

7 CONCLUSIONS, CONTRIBUTIONS, IMPLICATIONS FOR PRACTICE AND LIMITATIONS

7.1 INTRODUCTION

In Chapter 6, the conceptual framework and the Person-centered Nurse Residency Programme was presented. In Chapter 7, I will present a conclusion on all the domains of the Person-centered Nurse Residency Programme, along with its underlying constructs, and how it will lead to the ultimate purpose of human flourishing. I will then discuss the contributions of this study, the implications for practice, provide suggestions for future research, thereby answering the *Now what?* question. Finally, the study's limitations are presented.

7.2 AIM AND OBJECTIVES

The initial aim of the study was to co-construct a nurse residency programme specifically for the South African context to support NQPNs during remunerated community service by using a person-centered approach. The person-centered approach required me to identify the needs of NQPNs as perceived by different levels of stakeholders for inclusion in the nurse residency programme. The stakeholders included NQPNs, senior professional nurses, clinical facilitators, managers and educators from different institutions (see Section 4.3.2, see Table 4.1). The study emerged during the programme development phase (see Section 4.4.1.7) when the workshop participants verbalised that there was no value in developing an in-depth nurse-residency programme for NQPNs, if there aren't enough clinical facilitators appointed in healthcare institutions to successfully implement the Person-centered Nurse Residency Programme and to provide support to NQPNs. Consensus was reached among the workshop participants to change the aim of the study and to focus on identifying and training senior professional nurses on ward-level to act as facilitators in the Person-centered Nurse Residency Programme, in order to allow for continuous support to be provided to NQPNs. Objective 3 was amended and the competencies of facilitators were co-constructed, based on the needs of NQPN as perceived by the different levels of stakeholders, thereby adhering to the person-centered approach.

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 this aim, the objectives of the study were:

**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.

7.3 CONCLUSIONS

These two phases and related objectives are concluded in Sections 7.3.1 to 7.3.3.

7.3.1 PHASE 1: Needs assessment

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

As an initial step to achieve Objective 1, a needs assessment (Phase 1) was conducted to identify the needs of NQPNs to be included in the Person-centered Nurse Residency Programme as perceived by different levels of stakeholders, thereby demonstrating the principle of *inclusion* (see Section 4.3.2). A multi-method approach was used to conduct the needs assessment. In Step 1, a focus group meeting was conducted with six (6) NQPNs (see Section 4.3.3.1) and a self-administered qualitative open-ended questionnaire (Questionnaire A) (see Annexure C3) was distributed to seventy-seven (77) NQPNs. Twenty-eight (28) questionnaires were returned (see Section 4.3.3.2). A total of thirty-four (34) NQPNs' needs were assessed. In Step 2, a second self-administered qualitative open-ended questionnaire

(Questionnaire B) (see Annexure E1) was distributed to sixty (60) senior professional nurses, clinical facilitators, managers and educators in order to gain their perspectives on the needs of NQPNs to be included in the Person-centered Nurse Residency Programme. A total of seventeen (17) questionnaires were returned (see Section 4.3.3.3). Excerpts from the focus group script and Questionnaire A, excerpts from Questionnaire B, and International- and South African literature on experiences and competencies of NQPNs, along with my own interpretations of the data were compiled into four (4) Datasheets respectively (see Annexure F6.1, F6.2, F6.3, F6.4, see Section 4.3.3.2, Section 4.3.3.3), which formed the basis from which participatory data analysis was done. In my preparation of the data for analysis, some of the core needs that I identified were the development of communication skills, critical thinking skills, role-clarification, teamwork and a need for an orientation and a support programme. Participatory data analysis formed part of programme development (Phase 2) and will, therefore, be discussed in the following section on programme development.

7.3.2 PHASE 2: Programme development

Phase 2 consisted of two objectives. Each objective will be concluded.

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

To co-construct the Person-centered Nurse Residency Programme, I **collaborated** with different levels of stakeholders during a workshop, taking a **participatory** approach to data analysis (see Section 4.4). Seventeen (17) participants attended the workshop, which consisted of NQPNs, senior professional nurses, clinical facilitators, managers and educators (see Table 4.4). No experts from either NEA, SANC nor the DoH attended. Workshop participants were divided into four (4) smaller groups, each responsible for analysing one Datasheet (see Annexure F6.1, F6.2, F6.3, F6.4) to establish which needs were to be included in the Person-centered Nurse Residency Programme. A combined inductive/deductive approach was used to co-construct a Person-centered Nurse Residency Programme for NQPNs in remunerated community service.

The Person-centered Nurse Residency Programme consisted of six domains, namely: (1) *outcomes of the Person-centered Nurse Residency Programme*; (2) *objectives of the Person-centered Nurse Residency Programme*, (3) *prerequisites of the senior professional nurse*, (4) *foundational knowledge of the facilitator*, (5) *person-centered learning environment* and (6) *person-centered learning process*. The domain: (1) *outcomes of the Person-centered Nurse Residency Programme* focused on the learning outcomes of the NQPN and the domain: (2) *objectives of the Person-centered Nurse Residency Programme* focused on the overall objectives of the programme. The remaining four

domains; (3) *prerequisites of the senior professional nurse*; (4) *foundational knowledge of the facilitator*; (5) *person-centered learning environment* and (6) *person-centered learning process* respectively focused on the senior professional nurse that will be identified and trained as a facilitator and who will be responsible for implementing the Person-centered Nurse Residency Programme.

7.3.3 Outcomes of the Person-centered Nurse Residency Programme

Four *outcomes of the Person-centered Nurse Residency Programme* were identified, namely: (1) theory-practice integration; (2) effective problem-solving skills; (3) effective conflict management skills; and (4) effective management skills.

Theory-practice integration requires the NQPN to be able to transfer learning to the workplace environment and use evidence-based knowledge and cognitive thinking skills to suit the needs of the patient and the evolving healthcare context. Secondly, the NQPN should have developed effective problem-solving skills to manage patient care problems in a person-centered way. This involves the ability of the NQPN to follow the steps of the nursing process and to think critically while also considering legislation to ensure that safe care is rendered. The third outcome is the effective management of conflict in the workplace and possibly with patients or their significant others. Effective conflict management requires person-centered communication skills that are developed as part of the Person-centered learning process. The last outcome is that the NQPN must be able to effectively manage challenging situations that are synonymous with the South African healthcare context, such as staff shortages and high workloads. Challenging situations require of the NQPN to know how to make the correct decisions based on legality, ethics and the SOPs of the healthcare institution. For a comprehensive discussion on the *outcomes of the Person-centered Nurse Residency Programme*, the outcome statements are written for the NQPN and a complete list of the KSAs, please refer to Section 5.3.1. In Table 7.1, a summary of the *outcomes of the Person-centered Nurse Residency Programme*, illustrating which domains lead to meeting each outcome, along with the supporting sections is presented.

Table 7.1: Summary of the outcomes and the contributing domains of the Person-centered Nurse Residency Programme

| Outcomes | Contributing domains |
|---|--|
| Theory-practice integration | Foundational knowledge of the facilitator <ul style="list-style-type: none"> • Facilitation of learning (see Section 5.3.5.2) |
| | Person-centered learning environment <ul style="list-style-type: none"> • Workplace environment (orientation) (see Section 5.3.6.1) • Supportive organisational systems (supervision & feedback) (see Section 5.3.6.2) |
| Effective problem-solving skills | Foundational knowledge of the facilitator <ul style="list-style-type: none"> • Facilitation of learning (see Section 5.3.5.2) |
| | Person-centered learning environment <ul style="list-style-type: none"> • Workplace environment (Orientation & Exposure) (see Section 5.3.6.1) |
| | Person-centered learning process <ul style="list-style-type: none"> • Interprofessional collaboration (see Section 5.3.7.1) • Communication (see Section 5.3.7.2) • Apply ethico-legal principles (see Section 5.3.7.3) |
| Effective conflict management skills | Person-centered learning process <ul style="list-style-type: none"> • Communication (see Section 5.3.7.2) |
| Effective management skills | Person-centered learning environment <ul style="list-style-type: none"> • Workplace environment (orientation & exposure) (see Section 5.3.6.1) |
| | Person-centered learning process <ul style="list-style-type: none"> • Interprofessional collaboration (see Section 5.3.7.1) • Communication (see Section 5.3.7.2) • Apply ethico-legal principles (see Section 5.3.7.3) |

Table 7.1 provides a summary of the *outcomes of the Person-centered Nurse Residency Programme* illustrating which domains contribute to meeting each outcome.

7.3.4 Objectives of the Person-centered Nurse Residency Programme

Three *objectives of the Person-centered Nurse Residency Programme* were identified, namely: (1) professional socialisation (2) person-centered attitude and (3) feeling of well-being.

Professional socialisation involves the transition of the student nurse to professional nurse as well as his/her integration into clinical practice. The transition stage involves the development of the NQPN's technical skills while integration involves the development of non-technical skills (see Section 3.4.1.2, Section 3.4.1.3). Transition, therefore, should occur when the NQPN has successfully developed the ability to integrate theory into practice by implementing evidence-based knowledge (see Section 5.3.1.1). Integration, on the other hand, should occur when the rest of the *outcomes of the Person-centered Nurse Residency Programme* are met, namely (1) effective problem-solving skills;

(2) effective conflict management skills; and (3) effective management skills. When the NQPN has professionally socialised into the role of professional nurse the advantages should include a decrease in adverse events and lead to quality person-centered care being rendered (see Section 5.3.1.2, Section 5.3.1.3, Section 5.3.1.4). A central aim of the Person-centered Nurse Residency Programme is to develop the NQPN into a person-centered nurse practitioner. Person-centered nurse practitioners render quality patient care by following person-centered approaches, thereby also increasing patient satisfaction. Person-centered attitudes among staff members create effective staff relationships and create person-centered workplace cultures that lead to an increase in staff satisfaction, decreased turnover and retention of staff. By establishing positive interpersonal relationships, a feeling of well-being in the NQPN is established. By achieving these objectives, the ultimate purpose of human flourishing can be realised. In Table 7.2, a summary of the *objectives of the Person-centered nurse Residency Programme* is provided, illustrating which domains of the Person-centered Nurse Residency Programme lead thereto, along with the supporting sections.

Table 7.2: Summary of the objectives and contributing domains of the Person-centered Nurse Residency Programme

| Objectives | Contributing domain |
|--|---|
| Professional socialisation <i>(Consists of transition and integration)</i> | Outcomes of the Person-centered Nurse Residency Programme <ul style="list-style-type: none"> • Theory-practice integration (transition) (see Section 5.3.1.1) • Effective problem-solving skills (integration) (see Section 5.3.1.2) • Effective conflict management skills (integration) (see Section 5.3.1.3) • Effective management skills (integration) (see Section 5.3.1.4) |
| | Foundational knowledge of the facilitator <ul style="list-style-type: none"> • Facilitation of learning (see Section 5.3.5.2) |
| | Person-centered learning environment <ul style="list-style-type: none"> • Workplace environment (see Section 5.3.6.1) • Supportive organisational systems (see Section 5.3.6.2) |
| | Person-centered learning process <ul style="list-style-type: none"> • Interprofessional collaboration (see Section 5.3.7.1) |
| Person-centered attitude | Foundational knowledge of the facilitator <ul style="list-style-type: none"> • Knowledge of person-centeredness (see Section 5.3.5.1) |
| | Person-centered learning process <ul style="list-style-type: none"> • Interprofessional collaboration (see Section 5.3.7.1) • Communication (see Section 5.3.7.2) |
| Feeling of well-being | Person-centered learning process <ul style="list-style-type: none"> • Interprofessional collaboration (see Section 5.3.7.1) • Communication (see Section 5.3.7.2) |

Table 7.2 provides a summary of the *objectives of the Person-centered Nurse Residency Programme* illustrating which domains contribute to achieving each objective.

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

In the discussion on the remaining domains, the discussion will focus on the facilitator and what his/her role will be in supporting the NQPN to meet the *outcomes of the Person-centered Nurse Residency Programme* (see Section 7.3.3).

7.3.5 Prerequisites of the senior professional nurse

Senior professional nurses should be identified as potential facilitators based on five (5) prerequisites, namely: (1) clarity of beliefs and values; (2) professional competence (3) effective interpersonal skills; (4) effective time management skills; and (5) willingness to act as a facilitator.

For a senior professional nurse to be identified as a potential facilitator, he/she should be professionally competent and confident, with at least three (3) years' experience as a professional nurse. The senior professional nurse should be categorised as either a "*proficient*" or "*expert*" nurse according to Benner's *Novice to Expert Theory* (see Section 3.3.1), but without necessarily having obtained a post-graduate qualification in a clinical discipline, although it is preferred. Secondly, he/she must have clarity of his/her own beliefs and values and his/her personal beliefs and values should be in line with that of the SANC, which co-incidentally does agree with person-centered values, although the senior professional nurse may not be familiar with the concept. The senior professional nurse should furthermore have self-knowledge which allows himself/herself to identify and reflect on his/her own practices and competency that requires development and will enable him/her to support the NQPN. The third prerequisite refers to the ability of the senior professional nurse to display effective interpersonal skills, especially by being a team-player, when working with the rest of the interprofessional team and knowing how to effectively communicate with team members using verbal- and non-verbal communication strategies, as well as with patients and their significant others. The fourth prerequisite was that the senior professional nurse must have effective time-management skills to assist himself/herself in combining the dual role of nurse practitioner and facilitator. Lastly, the willingness of the senior professional nurse to act as a facilitator was identified as another essential prerequisite to ensure that there is a commitment to the job and a true dedication to the successful implementation of the Person-centered Nurse Residency Programme. For a comprehensive discussion on the prerequisites of the senior professional nurse, please refer to Section 5.3.4.

7.3.6 Foundational knowledge of the facilitator

After the senior professional nurse is identified as a potential facilitator based on having met all the required prerequisites (see Section 7.3.5), he/she must be trained on (1) person-centeredness and (2) the facilitation of learning to be able to effectively implement the Person-centered Nurse Residency Programme.

Foundational knowledge on person-centeredness includes having knowledge of its key principles, how it contributes to building effective staff relationships in the workplace and the development of positive workplace cultures. Person-centered practitioners should know how to communicate in a person-centered way, which requires knowledge of beliefs and values and cultural sensitivity. The facilitator's knowledge on person-centeredness will be applied in the way he/she treats patients and colleagues, whereby he/she will role-model this to the NQPN and in the way he/she interacts with the NQPN and facilitates learning, which leads to the discussion on the second foundational knowledge construct, facilitation of learning. The principles of adult-learning require the facilitator to use a person-centered approach to education. This is contributed to the fact that all individuals learn differently and have different learning needs, which the facilitator should be able to identify. The facilitator should then also know how to facilitate and evaluate the learning that took place in a way that suits the NQPN's learning style and with consideration for his/her beliefs, values and culture. Continuous needs assessments are essential for the continuous professional development of the NQPN, which also teaches him/her the importance of life-long learning and is an essential element of a competent nurse practitioner.

The foundational knowledge constructs will furthermore lead to a change in the existing prerequisites, as the senior professional nurse who is now trained as a facilitator, will apply person-centered principles to his/her role as a nurse practitioner and in the role of facilitator. The senior professional nurse's professional competence will be further developed through the knowledge that he/she has obtained during training. His/her beliefs and values will be supplemented and integrated with person-centered values and interpersonal skills will become person-centered. The use of his/her time-management skills will be essential in managing the dual role of nurse practitioner and facilitator. Outcome statements for the facilitator for both foundational knowledge constructs were written and the associated KSAs required of the facilitator to meet each outcome statement was identified. For a comprehensive discussion on the *foundational knowledge of the facilitator*, along with the outcome statements written for the facilitator, and a list of the KSAs, please see Section 5.3.5.

7.3.7 Person-centered learning environment

The learning environment must be conducive to person-centered ways of learning for NQPNs to reach their full potential and to feel supported. The constructs that referred to the *person-centered learning environment* were: (1) workplace environment; and (2) supportive organisational systems.

Newly Qualified Professional Nurses require exposure to different situations from which they can actively learn to develop their competencies. This includes giving them the opportunity to act in their professional capacity when interacting with other members of the interprofessional team and being provided with opportunities to fulfil important roles such as management functions. By providing the NQPN with adequate exposure to different situations in the skills environment, competency develops through active learning. At the same time, providing adequate orientation enables him/her to render safe patient care and it leads to professional socialisation. Equally important is the need for orientation to the workplace environment. To orientate the NQPN, the facilitator requires extensive discipline-specific knowledge and knowledge of the SOPs used in the ward to guide the NQPN to also safely and effectively care for his/her patient. The facilitator should create experiential learning opportunities for the NQPN by involving him/her in activities that can contribute to his/her professional development. Supervision and feedback are regarded as essential supportive organisational systems that enable the NQPN to integrate theory into practice. Outcome statements for the facilitator for both *person-centered learning environment* constructs were written and the associated KSAs required of the facilitator to meet each outcome was identified. For a comprehensive discussion on the *person-centered learning environment*, along with the outcome statements written for the facilitator, and a list of the KSAs, please see Section 5.3.6.

7.3.8 Person-centered learning process

The *person-centered learning process* is the continuous process that occurs in the learning environment on a daily basis through which the NQPN can learn and subsequently meet the *outcomes of the Person-centered Nurse Residency Programme* (see Section 7.3.3). Role-modelling by the facilitator plays a central part in the development of the competency of the NQPN, specifically when referring to the *person-centered learning process*. The constructs of the *person-centered learning process* included: (1) interprofessional collaboration; (2) communication; and (3) applying ethico-legal principles.

Nurse practitioners, including NQPNs, form part of the interprofessional team. By allowing NQPN to collaborate with interprofessional team members, active learning takes place. This, again, reiterates the value of exposing the NQPN to different situations to gain competence and develop professionally. The facilitator must be able to guide the NQPN in collaborating with the interprofessional team, which requires that the facilitator himself/herself should be competent in doing so. The facilitator therefore requires KSAs such as shared leadership- and decision-making skills, knowledge

of the different roles of the different team members as well as knowledge of the SOPs, ethics and legislation to ensure that safe patient care is rendered. Effective interpersonal skills, especially person-centered communication skills and being a team-player (see Section 5.3.4.3) forms a central component of the ability to collaborate with the inter-professional team. When the NQPN is guided by the facilitator to collaborate with the rest of the interprofessional team, he/she gains competence in the process, role clarification is achieved, and professional socialisation is facilitated. Interprofessional collaboration further aids in establishing effective staff relationships and thereby leads to creating a feeling of well-being in the NQPN.

The next *person-centered learning process* is communication. Communication forms part of all processes in the healthcare context and if the NQPN cannot effectively communicate, most of the *outcomes of the Person-centered Nurse Residency Programmes* cannot be met. Communication is a relevant skill when interacting with the interprofessional team, when doing handovers, when using verbal written strategies such as patient documentation and when communicating with patients. The facilitator must be able to guide the NQPN to communicate effectively with the interprofessional team and with patients by using effective communication techniques that ensure that the message is conveyed effectively while using a person-centered approach. Effective communication skills lead to the development of effective problem-solving skills, conflict management skills and management skills, and therefore enables the NQPN to meet the *outcomes of the Person-centered Nurse Residency Programme* (see Section 7.3.3).

The last *person-centered learning process* refers to the applying of ethico-legal principles. Ethical decision-making is a daily occurrence in the healthcare context and is an essential requirement to safely and effectively solve problems as an individual healthcare practitioner, as part of the interprofessional team, and to manage challenging situations. In order to develop this skill in NQPNs, the facilitator must assist the NQPN to apply ethico-legal principles effectively in different contexts. This requires that the facilitator must have a sound knowledge of relevant legislation and ethical principles and should incorporate this into the decision-making and problem-solving processes faced in the every-day nursing environment. For a comprehensive discussion on the *person-centered learning process*, along with the outcome statements written for the facilitator and a list of the KSAs please refer to Section 5.3.7.

7.4 CONCEPTUAL FRAMEWORK: PERSON-CENTERED NURSE RESIDENCY PROGRAMME

The Person-centered Nurse Residency Framework developed in Chapter 6 illustrates the Person-centered Nurse Residency Programme as an analogy of a growing flower underpinned by the philosophy of person-centeredness. The conceptual framework depicted the six domains of the Person-centered Nurse Residency Programme. The *outcomes of the Person-centered Nurse Residency Programme* were theory-practice integration; effective problem-solving skills; effective conflict management skills and effective management skills. The Person-centered Nurse Residency

Programme lays the groundwork for the NQPN to flourish as he/she meets the outcomes that will lead to achieving the objectives of professional socialisation, a person-centered attitude and a feeling of well-being, which are all contributory elements to human flourishing. At the same time, the healthful relationship established between the NQPN and the facilitator - underpinned by mutual values of respect, self-determination and understanding, as well as through the professional development that has occurred as a result of training, which enables the facilitator to use these valued competencies to implement the Person-centered Nurse Residency Programme - is also the means through which the facilitator flourishes. When both the NQPN and facilitator flourishes, a potential exists for the rest of the nursing staff and patients to also flourish, thereby creating a flourishing organisation.

7.5 CONTRIBUTIONS OF THE STUDY

This study has enhanced knowledge in the areas of theory, methodology and the nursing profession.

7.5.1 Theoretical contributions

In the theoretical area, this study has added to and strengthened the growing body of literature on the experiences and challenges of NQPNs in remunerated community service in South Africa, as reported on by themselves, senior professional nurses, clinical facilitators, managers and educators. A further contribution is made by my use of a “*bottom-up*”, person-centered approach to programme development. The person-centered approach encourages the use of collaborative, inclusive and participatory principles that are traditionally associated with practice development methodology. The use of the person-centered approach throughout the study was unique. Not only did I apply the approach in my way of working with participants during the needs assessment and programme development, but the Nurse Residency Programme was developed in such a way that will require the use of a person-centered approach by the facilitator upon implementation.

A further theoretical contribution of this study was the development of a conceptual framework in Chapter 6, which illustrates the Person-centered Nurse Residency Programme as a flower with an integrated view of the six domains namely: (1) *outcomes of the Person-centered Nurse Residency Programme*; (2) *objectives of the Person-centered Nurse Residency Programme*, (3) *prerequisites of the senior professional nurse*, (4) *foundational knowledge of the facilitator*, (5) *person-centered learning environment* and (6) *person-centered learning process*. The conceptual framework can be regarded as a tool that informs nursing education and nursing practice and can bring a shared understanding of person-centered support for NQPNs in remunerated community service.

7.5.2 Methodological contributions

The methodological contribution of the study related to the use and application of a relatively unknown approach in qualitative methodology, namely interpretive description. The interpretive description approach was initially developed for use in clinical nursing research, but it has also been applied to other contexts (St. George 2010:1625). In this study, interpretive description was applied to both the nursing- and educational contexts.

A second methodological contribution relates to the use of the interpretive description approach, which usually depends on the researcher's description and interpretation and combining it innovatively with a person-centered approach by giving participants the responsibility of interpreting the data. No other studies were identified in literature that combined interpretive description with a person-centered approach.

A third methodological contribution may be the combined use of an inductive/deductive approach to data analysis (see Section 4.4.1.7), whereas qualitative studies more frequently make use of inductive approaches to data analysis. Another contribution is the interpretive approach taken to data analysis where the needs of NQPN, as perceived by different levels of stakeholders including NQPNs, senior professional nurses, clinical facilitators, managers and educators, were used to co-construct the competencies that facilitators need to support NQPNs to meet the *outcomes of the Person-centered Nurse Residency Programme*.

7.5.3 Nursing profession

This study led to the development of the first-ever Person-centered Nurse Residency Programme for NQPNs in remunerated community service, specifically for the South African context. The Person-centered Nurse Residency Programme should enable tertiary hospitals and other healthcare institutions to ensure that person-centered support is provided to NQPNs, potentially decreasing their experience of reality shock and facilitating their integration into clinical practice. Implementing the Person-centered Nurse Residency Programme should increase NQPNs' competency levels and facilitate their professional development, which may lead to the rendering of quality care. The experience of completing the Person-centered Nurse Residency Programme allows for the flourishing of the NQPN and the flourishing of the facilitator through the establishment of positive interpersonal relationships and professional development.

The competencies included as prerequisites (see Section 7.3.4) can be used to correctly identify senior professional nurses that are suitable candidates to potentially act as facilitators. In doing so, the most effective and willing facilitators can be used in the implementation of the Person-centered Nurse Residency Programme, which should assist in ensuring that NQPNs are supported effectively. The fact that the Person-centered Nurse Residency Programme uses senior professional nurses on ward level to act as facilitators increases the ability of the Person-centered Nurse

Residency Programme to provide continued support to NQPNs, which will contribute better to their professional development. Continued support may further increase their job satisfaction and retention for the nursing profession and address the critical nursing shortage. The use of senior professional nurses as facilitators will at the same time decrease the workload of clinical facilitators formally appointed by healthcare institutions, allowing them to focus on other staff members also requiring their support.

When implementing the Person-centered Nurse Residency Programme, facilitators role-model person-centeredness to other healthcare practitioners, which should lead them to also adopting a person-centered approach to their own practice. When more nurse practitioners adopt a person-centered approach, a person-centered workplace culture is established for all staff through the formation of effective staff relationships. At the same time, a more supportive workplace culture for NQPNs is also created and person-centered approaches are adopted to all practitioners' care practices, thereby ensuring that high-quality person-centered care is rendered.

The conceptual framework may guide healthcare institutions in the implementation of nurse residency programmes in their own institutions. The structure of the Person-centered Nurse Residency Programme is based on my epistemological stance as a nurse practitioner, and in my expert opinion - developed from conducting this study - I am convinced that it can easily be transferred to any type of healthcare institution and does not just suit the tertiary hospital context. If unsure, the extensive description of the contextual factors will further assist other levels of healthcare institutions to decide if the Person-centered Nurse Residency Programme can be transferred to their facility or make decisions on which aspects should be adopted and adapted to fit their own context. Should healthcare institutions decide to develop their own Person-centered Nurse Residency Programme, the systematic approach followed and which I reported on should assist them in duplicating the process.

7.6 IMPLICATIONS FOR PRACTICE

The implications for practice relating to this study are based on the findings summarised in Table 7.1. Implications for practice are written pertaining to policymakers, which includes the SANC and the DoH, nursing practice and education.

7.6.1 Implications for policymakers

The implications for policymakers are:

- Backing from policymakers is essential in successfully implementing nurse residency programmes. Initial costs will be involved to develop context-specific nurse residency programmes for the different types of public healthcare institutions in which NQPN are placed for remunerated community service. Sufficient training will need to be provided to individuals who will be responsible for developing the nurse residency programmes, which will have further cost implications. Alternatively, a standardised nurse residency programme that can be implemented

across different types of healthcare facilities with only minor adaptations being made thereto to fit the specific context would be valuable. The Person-centered Nurse Residency Programme developed in this study should suffice as a standardised Nurse Residency Programme as all aspects can be applied to different types of public healthcare facilities.

- A partnership will need to be established with an accrediting agency to ensure that newly developed nurse residency programmes are of a high standard and that their implementation is monitored for quality.
- Additional funding will need to be made available to public healthcare facilities to provide frequent training opportunities for senior professional nurses to act in the role of facilitator.
- Facilitators need to be trained and therefore educational experts with a sound knowledge of person-centeredness will need to be employed by the DoH or the SANC. These experts will need to be trained on nurse residency programmes and will then be responsible for providing training to facilitators and various public healthcare facilities where NQPNs in remunerated community service are placed. This again will, therefore, have cost implications.
- Funds will be needed to provide sufficient training opportunities for new facilitators to ensure that there are sufficient numbers to meet the demand at all public healthcare facilities where NQPNs are placed. This training will also need to be supplemented with training of existing facilitators to ensure that they have evidence-based knowledge and to support their own professional development.

7.6.2 Implications for nursing practice

The implications for nursing practice are:

- To ensure the success of nurse residency programmes, it is essential that the principles of person-centeredness should be incorporated into the fundamental workings of the organisation, such as its vision, mission, policies and procedures. If all staff adopt these person-centered approaches, a supportive workplace culture can be established for all staff, including the NQPN. Person-centered cultures will further contribute positively to aspects such as staff satisfaction, attrition rates and staff relationships, which will aid in addressing many underlying problems currently experienced in the South African healthcare sector, including staff shortages and negative workplace cultures. Furthermore, when person-centeredness is applied to the way in which the healthcare practitioners render care to patients, high quality person-centered care will be the result.
- Attention will need to be paid to successfully identifying senior professional nurses in all wards that have the prerequisites to become a facilitator. A system will need to be identified that can guide this process, whether it be summative and formative assessments, nominations, volunteering, or a combination thereof. Time will have to be set aside, and a budget will need to be allocated to the basic training of these facilitators. A possibility of some form of remuneration would also be valuable. Adequate recognition for the facilitator's role and contribution to practice should also be given, which can be in the form of an annual event or sponsored gifts.

- Responsible staff will be needed to conduct regular needs assessments among different levels of stakeholders. Any significant additions to the existing Person-centered Nurse Residency Programme will have to be communicated to policymakers. Smaller adaptations to the Person-centered Nurse Residency Programme can be made on organisational level by the facilitators in collaboration with the formally appointed clinical facilitators and management.
- Facilitators will require support from the organisation to successfully fulfil their role. This can be done through regular forums with management and meetings with ward managers in order to liaise with them and discuss ways in which they can provide support to facilitators to make their role easier. Another significant contribution would be to have regular opportunities to meet with educational experts at tertiary education institutions to discuss certain needs identified in practice that can be addressed at education level.
- Significant value can be placed on the implementation of the Person-centered Nurse Residency Programme in accordance with residency programmes of healthcare professionals from other disciplines when covering topics such as ethics and interprofessional teamwork. This will further assist in creating shared values for a positive workplace culture.

7.6.3 Implications for nursing education

The implications for nursing education are:

- Incorporating training on person-centered approaches to care on tertiary education level from the first year would be valuable to ensure that the correct beliefs and values are developed in student nurses from inception of training. If person-centeredness is a fundamental principle well known to nursing students, less effort will be needed to change existing practices to person-centered practices during the implementation of the Nurse Residency Programme.

7.6.4 Implications for future research

Further research relating to the topic of the study is suggested, namely:

- Investigate the value of making remunerated community service a compulsory requirement for NQPNs graduating under all Regulations as a means to levelling competency.
- Develop a macro- and micro curriculum for the Person-centered Nurse Residency Programme.
- Pilot and evaluate the implementation of the Person-centered Nurse Residency Programme in the tertiary hospital in South Africa.
- Evaluate the outcomes of the implementation of the Person-centered Nurse Residency Programme.
- Evaluate patient- and nurse satisfaction following the implementation of the Person-centered Nurse Residency Programme.

7.7 LIMITATIONS

The limitations identified relating to the study were:

- From my epistemological stance, I acknowledge that the disciplinary knowledge of nursing is infinite and that it was, therefore, impossible to reach data- or theoretical saturation due to this. The knowledge obtained is authentic to the context to which I was exposed at the time during which the study was conducted. Variation may occur if the study is conducted in a different context.
- Because reality is subjective and each person constructs his own reality, and due to people changing, I could not identify an absolute truth with regard to the challenges and competencies of NQPNs as reported on by themselves and as perceived by the senior professional nurses, clinical facilitators, managers and educators.
- I only had access to the guidelines for the orientation and support programme implemented in the Gauteng province and could not compare it with any of the other provinces' guidelines. I could therefore only give critique on the guidelines in my possession. Guidelines from other provinces may be structured differently.
- Specific needs of NQPNs working in specialised wards during their remunerated community service were not considered during the development of the Person-centered Nurse Residency Programme. It may be that the prerequisites of the senior professional nurse (facilitator) that has to support NQPNs in specialised units may differ from those working in normal wards. A post-graduate qualification in a clinical discipline would definitely be a prerequisite for this facilitator.
- The use of self-administered qualitative open-ended questionnaires did not allow for probing which could have resulted in obtaining more in-depth data.
- The convenience sample of international literature used for the workshop placed a limitation on the data obtained using this specific data source. Additional data may have been obtained if more articles were used.
- Representatives from SANC, DoH and NEA were not included in participatory data analysis as initially intended due to a lack of response. They may have made a significant contribution to the development of the Person-centered Nurse Residency Programme as they have a different level of expertise than the rest of the stakeholders included in this study.

7.8 CONCLUSION

The ever-shrinking- and incompetent nursing population, of which NQPNs form part, is detrimental to the quality of care rendered to the South African population. The implementation of remunerated community service among NQPNs as a means to address the above-mentioned problems have proven to be ineffective as NQPN are still leaving the nursing profession in their masses, and a lot of those remaining are just as incompetent as they previously felt and were perceived as. A contributing factor to the failure of the remunerated community service year in doing what it was intended to do, namely develop NQPNs' competence and retain them for the profession, is the lack of a standardised

nurse residency programme that addresses the needs of NQPNs as perceived by different levels of stakeholders. This is further exacerbated by the inability of public healthcare institutions to provide NQPNs with the continuous support they require during the remunerated community service year due to the lack of clinical facilitators that are appointed to fulfil this role.

This study illustrated the person-centered process of co-constructing a context-specific Person-centered Nurse Residency Programme for NQPNs. By basing the development of the Nurse Residency Programme on the needs of different levels of stakeholders that mostly consist of ground-level staff and NQPNs themselves, person-centered needs can be met and better buy-in can be anticipated upon implementation thereof. The successful implementation of the Person-centered Nurse Residency Programme is dependent on the correct identification of suitable senior professional nurses on ward-level, with the required prerequisites that can be trained to become competent, person-centered facilitators. As support is offered on ward-level, it is continuous, and therefore more effective. The successful implementation of the Person-centered Nurse Residency Programme may lead to the same advantages as those that have been found internationally, namely the retention of NQPNs, which thereby assists in addressing the critical nursing shortage experienced in South Africa, as well as increased competency of NQPNs that leads to the rendering of better quality care, thereby ensuring better patient outcomes and increased patient satisfaction. The ultimate purpose of human flourishing may be achieved when the Person-centered Nurse Residency Programme is implemented, not only for the NQPN, but also for the facilitator and potentially patients and their families. The NQPN flourishes when the transition from student nurse to professional nurse is complete, he/she has integrated into clinical practice, person-centered relationships are formed, and a state of well-being is established. Equally so, the facilitator flourishes through the forming of person-centered relationships and as a result of his/her own professional development that has occurred due to the training received, providing him/her with new opportunities and a feeling of meaning in the workplace.

I end this Thesis with a quote from Wynton Marsalis - challenging my fellow South African nurse practitioners.

- *"It's harder to build than to destroy. To build is to engage and change"* -

Let us accept this challenge and build the nursing profession in South Africa, and our Newly Qualified Professional Nurses – they are after-all our only hope to receiving quality care when we will need it most.....

