thought that it should be applied directly to practice instead of function as a reflection on practice.		Danbjørg and Birkelund (2011:171)

Table 3.3 presents a summary of ten (10) studies conducted on international level discussing the experiences and competencies of NQPNs. These studies were used to compile Datasheet 3 (see Section 4.4.1.7, Annexure F6.3). It is evident that more studies were conducted using a multi-level stakeholder sample when compared to South African studies (see Table 3.2). What is further interesting is that many of the findings are similar to that of South African studies. Complaints about feeling unsupported, incompetence, poor communication skills, stressful work environments etc. are experienced worldwide and are not just unique to the South African context. Similarly, the recommendation of developing and implementing a type of Transition-to-Practice programme, such as a nurse residency programme is presented across almost all of the studies. This strengthens the case that there is a great need for such a programme and that it is considered to be a valuable and effective way in which to support NQPNs in their first year of clinical practice.

I conclude this literature review in stating that there is ample evidence from studies conducted internationally and in South Africa that NQPNs face challenges during their first year in practice and that they require support during the transition period from student nurse to professional nurse. Literature therefore provides a description of the experiences and challenges of NQPNs during their first year in clinical practice, thereby answering the question of "*What?*" is going on in practice. This is further supported by various theories such as Benner's *Novice to Expert Theory* (see Section 3.3.1) and Merton's *Three Stage Theory of Professional Socialization* (see Section 3.4.1) which are well-known theories in the nursing context. Although these theories do not create an understanding of a single reality, they add value to understanding competency and skill development, the transition period and professional socialisation. The description of the challenges of NQPNs in international studies was interpreted which led to the development of context-specific nurse residency programmes that successfully provide support to NQPNs during the transition period. No evidence of a similar programme was found to exist in South Africa. It can, therefore, be said that the South African studies have created knowledge through description, but it lacks interpretation. The question of "*So what*?" therefore remains unanswered and thus constituted the need for an interpretive description study.

3.8 SUMMARY

In Chapter 3, I discussed the literature on competency and skills development and the transition period that NQPNs go through during which they often experience reality shock. Supporting theories were presented and the importance of support provision to NQPNs was argued. An accredited international nurse residency programme as an effective support measure was discussed with reference to its development and implementation as well as the advantages thereof. The experiences and challenges of NQPNs in remunerated community service in South Africa over various provinces were reviewed as well as international literature and the need for a nurse residency programme in South Africa was motivated. In Chapter 4 the research methodology of this study will be discussed.