Developing a conceptual framework for a Person-centred Nurse Residency Programme

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Highlights

- Conceptual framework based on theories, empirical data, underpinned by constructivism, person-centredness
- Interdependent domains: learning outcomes,- processes, - environment, prerequisites
- Outcomes: theory-practice integration; problem-solving; manage conflict; management
- Affective outcomes: professional socialization and well-being
- Framework aims to achieve human flourishing and person-centred practice

Abstract

Newly Qualified Professional Nurses (NQPNs) require support while transitioning from student to professional nurse. Nurse residency programmes guided by competent facilitators provide such support. We developed a conceptual framework for a Person-centred Nurse Residency Programme. This qualitative interpretive descriptive study was conducted in three phases. In phase 1, we assessed the support needs of purposively selected NQPNs as well as senior professional nurses. Data were collected using multiple methods and analysed during a consensus workshop held in Phase 2. In Phase 3, we developed a conceptual framework which was validated by six nurse education experts. The final framework comprised of four domains: learning outcomes, learning processes, learning environment, prerequisites of the facilitator, and was underpinned by the educational theories of constructivism and person-centeredness. Advocates of nurse residency programmes should recognise that these domains are interrelated and aim to achieve person-centred support for NQPNs.

Keywords: Conceptual framework; Newly qualified professional nurse; Person-centred nurse residency framework; Person-centred nurse residency Programme

1. Introduction

The critical shortage of healthcare professionals, of which nurses make up 5% (World Health Organization, 2020), leaves the future of healthcare in dire straits. The shortage of healthcare workers results in an increased workload on remaining staff (Khademi et al., 2015; Rajan, 2013) and poor-quality healthcare for patients (Haddad et al., 2020; Arena, 2016). Strategies for retaining healthcare workers, especially nurses, are focussed on Newly Qualified Professional Nurses (NQPNs) (Kim et al., 2015) who are known to leave nursing due to inadequate support received while transitioning from student to professional nurse (Commission of Collegiate Nursing Education [CCNE], 2015).

Internationally, standardised nurse residency programmes have successfully increased support for, and retention of NQPNs (Wood, 2016; Bratt, 2013). To facilitate professional development, residency programmes rely on the guidance and support of expert facilitators (Kim et al., 2015). The competence of facilitators is crucial for creating a positive learning experience during the transition period (Shinners et al., 2013).

To further professional development, facilitators should use a person-centred approach to education (Bhatti and Ahmed, 2015), as it is a way in which to provide continuous and personalised support (Krsek and McElroy, 2009). For learners, person-centred education requires a shift from passive- to active learning; deep learning; autonomy, facilitation (Attard et al., 2010) and a positive learning environment (Winterbottom, n.d.). Person-centred education has been positively linked to knowledge retention and theory-practice integration (Attard et al., 2010). Another advantage of person-centred education may be that it encourages NQPNs to adopt a person-centred approach in their own practice (Stirk and Sanderson, 2012). Person-centred care, where people are placed at the centre of the healthcare system (McCormack and McCance, 2017) is linked to quality care (Institute for Healthcare Improvement, n.d.) and has become the philosophy of most healthcare systems (McCormack and McCance, 2017).

Currently, to the best of our knowledge, there are no nurse residency programmes in South Africa although such residency programmes are needed to address the reported incompetence of NQPNs (Faraz, 2016; Magano, 2016) and retain nurses for the profession. Importantly, nurse residency programmes should be developed while considering the context of the healthcare setting to ensure successful implementation (Bratt, 2013). According to O'Donnell et al. (2017), nurse residency programmes should also consider the type of nurse it hopes to develop after completing the programme. Residency programmes should also clearly articulate the support process that facilitators should use. In this paper, we discuss how a nurse residency programme should be developed and implemented by competent facilitators, using a person-centred approach, to bring about a competent, person-centred nurse practitioner. We discuss a conceptual framework that may inform such a Person-centred Nurse Residency Programme.

2. Developing a conceptual framework

According to Miles and Huberman (1994), conceptual frameworks aim to categorize and describe relevant concepts and identify relationships between these concepts. This aim is achieved by incorporating applicable theory and empirical research to construct the conceptual framework to plan for, guide the implementation and review a nurse residency programme for NQPNs. Underpinning theories of this framework included constructivism and person-centredness (McCance and McCormack, 2017).

2.1. Theories

Our personal values and beliefs are reflected by a person-centred approach, an approach which also infuses the way in which we conducted this research. By employing the three principles of person-centredness, namely collaboration, inclusion, and participation (McCance and McCormack, 2017; Shaw, 2013), we were able to work with multiple stakeholders to develop the conceptual framework. Using these principles, we developed the conceptual framework using a "*bottom-up*" approach, which is known to be more successful than traditional "*top-down*" approaches (Nagabhushana and Hegde, 2016). In education, a person-centred approach is synonymous with a student-centred approach, which is informed by constructivism.

The learning theory, constructivism, postulates that knowledge is personal, and learning is actively constructed in unique and multiple ways through social interaction. Learning is a process consisting of accommodation and assimilation and is internally controlled by the learner (Burns et al., 2002). Learners form understanding by reflecting on experiences and linking new knowledge to existing knowledge (Bada, 2015). The facilitators of learning should determine what knowledge exists and use different approaches to address learners' individual needs, with the ultimate purpose of meaningful learning and achieving learning outcomes (Taber, 2011).

The Person-centred Practice Framework developed by McCance and McCormack (2017) comprises of four relational domains: "*prerequisites*", "*care environment*", "*person-centred processes*" and "*person-centred outcomes*". The framework, as it was originally implemented in the care environment, operationalises person-centredness. The framework assumes that prerequisites are considered first, then the care environment. Both these assumptions must be met to provide effective care through care processes to attain person-centred outcomes. We adopted this framework and applied the principle of 'design down and deliver up' (O'Neill, 2015) to adapt the framework to the educational context, thus starting with learning outcomes and continuing outwards. The new adapted domains for the Person-centred Nurse Residency Framework formed the 'pre-categories' for data analysis and included (1) learning outcomes, (2) person-centred learning processes; (3) person-centred learning environment and (4) prerequisites of the facilitator.

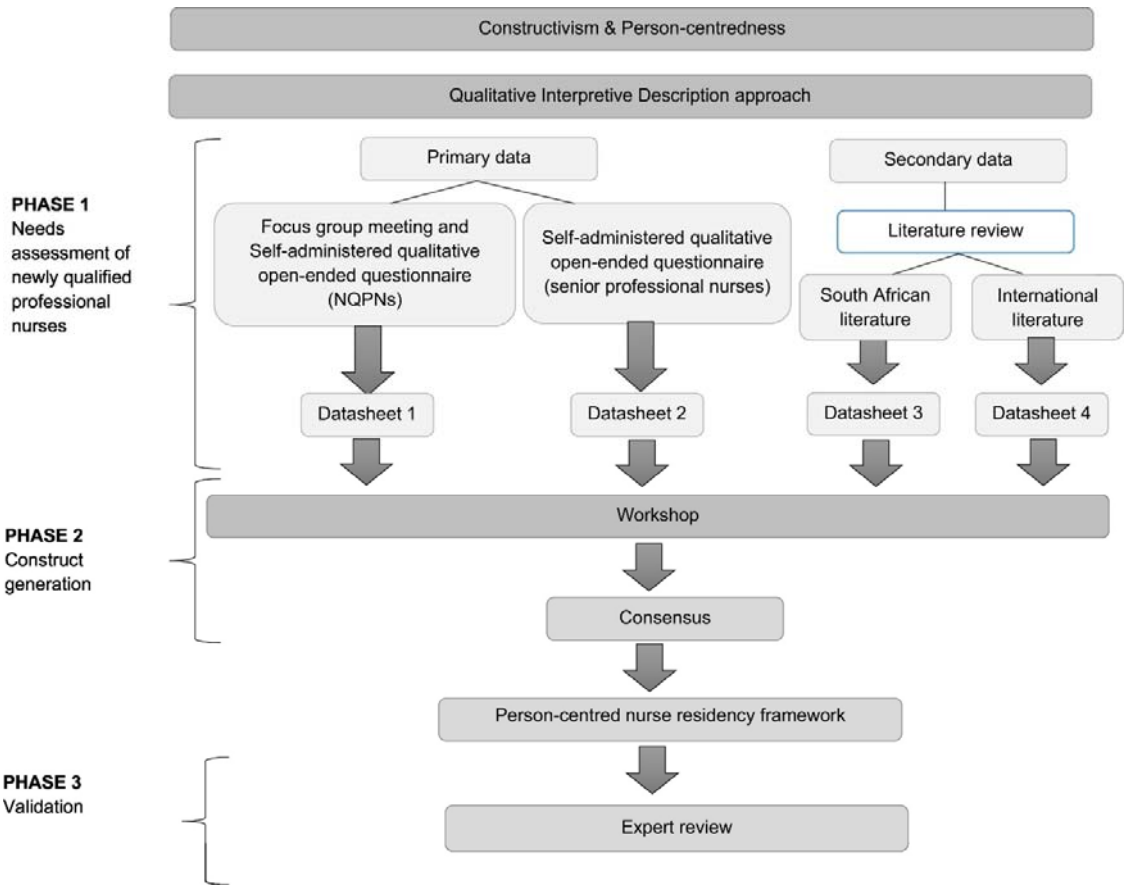

Fig. 1. Empirical process followed to develop a conceptual framework for a Person-centred Nurse Residency Programme.

2.2. Empirical research

We used a qualitative interpretive descriptive approach as described by Thorne (2016) to develop the Person-centred Nurse Residency Framework. Fig. 1 shows the different Phases of the research process that informed the framework.

In Phase 1, primary data were collected from NQPNs (nurses with fewer than five years' experience) and senior professional nurses from different backgrounds (professional nurses with more than five years' experience, clinical facilitators, nursing managers, and nurse educators). Our epistemological stance as nurses motivated the reason for categorising NQPNs as nurses with less than five years' experience because the realities of 12-hour shifts, day- and night duty rotation as well as limited numbers of NQPNs within their first year of practice employed at the tertiary hospital would complicate the recruitment of nurses in this specific category. The nurses in this group's experiences as NQPNs were also fairly recent and therefore they could accurately reflect on their time as newly qualified professionals. Six (6) NQPNs participated in a focus group meeting and 28 NQPNs completed a self-administered, qualitative, open-ended questionnaire. Two main questions were asked namely, which factors contributed to the NQPNs' professional development during their community service year, and secondly, what content they would like to include in a residency programme. An additional 17 senior professional nurses completed another self-administered qualitative open-ended questionnaire. Two questions were asked namely how they perceived the competency of NQPNs and secondly, what content they would like to include in a residency programme.

Secondary data were collected via literature review. Contextual relevance was enhanced by searching specifically for articles published on the experiences and competencies of NQPNs in South Africa. The search terms included *newly qualified professional 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 published between 2008 and 2017. Sixty-three (63) publications were identified after removing duplicates. Fifty-eight (58) publications were not applicable and excluded. Four publications were relevant to the topic and retained. Refining and expanding a literature review are significant in interpretive description (Thorne, 2016) and therefore we expanded our search using Google, which led to the inclusion of six (6) additional publications. We repeated the literature search to include international articles. We conveniently selected 10 relevant South African publications and 10 international publications. We preliminarily analysed the data from the data sources (focus group meeting, questionnaires, and summaries of the international and national articles) by writing excerpts from each, along with our own interpretations of the data (Thorne, 2016). The data were compiled into four datasheets, each representing a data source.

In Phase 2, a consensus workshop was held with two NQPNs and 15 senior professional nurses from different backgrounds, some of whom also participated in Phase 1. The participants were divided into four small groups comprising an assortment of participants from different backgrounds. Each group received one data sheet to analyse collaboratively. In accordance with Thorne (2016), data were analysed using an inductive/deductive approach. Firstly participants analysed and thematised support needs of NQPNs. We briefly explained the Person-centred Practice Framework (McCance and McCormack, 2017) and the preliminary ‘pre-categories’ to the participants, who then categorised the support needs under the adapted educational ‘pre-categories’. Participants could add or remove pre-categories if required by the data to do so, which is consistent with Perry and Jensen's (2001) modified version of the grounded theory approach. After the needs were categorised, the framework was decluttered, and adjusted until everybody agreed on the framework.

In Phase 3, six nurse education experts evaluated the conceptual framework based on the following criteria: comprehensiveness of content; logical consequence; conceptual clarity; level of abstraction and clinical utility (Brathwaite, 2002; Sidani, 2000; Fawcett, 1995). The experts agreed that the content of the conceptual framework was adequate because the constructs and links between the constructs were well described. The logical congruence and progression of the domains showed the inter-reliance of domains. The level of abstraction was low because concrete concepts were used in the conceptual framework. The experts concluded that the conceptual framework was comprehensive, clear, and usable in clinical environments.

3. Ethical considerations

This study was approved by the Hospital and the Faculty of Health Sciences Research Ethics Committee (344/2016). Participants voluntarily gave written consent by completing a Participant Information and Informed Consent Document and could withdraw from the study at any time. Anonymity could only be guaranteed for participants who completed the questionnaires during data collection, as the questionnaires were placed in a sealed envelope after completion. The rest of the participants were requested to maintain confidentiality and to not discuss any information with individuals who were not involved in the study.

4. Rigour

We used the quality indicators for interpretive descriptive studies as described by Thorne (2016) to enhance the credibility of the study. We achieved representative credibility through methodological- and personal triangulation (Polit and Beck, 2017; Thorne, 2016). We kept an audit trail reflecting the analytic logic of decision-making and interpretation throughout the study. We used multiple data sources and collaborated with participants, which increased our confidence in the conclusions. Interpretive authority was shared among multiple stakeholders who were all professional nurses, thereby eliminating researcher bias and ensuring trustworthiness.

5. Conceptual framework

Fig. 2 depicts the conceptual framework for a Person-centred Nurse Residency Programme.

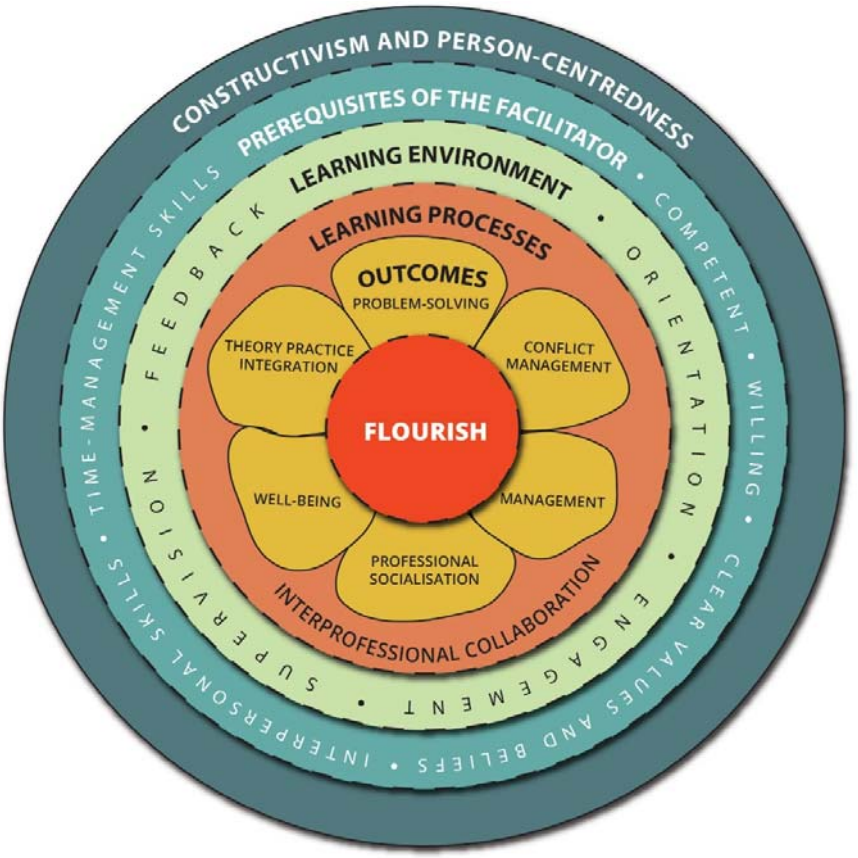

Fig. 2. Conceptual framework for a Person-centred Nurse Residency Programme.

6. Results and discussion

Using multiple data sources, including stakeholder input and literature review, we developed a conceptual framework for a Person-centred Nurse Residency Programme. By adapting the Person-centred Practice Framework developed by McCance and McCormack (2017), we developed a Person-centred Nurse Residency Framework which included the following categories (domains); (1) learning outcomes, (2) person-centred learning processes; (3) person-centred learning environment and (4) prerequisites of the facilitator.

7. Learning outcomes

In Fig. 2, our Person-centred Nurse Residency Programme has six learning outcomes, represented by petals, including four knowledge and skills, and two affective learning outcomes. The first learning outcome is that the NQPN should be able to transfer learning into practice, implementing evidence-based practice and person-centred care (Breit, 2015). In South Africa, NQPNs are often put in charge of a unit immediately and need to be able to address challenges in the workplace. Linked to the first learning outcome, the second learning outcome states that NQPNs must effectively solve problems. Problem-solving skills are essential for solving challenges relating to patient care, interprofessional teamwork (Hills, 2012) and management (Kearney-Nunnery, 2016). Challenging situations require

correct decision-making based on legality, ethics and the Standard Operating Procedures (SOPs) of the healthcare institution combined with decision-making skills, critical thinking skills, problem-solving skills and communication skills (Kearney-Nunnery, 2016). The third outcome in the framework is conflict management in the workplace. Conflict is heavily influenced by individual factors, contextual factors and interpersonal conditions (Almost et al., 2016). The fourth learning outcome is that NQPNs should manage the unit daily, for example budget planning, planning for adequate staffing and stock, and maintaining equipment in order to develop their management skills.

Achieving the first four outcomes will allow NQPNs to attain two affective outcomes: professional socialization and a feeling of well-being. The primary goal of professional socialization is acquiring the culture of the nursing profession (Rebeiro et al., 2015). Professional socialization is the process through which NQPNs adopt person-centred values, portray healthful relationships and render person-centred care. When NQPNs feel valued, respected and supported, a feeling of well-being is achieved (Jarden et al., 2018) which enables them to flourish (Dewing and McCormack, 2016).

8. Person-centred learning processes

Person-centred learning processes refer to processes that occur in practice on a daily basis through which the NQPN learns. Interprofessional collaboration is closely linked to person-centredness, because both these processes share values and beliefs e.g. respect for all, effective communication and shared decision-making (Hills, 2012; WHO, 2020). In this framework, interprofessional collaboration is the cornerstone enabling all learning outcomes. NQPNs learn to form healthful relationships with patients and other healthcare professionals, promoting a person-centred workplace culture (WHO, 2020) and enabling human flourishing (Manley et al., 2011). Building healthful staff relationships establishes a feeling of well-being in the NQPN (Schön Persson et al., 2018). Well-being is further enhanced through effective communication, which is central to interprofessional collaboration (Registered Nurses' Association of Ontario [RNAO], 2013). For NQPNs, critical dialogue between members of the interprofessional team develops the ability to make ethical decisions (Butts and Rich, 2019), which should be within the legal framework (Singh and Mathuray, 2018) and develops problem-solving skills. NQPNs should also be exposed to conflict management within the interprofessional team (Almost et al., 2016). Collaboration facilitates shared decision-making which leads to professional socialization (Lee et al., 2016; Kearney-Nunnery, 2016; RNAO, 2013). Collaborating with the interprofessional team establishes shared values and respect, fostering a person-centred attitude (Kramer et al., 2011; WHO, 2020). Person-centred attitudes among staff members contribute to a person-centred workplace culture that increases staff satisfaction, retains staff (Huyghebaert et al., 2018) and improves patient outcomes (Institute for Healthcare Improvement, n.d.).

9. Person-centred learning environment

Our framework also states that NQPNs should have a safe learning environment. A safe learning environment is created through person-centred learning (Van Rooyen et al., 2018) and allows NQPNs and facilitators to flourish. Newly Qualified Professional Nurses feel confident when they are orientated to the physical workplace environment, discipline- and organization-specific features and SOPs. This confidence promotes theory-practice integration (Ballard et al., 2012). While in a residency programme, NQPNs should have the opportunity to engage in care activities, which embeds person-centredness and contributes to professional socialization (Kramer et al., 2011). Supportive supervision within the learning environment enables NQPNs to achieve learning outcomes (Pitkänen et al., 2018). Critical reflection and competence are promoted when supervision is complemented by timeous constructive and appreciative feedback (Everett et al., 2014).

10. Prerequisites of the facilitator

Our framework stipulates that a Person-centred Nurse Residency Programme has to be implemented under the auspices of a facilitator, who is paramount to the success of the programme. Facilitators should be carefully selected according to specific criteria. Ideally, facilitators should be experienced professional nurses, preferably in the unit with the NQPN, to ensure continuous person-centred support. Facilitators should be professionally competent and confident with at least three (3) years' experience, without necessarily having obtained a post-graduate qualification in a clinical discipline, although it is preferred (Botma et al., 2012). A competent facilitator should have functional knowledge, encompassing clinical judgement and decision-making (Botma and Hugo, 2017). Facilitators should be able to apply the two theories underpinning the framework, namely constructivism and person-centredness. Facilitators should also be willing and dedicated to the successful implementation of the programme (University of Saint Mary, n.d.). Senior professional nurses show commitment by being willing to learn how to facilitate and mentor. Trained facilitators who demonstrate principles of person-centredness will learn from, share power with, and trust NQPNs (Zucconi, 2015). Facilitators who are willing to learn from NQPNs also set a good example for NQPNs, demonstrating the importance of lifelong learning (Lazarus, 2016). Facilitators must demonstrate person-centred values and beliefs in their own care practices as well as when interacting with NQPNs. By using effective interpersonal skills, the facilitator creates a positive learning environment (Lejaha, 2015). Time constraints negatively affect facilitation (Kalischuk et al., 2013) and thus, effective time management skills are essential to succeed in the dual role of nurse practitioner and facilitator. Through effective role-modelling, facilitators may encourage NQPNs to adopt person-centred values and beliefs, and effective interpersonal- and time management skills in their own practice.

11. Limitations and future research

From our epistemological stance, we believe that the disciplinary knowledge of nursing is infinite, hence, there is always more to learn. Generalization of the Person-centred Nurse Residency Framework to other contexts should therefore be done cautiously as variation may occur if the study is conducted in a different context. Specific needs of NQPNs working in specialised wards during their remunerated community service were not considered during the development of the Person-centred Nurse Residency Framework and therefore may differ. Consequently, prerequisites of the facilitator in specialised wards may also differ from those in normal wards. The self-administered qualitative open-ended questionnaires did not allow for probing which limited the depth of the data obtained. The convenience sample of 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.

While our framework may be limited due to the integration of contextual empirical data, we believe that the framework may be transferable to other settings. We recommend that a residency programme based on this Person-centred Nurse Residency Framework should be developed and evaluated in the context where it will be applied, followed by development of the macro- and micro curriculum. Implementation of the Person-centred Nurse Residency Programme should then be piloted and evaluated.

12. Conclusion

In this paper, we developed and discussed a conceptual framework for a Person-centred Nurse Residency Programme. The framework is based on theory and the synthesis of empirical data. The conceptual framework consists of four domains, namely learning outcomes, learning processes, learning environment and prerequisites of the facilitator. The domains are nested in the theories of

constructivism and person-centredness. The framework shows the inter-reliance of the domains and how the domains and underlying constructs contribute to achieving the outcomes. The outcomes identified for the NQPNs are theory-practice integration; effective problem-solving skills; effective conflict management skills, effective management skills, professional socialization and well-being. This conceptual framework guides the development of a Person-centred Nurse Residency Programme to support NQPNs while transitioning from student to professional nurse. Our framework supports the global goal of moving towards person-centred care and improving patient outcomes. Implementing a Person-centred Nurse Residency Programme may create opportunities for NQPNs and facilitators to flourish, ultimately increasing nurse retention and patient outcomes.

CRediT authorship contribution statement

Author	Contribution
Yolande Hayton	Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Visualization, Project administration, Funding acquisition
Yvonne Botma	Methodology, Validation, Formal analysis, Investigation, Writing – original draft, Supervision
Tanya Heyns	Conceptualization, Methodology, Validation, Formal analysis, Writing – original draft, Supervision

Declaration of competing interest

None.

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