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TRANSITION SUPPORT NEEDS OF NEWLY-QUALIFIED PROFESSIONAL NURSES WHO UPGRADED FROM ENROLLED NURSES

Submitted in fulfilment of the requirements for the degree

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by

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Declaration

I declare that **TRANSITION SUPPORT NEEDS OF NEWLY-QUALIFIED PROFESSIONAL NURSES WHO UPGRADED FROM ENROLLED NURSES** is my own work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted for any other degree at any other institution.

Name

Date

This dissertation is dedicated to my husband, Willie and my children, Willie and Viane Venter

Acknowledgements

"I can do all things through Christ who strengthened me."

Philippians 4:13

My deepest gratitude to God, my heavenly Father, for the grace and strength to undertake and complete this study.

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ABSTRACT

Introduction: When enrolled nurses upgrade to newly-qualified professional nurses, they are considered more prepared to adapt to professional nurse roles and are expected to "hit the floor running". However, transitioning from enrolled nurse to newly-qualified professional nurse has been found difficult and stressful due to the shift from enrolled nurses' familiar dependent practitioner role to the less known professional nurses' independent practitioner role. Currently there is no official programme to address the transition support needs of newly-qualified professional nurses who upgrade from enrolled nurses in Mpumalanga private hospitals. In the Mpumalanga private hospitals, for the period 2012-2013, the estimated average turnover rate for newly-qualified professional nurses was 33-47%.

Aim: The aim of this study was to explore and describe how newly-qualified professional nurses who upgraded from enrolled nurses experienced transition support during the transition period in private hospitals in the Mpumalanga Province.

Research design: A qualitative holistic multiple case study research design was utilised to explore and describe how newly-qualified professional nurses who upgraded from enrolled nurses experienced transition support during the transition period in private hospitals in Mpumalanga Province.

Method: Ten newly-qualified professional nurses, who graduated in 2012-2015 with a minimum of six months' and a maximum of four years' work experience in two private hospitals in Mpumalanga Province, participated in this study. In-depth semi-structured interviews were conducted and an inductive approach was utilised for content analysis of verbatim transcripts and field notes.

Findings: The study found that at the private health care level, there is minimal understanding and recognition of the transition support needs of the newly-qualified professional nurse making the transition to clinical healthcare practice in private hospitals as professional nurses. Consequently, there is no newly-qualified professional nurse transition support programme during the transition period. Moreover, the newly-qualified professional nurse needs transition support mostly during the first two stages of the transition period.

Keywords: enrolled nurse, newly- qualified professional nurse, transition, transition support needs

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ENs   Enrolled Nurses

NPNs   New Professional Nurses

NQPNs   Newly-Qualified Professional Nurses

PNs   Professional Nurses

SANC   South African Nursing Council

CHAPTER 1

ORIENTATION TO THE STUDY

"Life is pleasant.
Death is peaceful.
It is transition that's troublesome."

-Isaac Asimov-

1.1 INTRODUCTION

The South African nursing workforce primarily comprises professional nurses (PNs) and enrolled nurses (ENs) who have different educational preparation (South African Nursing Council (SANC) 1993) and scope of practice (SANC 1984). ENs are prepared in a two-year vocational education training programme (SANC 1993) and work under the supervision and delegation of professional nurses (Marquis & Huston 2012:255). The two-year training programme and scope of practice resembles the two-year training period and scope of practice of ENs in the United States of America (USA), New Zealand (NZ), the United Kingdom (UK) (Cubit & Lopez 2012:206) as well as Australia (Cubit & Ryan 2011:65). However, in South Africa ENs can upgrade their qualification through a further two-year training course to become professional nurses (SANC 1989).

In international literature, terminology referring to new professional nurses (NPNs) varies from new graduate nurses (Ortiz 2016:19), new nursing graduates (Missen, McKenna & Beauchamp 2014a:2431), new graduate nurse practitioners (Sargent & Olmedo 2013:603), neophyte graduate nurses (Johnstone, Kanitsaki & Currie 2008:46), newly licensed registered nurses (Kramer, Maguire, Halfner & Budin 2012:156), new qualified nurses (Bjerknes & Bjørk 2012:1), newly-qualified registered nurses (Teoh, Pua & Chan 2013:143) to new registered nurses (Deasy, Doody & Tuohy 2011:109). In the South African context, ENs who have upgraded to professional nurses are referred to as newly-qualified professional nurses (NQPNs). All new professional nurses face a period of transition (Parker, Giles, Lantry & McMillan 2014:155) that requires them to adjust to the workplace culture and reality of the clinical setting (Kilstoff & Rochester 2004:12).

Rapley, Davidson, Nathan and Dhaliwal (2008:116) found that during the transition period NQPNs

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realised " to walk in the shoes of the RN [registered nurse] …" was completely different from what they had experienced when they were ENs. The expectation of clinical practice for NQPNs who previously worked as ENs (Kilstoff & Rochester 2003:13&17) to be nursing practice-ready is even higher, due to their previous socialisation in nursing (Cubit & Lopez 2012:210). This expectation contributes to nursing role conflict (Kramer, Brewer & Maguire 2011:349; Feng & Tsai 2012:2069) due to difficulties in reconciling discrepant role conceptions that arise through the shift from working dependently under the supervision of professional nurses to working independently as professional nurses that supervise (Duchscher 2009:1104; Kramer et al 2011:349; Feng & Tsai 2012:2069).

Transition is stressful (Gardiner & Sheen 2016:8) and fraught with challenges (Newton & McKenna 2007:1232). The challenges are experienced as having feelings of incompetence; having an overwhelming sense of responsibility (Voldberg, Gronkjaer, Sorensen & Hall 2016:1760); being fearful of physicians, and finding it difficult to organise, prioritise, and delegate tasks (Chandler 2012:103). The stress and challenges normally experienced during the transition process highlight inadequate support for new professional nurses thus NQPNs in this study (Feng & Tsai 2012:2066; Missen, McKenna & Beauchamp 2014:140; Gardiner & Sheen 2016:11).

1.2 BACKGROUND AND LITERATURE REVIEW

The background to the study problem and literature reviewed will be discussed in Sections 1.2.1 to 1.2.4.

1.2.1   Transition period

Meleis, Sawyer, Hilfinger-Messias and Schumacher (2000:12) describe transition as a period in which changes take place in an individual or an environment that possess certain commonalities. New professionals are confronted with the loss of previous social connections and supports; absence of known reference points; appearance of new needs; inability to meet old needs in new environments, and incongruence between previous and new expectations in work environment (Kumaran & Carney 2014:606; Laschinger, Cummings, Leiter & Wong 2016:91).

1.2.1.1 Transition from student to professional

The transition from student to professional is one of the most extensively researched transitions

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(Phillips, Esterman, Smith & Kenny 2013:14; Freeling & Parker 2014:150; Awaisi, Cooke & Pryjmachuk 2015:1723; Laschinger et al 2016:82). Transition is experienced over a wide spectrum of professions including law (Campbell & Lindsay 2014:3); engineering (Cech 2012:85); teaching (Feiman-Nemser 2012:10); arts (Risner 2015:60); health professions (Clarke, Martin, Saldo & De Visser 2014:222); dentistry (Blanchard & Blanchard 2006:531), and nursing (Shatto, Meyer & Delicath 2016:e97). Therefore, the transition process is not new and new professionals from professions other than nursing are also faced with challenges associated with the entry-to-practice transition from student life to a professional role (Dollase 1992:10; Morley 2009:507; Cech 2012:87).

In a study of new physical therapists, Black, Jensen, Monstrom, Perkins, Ritzline, Hayward and Blackmer (2010:1764) established that general experiences and topics appeared as new physical therapists developed. The study found that new physical therapists were occupied with their professional identity formation and role transitions and that their communication skills development and confidence levels were related. The clinical setting affected new physical therapists' functioning and learning was directed at their own development and occurred through social interaction and experience. Different professions identified a lack of or gaps in the knowledge and skills of new professionals as they advanced to practice (Missen, Beaucamp, McKenna & Larkins 2016a:112). In engineering, Katz (1993:171) found that new professionals were lacking or inadequately prepared in teamwork dynamics and effective communication with colleagues and managers. Katz questioned the educators' and students` role in better preparation to 'ease' the transition for their future roles.

Transition tends to be more common in professions where the individual is required to have a high degree of specialised skill and knowledge and may be required to work autonomously, or where the application of academic knowledge needs to be transferred to a clinical context and reflection is needed to build professional judgement (Schon 1983; 1987). Nursing is a profession that experiences the transition process (Kramer 1974:4; Duchscher 2009:1103).

Duchscher (2001:428) defines transition as 'a period of time a new staff member undergoes a process of learning and adjustment to acquire the skills, knowledge, attitudes and values required to become an effective member of the healthcare team'. Transition is also considered 'a process in which an individual bridges two environments or states of being' (Madjar, McMillan, Sharkey, Cadd & Elwin 1997:4), a phase where individuals undergo a course of learning and change, and are

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incorporated into to a new society, namely the clinical setting. The transition process is accepted as a dynamic time of personal adjustment and adaption and a significant component in modelling the new identity (Crafter & Mauder 2012:16). Most definitions propose that the transition journey flows from a position of security and familiarity towards a position of new and unknown terrain for NQPNs. According to MacLellan, Levett-Jones and Higgins (2015:393), transition refers to a passage and a development that occurs over a period and is supplemented by an adaption to roles, relationships and patterns of behaviour.

Scanlon (2011:14) believes that transition to becoming a professional is about taking the skills and knowledge gained in the formal educational setting and applying them in the work setting. Knowledge, skills and performance are vital to the individual's sense of professional identity. However, development of professional identity and professional self is iterative and evolutionary. Scanlon (2011:14) furthermore considers transition as continuous and ever changing, and cultivates the importance of lifelong learning to modern professionals. This notion contradicts the traditional portrayal of transition from student to professional being personified in a movement from 'novice to expert' (Benner 1984:201).

Today professional transition takes place throughout the professional career (Scanlon 2011:14). There is a possibility that numerous transitions will occur within the highly inconsistent work setting as the person follows the path of 'becoming' professional (Duchscher 2009:441). According to Scanlon (2011:14), professionals are working in a knowledge environment where they must constantly adjust to new knowledge and new settings in which knowledge is authenticated, while professional identity develops across potentially numerous transitions. The concept of lifelong learning and transition being part of continuous professional development has been accepted in terms of professional environment changes. The facilitation of transition in the professional environment is a process which assists new practitioners to develop the ability to work autonomously and strengthen and improve their skills. It recognises that new professionals are registered, legally able to practise and no longer students. Facilitation of the transition process is not about 'reteaching undergraduate education' and 'filling in gaps', but about enabling new practitioners to apply their skills and knowledge and develop further as part of their lifelong learning (Healy & Reed 2015:11).

The transition period can differ from NPN to NPN and in the context of this study from NQPN to NQPN. The initial twelve months of transitioning from student to NQPN consists of a complex

predictable variety of emotional, intellectual, physical, socio-cultural and developmental changes. These changes encourage personal and professional development which forms part of the process of becoming as illustrated in Figure 1.1 (Duchscher 2008:442).
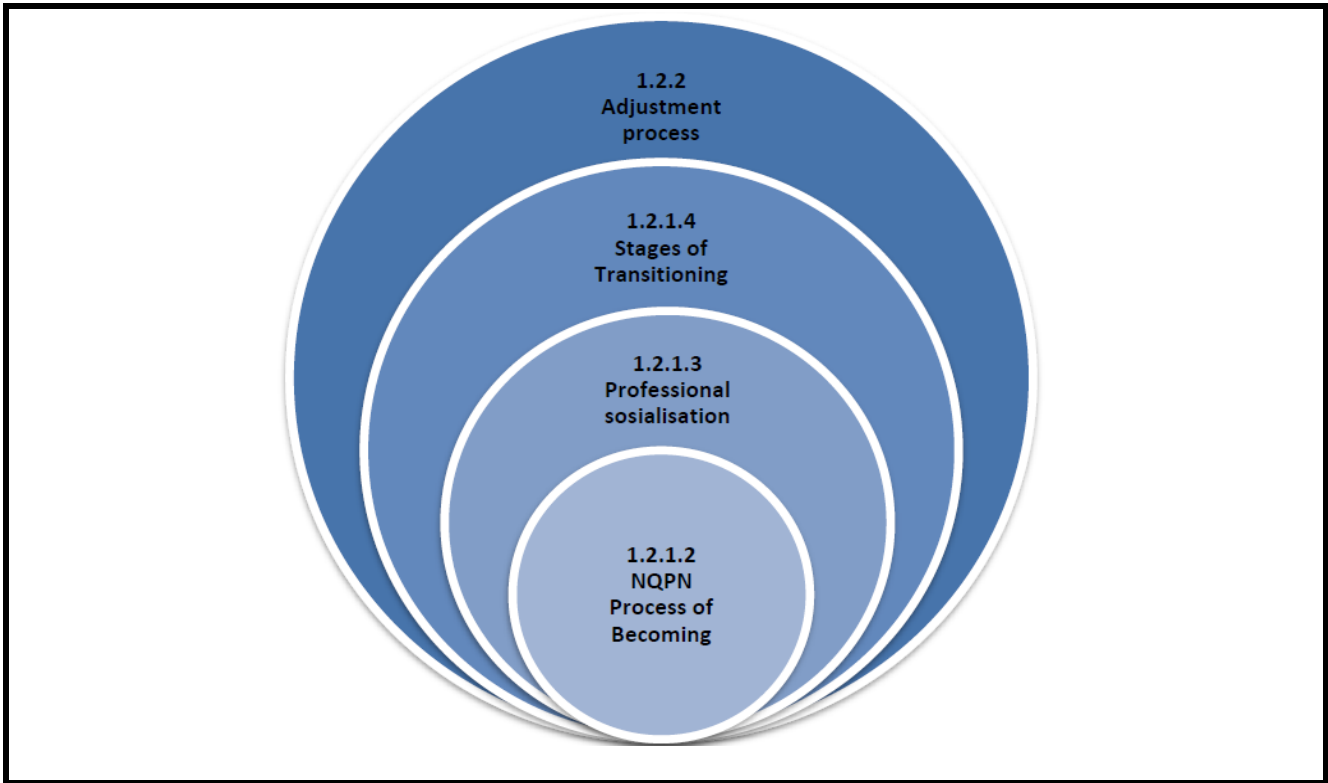
Figure1.1 Non-linear process of becoming of the NQPN   Adapted from Duchscher (2008:441)

1.2.1.2 Non-linear process of becoming of NQPNs

NQPNs' experience of transition when entering professional practice is distinguished as a vital adjustment process in terms of adapting personal and professional roles at the beginning of a nursing career (Duchscher 2008:442). This experience is not separated from the building blocks of socialisation and professionalisation. The transition of NQPNs entails a non-linear experience that flows through personal and professional, intellectual and emotive, and skill and role relationship changes and has within it experiences, meanings, and expectations as illustrated in Figure 1.1. Even though it is reasonable to expect NQPNs to experience a personalised transition, the first year of work experience consists of a variety of multi-faceted emotional, intellectual, physical, socio-cultural, and developmental questions that lead to personal and professional evolution (Duchscher 2008:442).

NQPNs are confronted with a complex and stressful transition from student to NQPN (Gardiner & Sheen 2016:8). Therefore NQPNs are not only to be socialised into the context of nursing practice and held accountable for patient care, but also need to learn various formal and informal rules and regulations of the nursing profession in the nursing society, which will shape their behaviours (Maben, Latter & Clark 2006:469). Therefore when entering clinical practice, NQPNs experience a process of transitioning and professional socialisation.

1.2.1.3 Professional socialisation

Socialisation is the process of learning new roles, knowledge, skills, and characteristics of a group in the society. According to Hinshaw (1977:25), persons are permitted to become part of groups and cultures through acquisition of the behaviours and attitudes. Creasia and Parker (2007:58) define professional socialisation as a process by which an amateur person is integrated into a profession. This process centres on the learning of the norms, attitudes, behaviours, skills, roles and values of the profession. To become professionally socialised, integration of values and norms of the profession into personal behaviour and the self-concept needs to occur. Professional socialisation is expressed as a process and an outcome. As a process, it is the transfer of values, norms and perspectives that are exclusive to the profession. As an outcome, it is the self-concept development as a member of a profession with the required knowledge and responsibilities (Lai & Lim 2012:32).

According to Feng and Tsai (2012:2066), there are three components in NQPNs socialisation process: overwhelming chaos, learning by doing, and being an insider. These aspects are discussed briefly in the following sections:

- *Overwhelming chaos*

At commencement of practice NQPNs are exposed to multiple environmental and professional stimuli and may suffer from sensory overload (Feng & Tsai 2012: 2067). The professional stimuli consist of role ambiguity, new skills and colleagues. Aggravating factors to the stimuli are NQPNs' lack of knowledge and clinical experience. Organisational stimuli include short staffing, lack of support, and time constraints. As students, NQPNs are focused on one patient at a time and perform under clinical educators' supervision and support. However, in nursing practice, NQPNs need to take care of multiple patients with limited support and supervisory assistance available (Blevins & Millen 2016:194). The overwhelming chaos makes NQPNs feel disorganised, helpless, a failure and uncertain about their professional role (Voldberg, Gronkjaer,

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Sorensen & Hall 2016:1760). Even though NQPNs want to provide appropriate nursing care, they lack knowledge, skills, time and energy to do so. Most NQPNs blame their unpreparedness on their nursing education`s lack of preparation. As students, the NQPNs could not manage the responsibility of a professional nurse since they never had full responsibility for patient care before. Speed is considered a performance indicator and NQPNs struggle with being slow and incompetent due to inexperience. NQPNs therefore experience intense frustration due to the overwhelming chaos during the first months of transition from student to NQPN (Feng & Tsai 2012: 2067).

- *Learning by doing*

The process of becoming a professional nurse consists of more than completing theory and registration but also entails a variety of norms being internalised during induction. According to Feng and Tsai (2012:2067), NQPNs feel their formal education is inadequate for clinical use and have difficulty in recalling it. To increase their caring competence, NQPNs learn through self-direction and according to professional need. NQPNs consider not knowing a weakness and refrain from participating in orientation programmes and training offered. Even when training opportunities do arise that NQPNs would want to attend, they do not attend due to high patient workload and exhaustion (Feng & Tsai 2012:2067).

- *Being an insider*

Feng and Tsai (2012: 2068) add that in the fifth month of transition to practice, NQPNs feel more relaxed and confident about working in the clinical practice. NQPNs consider team cohesion and being an insider crucial and focus on gaining experience, and being on par regarding relevant knowledge and their ward's rules.

NQPNs' experience of transition when entering professional practice, although not completely separate from the constructs of socialisation and professionalisation, is differentiated here as the process of making a significant adjustment to changing personal and professional roles at the start of their nursing career (Duchscher 2008:442).

1.2.1.4 Stages of transitioning

Kramer (1974:230) reported on the process of transition to professional practice among NQPNs

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and why nurses left. Schumacher and Meleis (1994:119) define transitions as the progression from one state, condition, or place to another which can cause intense changes in the individuals' and their family`s lives and have a significant influence on well-being and health. The transition process unfolds in an expected manner from the honeymoon phase, where NQPNs are excited and disillusioned, through a shocking attack on their professional principles to a recovery and resolution phase marked by the return of a sense of stability (Kramer & Schmalenberg 1978 cited in Duchscher 2008:442). The initial twelve months of the NQPN`s transition to professional practice is a process of becoming, consisting of a personal and professional journey where participants evolve through three stages identified as doing, being, and knowing (Duchscher 2008:449). Doing consists of learning, performing, concealing, adjusting and accommodation leading to transition shock. Being entails searching, examining, doubting, questioning and revealing causing a transition crisis. Knowing refers to separating, recovering, exploring, critiquing and accepting evolving into establishing of stability (Duchscher 2008:443). However, during the doing stage transition shock occurs which is 'the most immediate, acute and dramatic stage' in the process of professional transition (Duchscher 2009:1104). Transition shock experienced by NQPNs adds to the anxiety and tension of this initial professional socialisation process (Duchscher 2009:1110).

- *Transition shock*

Kramer (1974:4) coined the term '*transition shock' to* describe the difference between training principles and practice principles. NQPNs experience the inconsistency between the reality of healthcare nursing practice and the expected reality taught from nurse training which causes tension in NQPNs during this transition period to professional practice in the hospital setting (Kramer 1974:4). Transition shock appears as the experience of moving from the known role of a student to the less familiar role of professional practising nurse and occurs within the first four months of transitioning from student to NQPN. Important to this experience for NQPNs are the apparent contrast between the relationships, roles, responsibilities, knowledge and performance expectations required within the more familiar academic environment to those required in the professional practice setting (Duchscher 2009:1105).

NQPNs' first professional role transition experiences vary in intensity and are based on a predictable array of emotional, intellectual, physical, socio-cultural, and developmental issues, and present in NQPNs emotional, intellectual and physical well-being (Duchscher 2009:1105). Personal and professional adjustments evolve and progress most intensely through the first four months

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post-orientation (the time after which workplace orientation processes and additional induction learning had taken place and after NQPNs had been teamed up with a senior professional nurse for the purposes of learning expected routines, roles and responsibilities). At the termination of this post-orientation period, the exhaustion and isolation that both fed and resulted from the disorientating, confusing and doubt-ridden chaos that represented their newfound reality cause a deliberate withdrawal from the intensity of the shock period (Duchscher 2009:1105).

NQPNs' professional role transition stages are a non-linear process in which NQPNs transition through developmental and professional, intellectual and emotive, skill and role-relationship changes, that each consist of experiences, significances and prospects. The experience of transition is affected by prior developmental and practical experiences and situations. These exposures stipulate and determine NQPNs' expectations regarding development of professional identity, role adjustment, role conflict, and the professional practice role (Duchscher 2009:1110).

- *Professional identity*

The notion of self-concept applies mostly to the profession and professional self rather than to the personal psychological self and thus relates to professional identity. Fagermoen (1997:435) defines nurses' professional identity as 'the values and beliefs held by nurses that guide their thinking, actions and interactions with the patient'. Professional identity can be revealed in the nurse's professional self-concept (Ten Hoewe, Jansen & Roodbol 2014:303). Public image, work environment, work values, education and culture are contributing factors in the formation of the self-concept and professional identity (Ten Hoewe et al 2014:307). Abu Al Rub (2004:74) and Heslop, McIntyre and Ives (2001:627) state that NQPNs' aim is to build their professional identity on a safe personal concept since workplace interaction is the key factor in the process of developing a secure sense of self as a professional, work competence and confidence.

- *Role adjustment*

The adjustment from being a student to becoming a nurse is marked by a 'psychological shift' (Bjerknes & Bjørk 2012:6). This adjustment is related to the realisation that the key distinction between being a student and a professional is the responsibility and accountability for decision making in practice in that NQPNs had become answerable for all their decisions in practice (Maben & Macleod Clark 1998:150; Dearmun 2000:163). NQPNs want to prove that they can manage and thus accept workload and responsibilities which may cause increased stress levels (Bjerknes &

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Bjørk 2012:6). According to Lindberg-Sand (1996), NQPNs see responsibility in conjunction with time efficiency. Bjerknes and Bjørk (2012:6) state that the enhancement of the feeling of being responsible correlates with the speed with which duties are performed.

- *Role conflict*

Kelly and Ahern (2009:914) found that a key factor of NQPNs' 'not feeling really prepared' was being ill-equipped for making decisions and the responsibility that forms part of the professional role. In their capacity as students, exposure to decision making was limited. Most NQPNs noted one month into practice that they were not ready for their professional role and it contributed to inner conflict. NQPNs are not prepared for the whole professional nurse role or the reality of the role of the professional nurse, which leads to role conflict. Six months into practice the role conflict develops into disillusionment. NQPNs were disillusioned by the availability of time to spend with patients and being a slave to doctors' orders most of the day. Some NQPNs may question whether to stay or leave the nursing profession (Kelly & Ahern 2009:914).

NQPNs experience multiple conflicts in their transition from student to NQPN between institutional discussions of education and health service (Hamilton 2005:77; Pfaff, Baxter, Jack & Ploeg 2014:1148). According to the educational institution, NQPNs are considered critically thinking and knowing care givers, able to apply knowledge in the nursing practice. The NQPNs' educational preparation works to prepare them as educated practitioners with the potential ability to make independent decisions within the limits of their knowledge and experience. This stance is hampered by increased organisational and bureaucratic needs which place NQPNs under pressure to meet organisational needs at a quick pace instead of patient and professional needs. Health service considers NQPNs functional, efficient, organisational, service providing nursing practitioners. The conflict between the education and service sectors still is present and affects NQPN attrition from the profession (Hamilton 2005:77; Booth 2011:3)

- *Components of the professional practice role*

The professional practice role of clinical nurses consists of the responsibility and accountability for providing care and managing clinical situations for multiple patients simultaneously (Kramer, Brewer, Halfer et al 2013:692). Although literature refers mostly to NPN, in this study and context the term refers to NQPN. Kelly and Ahern (2009:912) found that prior to transition to practice NQPNs were ill-equipped and had restricted knowledge of what the professional practice role

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involved. Prior to commencing transitioning to practice, NQPNs believed that they were prepared for their role as professional nurses. Shortly after being in practice, they realised that there were crucial parts of their role they were not prepared for, like accountability and responsibility, role competence and lack of support.

NQPNs experience difficulties in their new position in being *accountable.* The loss of the security and protection as a student in conjunction with the heightened awareness of individual professional nurse accountability is stressful to NQPNs. NQPNs consider accountability during the first stage of transitioning a burden but realise as the transition process progresses that it is a professional requirement (Kumaran & Carney 2014:608). According to Whitehead and Holmes (2011:21), NQPNs 'professional *responsibilities* in nursing practice can be subdivided into management; delegation; drug administration; and prioritising. Maben and McLeod Clark (1998 cited by Whitehead & Holmes 2011:21) describe NQPNs' new responsibility and accountability as overpowering and the management skills of NQPNs as concerning. Therefore the managerial expectations of NQPNs being able to adjust and integrate fast are unrealistic. Discrepancies in the vocational training between the theoretical preparation and the clinical preparation have a negative effect on the NQPNs responsibilities due to lack of exposure in nursing disciplines. NQPNs are found to be unskilled in the wide professional nurse managerial responsibilities such as patient management, self management and team management (Gerrish 2000:477). As students, they worked under supervision but now as NQPNs they need to learn fast to supervise, which can be overwhelming to them. Jasper (1996:745) suggested that NQPNs learn as part of their new professional role to manage with the change from dependent supervised students to independent unsupervised NQPNs which contributes to self-confidence levels. Most NQPNs consider themselves *competent in their role* across a variety of disciplines and believe that they have adequate interpersonal skills, clinical skills and knowledge and ability in effectively prioritising care delivery (Deasy, Doody & Tuohy 2011:111).

The term *support*, from Old French 'supporter' and Latin 'supportare', meaning to bring, to carry, is defined in various English dictionaries as 'to give aid or courage' and 'to give strength to' (Johnstone et al 2008:47) and refers to giving approval, moral support, comfort, or encouragement to an NQPN (Kramer 1974). Most NQPNs expect to be orientated to their professional roles and wards (Deasy et al 2011:111) and expect to have multiple support sources available as NQPNs when entering nursing practice. Although informal support such as

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professional nurses, clinical nurse managers and the multidisciplinary team are available most NQPNs are not formally guided and most of them go from a student 'buddy' system to full NQPN responsibility without reasonable access to specialist advice or practice support (Duchscher 2008:444). Aspects like horizontal violence (Dyess & Sherman 2009:406; Teoh et al 2013:145) and nursing staff shortage (Whitehead 2001:333) seem to be significant components in the lack of support experienced by newly employed NQPNs instead of senior colleagues' resistance to assist.

1.2.2 Adjustment process

During the first three to four months of their professional role transition, NQPNs experience an adjustment process that is developmental, intellectual, socio-cultural and physical in nature which is supported by changing roles, responsibilities, relationships and levels of knowledge in NQPNs' personal and professional lives (Duchscher 2009:1111).

1.2.2.1 Emotional adjustment

During the first stage of transition NQPNs are exposed to a variety of labile emotions, continuous concerns and fears that they adjust to emotionally (Duchscher 2009:1106). The stability, predictability, familiarity and consistency of the first exposure to a clinical situation and interaction with a new colleague have an effect on how NQPNs respond emotionally to existing role transition stress. NQPNs experience unbearable psychological stress levels during the first four months of transition. The emotional adjustment is intense due to the psychological impact of poor or lack of emotional support, altered confidence levels due to insufficient clinical practice experience, lack of communication skills and fitting in the nursing culture. Factors like emotional fatigue, loss of autonomy, lack of support of professional practice values and anticipated roles and unrealistic performance expectations by the organisation, peers and NQPNs themselves also intensify their emotional responses. Some NQPNs experience being challenged by a senior colleague on purpose to shake their confidence (Duchscher 2009:1106).

During the third to fourth month of transitioning NQPNs experience severe emotional exhaustion due to lack of control and powerlessness associated with the transition shock experience. The major concerns NQPNs experience are being seen as clinically incompetent, endangering and causing harm to patients, unable to manage allocated roles and responsibilities, and being rejected by co-workers as valuable to patient care. NQPNs experience a severe loss of support as a student; intellectual counsel by fellow students and educators; emotional support, consultation and

feedback that contributes to feelings of isolation and self-doubt. Access to a support network of peers and co-workers is considered an important link to the on-going professional development of NQPNs. Many NQPNs battle with maintaining their beliefs, intentions and aspirations for providing nursing care. NQPNs experience feelings of guilt due to their inability to perform the practice beliefs they consider elemental to their professional role (Duchscher 2009:1107). NQPNs have difficulty in their emotional adjustment to the experience of loss, confusion, disorientation and doubt and put great effort into hiding their 'feelings of inadequacy' from their new peers. These experiences and feelings are internalised and lead to emotional exhaustion (Duchscher 2009:1107).

1.2.2.2 Physical adjustment

The physical adjustment response during transition shock is grounded in a large amount of energy which is consumed by NQPNs in the effort of taking up their new professional role according to the standard required and pretending to do it with ease. Changes in NQPNs' previous stable personal lives and the expectation to perform clinical decision-making skills for which NQPNs are accountable but inexperienced for are exhausting. The tension level of the NQPNs' professional accountability is increased by: (1) vague co-worker practice expectations; (2) NQPNs' inaccurate perceptions regarding successful transition; (3) unexpected co-worker role-relationship conflict; (4) physical work demands, and (5) lack of feedback to measure professional role transition progress against. NQPNs suffer from exhaustion due to their pre-occupation during the day with thoughts of what has happened in practice and what is to happen next and at night in their dreams (Duchscher 2009:1108). In summary, NQPNs experience loss, doubt, confusion and disorientation during transition shock which contributes to their exhaustion (Duchscher 2009:1106). NQPNs adjust through reflection of their experiences in practice, keeping focused on their performance in the new role of NQPN at the required level without making it known how hard it was for them and the physical impact it had on them (Duchscher 2009:1108).

1.2.2.3 Intellectual adjustment

At transitioning from student to practice, NQPNs participate in a work setting orientation which explains the professional nurse role and practising milieu. NQPNs are excited, fascinated and energised about the prospect of independent practice. NQPNs assume that this transition is just another conceptual application of pre-graduation education. Reality shock occurs once NQPNs realise they are on their own in the real world with their professional responsibilities and nursing workload (Duchscher 2009:1109). NQPNs' emotions quickly change from excitement and awe to

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devastating fear, doubt and stress. NQPNs have an unrealistic optimistic expectancy in terms of role and workload adaption. The transition in responsibility from student to NQPN and the transition process itself was never iterated with NQPNs. NQPNs quickly realise that senior professional nurses are not there to assist them but that work is divided between them and that assistance is limited through high workloads. NQPNs have concerns regarding being safe nursing practitioners and practising within their scope of practice while performing expected duties. NQPNs experience being slower at decision-making and completion of allocated duties and are concerned about managing clinical situations beyond their cognitive or experiential comfort level (Duchscher 2009:1109). NQPNs adjust by spending time reflecting on undergraduate theory and training. NQPNs also focus on maintaining their self-confidence levels and acceptance by peers by refraining from asking assistance from peers with shared demanding workloads for fear of being perceived as inconsiderate or inexperienced. Even though NQPNs verbalised their insecurities regarding their capabilities to handle workload and clinical situations, they were forced to rely on their own intellect, were able to manage it and succeeded (Duchscher 2009:1109)

1.2.3.4 Socio-developmental and cultural adjustment

During the first four months, the main socio-cultural and developmental objectives for NQPNs are to find and trust their professional identity and discern it from co-workers and become integrated in the larger professional nursing culture. NQPNs need to balance a personal life with professional work, and incorporate theory with practice experienced. The transition shock experience is greatly affected by relationships with co-workers. NQPNs are self-critical and hypersensitive to any form of condemnation, disregard or distrust and then of approval, praise or support. Due to lack of formal feedback, NQPNs tend to look for other cues to measure competency, practising safely and progress in development of professional nurse role. During the transition period of the initial four months there is development and establishment of NQPNs' personal professional identities (Duchscher 2009:1108). This developmental change is considered stimulating and frightening by NQPNs, determining the alterations required, creating personal relationships, and changing their personal view of the self. NQPNs focus a large amount of the initial transition period distinguishing between their own professional nursing roles in relation to co-workers. Being a student requires performing different roles that leaves NQPNs confused when transitioning from student to NQPN. NQPNs are absorbed with nursing tasks instead of professional nurse responsibilities such as patient advocacy, patient education and counselling. NQPNs are inclined to spend less time with patients and families due to underdeveloped organisational skills that keep them pre-occupied with

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timely task completion. Considering the NQPNs' unstable self-confidence levels, interaction with other professionals who see themselves as superior, is exhausting. NQPNs experience severe stress when supervising, delegating and directing to nursing and non-nursing staff that are older and more senior than the NQPN. Most NQPNs have not been prepared for these roles nor had an opportunity as a student to perform such duties (Duchscher 2009:1108). NQPNs adjust socio-culturally and developmentally through looking for other cues to measure the safety, competence and growth of their practice. NQPNs are hypersensitive and self-critical but developmental change occurs through developing a better professional self-concept in changing family and friend relationships and changing the way in which they view themselves (Duchscher 2009:1108)

1.2.3 Predictors of successful / unsuccessful transition

Meleis's (2007:421) transitions theory defines personal- and community-level transition conditions that predict the promotion or inhibition of transition that new professional nurses may experience as successful or unsuccessful. A successful transition is characterised by a subjective sense of well-being, increased confidence and competence, mastery of skills, and autonomous practice, and an unsuccessful transition by negative emotions, a lack of confidence, turnover, and limited support (Meleis 2007:421).

Phillips, Esterman, Smith and Kenny (2013:1319) consider institutional factors experienced by NQPNs in the work environment during transition the strongest predictors of a successful transition from student to NQPN. Three main institutional factors feature, namely a concrete orientation to the new clinical practice nursing environment; the skill to manage complex clinical patient situations, and respect from their co-workers. NQPNs transition into nursing practice with broad but elementary skills obtained pre-graduation. Hospital institutions need to consider patient allocations and acuity levels in relation to NQPNs' capabilities and experience before placement to assist NQPNs' transition. To build confidence and assure progress, NQPNs require feedback on performance (Johnstone et al 2008:50; Ortiz 2016:22). Recognition from senior co-workers contributes to self-confidence and clinical competence in nursing practice and reduces overall transition stress (Ortiz 2016:22; Phillips et al 2013:1319). Moreover, the implementation of an NQPN transition support programme is beneficial to the NQPN transition in the clinical work environment.

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1.2.4 NQPN transition support programmes

An NQPN transition support programme refers to a period of structured transition for NQPNs during which they will be supported by a preceptor or mentor to develop their confidence as autonomous professionals, refine skills, values and behaviours and to continue on their journey of life-long learning (Department of Health 2010:11). Nursing practice in the first year is vital to developing NQPNs into safe practitioners and preparing NQPNs for the clinical work environment requires support in the transition. Therefore there is a need for effective transition support programmes that are developed to prepare NQPNs in providing safe, competent, and effective patient care. Phillips et al (2013:1319) emphasise NQPN transition support programmes as a key strategy to retain NQPNs. Significant correlations between NQPNs having a structured transition support programme to adjustment, satisfaction, and support of the NQPNs on the ward were found (Phillips et al 2013:1319). In addition to support, guidance and mentorship also facilitate transition of NQPNs into the workplace and adjustment to organisational socialisation (Strauss, Ovnat, Gonen, Lev-Ari & Mizrahi 2016:424).

Various countries like America (Kramer et al 2012:155), the UK (Whitehead, Owen, Henshaw, Beddingham & Simmons 2016:58), Australia (Henderson, Ossenberg & Tyler 2015:225) and Israel (Strauss et al 2016:424) are known for facilitating NQPN transition support programmes. However, the researcher found no evidence of such a transition support programme facilitated for NQPNs in private healthcare organisations or private hospitals in Mpumalanga Province in South Africa.

1.3 PROBLEM STATEMENT

In private hospitals in Mpumalanga there is currently no official programme to address the transition support needs of NQPNs who upgrade from ENs. The estimated average turnover rate for NQPNs in these hospitals was 33-47% for the period 2012/2013 (Hospital 1 & 2 statistics) due to reasons unknown. In South Africa, Matlala and Van der Westhuizen (2012:22) identified the lack of/or ineffectiveness of transition support as one of the root causes of turnover among NPNs. According to MacKusick and Minnick (2010:337) and Kramer (1974:4), a lack of transition support is a primary reason for NQPNs to leave professional clinical practice globally.

When ENs upgrade to professional nurses, they are considered more prepared to adapt to professional nurse roles and responsibilities (Cubit & Lopez 2012:210) and are expected to 'hit the

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floor running' (Kilstoff & Rochester 2003:13). However, transitioning from ENs to NQPNs is considered difficult and stressful (Deasy et al 2012:112) due to the experience of moving from the familiar dependent practitioner role of ENs to the less known independent practitioner role of professional nurses (Kramer, Brewer & Maguire 2011:349). Furthermore, Parker et al (2014:154) and Duchscher (2008:444) emphasise the importance of adequate support early in the transition experience. The absence and/or availability of transition support play a significant role in job satisfaction, professional commitment, stress levels, motivation, and competency of NQPNs, and ultimately the cost of quality patient care (Bjerknes & Bjørk 2012:6; Cheng, Tsai, Chang & Liou 2014:7).

With or without support, it will be challenging for NQPNs to make the transition from novices to established new professional nurses and become incorporated as valuable team members in the work setting (Bjerknes & Bjørk 2012:6). Hence, the need to conduct research to explore the transition support needs of NQPNs who previously worked as ENs.

1.4 SIGNIFICANCE OF THE STUDY

The outcomes of this study will inform private healthcare management and policymakers on the transition support needs and challenges experienced byNQPNs currently in practice. The findings could be utilised to meet transition support needs, and improve job satisfaction and retention of NQPNs. This, in turn, might enhance the quality of nursing care. Findings from this study may add valuable insight into how NQPNs who upgraded from ENs experience transition support during the transition period since research on the topic is limited in South Africa.

1.5 AIM

The aim of this study was to explore and describe how NQPNs who upgraded from ENs describe their transition support needs during the transition period in private hospitals in Mpumalanga Province.

1.6 RESEARCH QUESTION

To achieve the aim, the study wished to answer the following research question:

How do NQPNs who upgraded from ENs describe their transition support needs during the transition period in private hospitals in Mpumalanga Province?

1.7 PARADIGM

For the purpose of this study, a constructivist paradigm was followed with the focus on discovering deeper meaning through co-constructing and interpretation of findings during interaction between the researcher and the participants. Denzin and Lincoln (2005:138) define a paradigm as the researcher's network that encases ontological, epistemological, and methodological views. The constructivist paradigm refers to multiple realities (relativist ontology) where researcher and participant co-create understanding (subjective epistemology) and a naturalistic set of methodological procedures (Denzin & Lincoln 2005a:24). Constructivists believe in multiple, constructed realities and that subjective reality is shaped by the experiences and views of the participants, social setting, and the researcher-individual interaction (Ponterotto 2005:130). In this study, the researcher interacted with the participants subjectively to access their interpretation of transition support needs which was crucial to understand the phenomenon of transition support needs. The researcher recognised that the findings generated were a construct created through the relations between the researcher and the participants in the specific culture.

One of the benefits of this approach is the close relationship between the researcher and the participant, while facilitating participants to share their experiences. Through these experiences the participants are able to describe their views of reality and this allows the researcher a better understanding of the participants' actions (Robottom & Hart, 1993 cited in Baxter & Jack 2008:545)

1.8 PHILOSOPHICAL ASSUMPTIONS

The philosophical assumptions underlying the paradigm are ontological, epistemological and methodological, and will be discussed briefly in sections 1.8.1 to 1.8.3.

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1.8.1 Ontology

Ontology refers to a theory of existence and is concerned with the nature of reality and of human beings. The aim of constructivist research is to interpret the participants' subjective experiences as the reality of the participants (Lee 2012:406). In this study, the participants' reality was the transition support needs in their selected private hospitals in Mpumalanga Province.

1.8.2 Epistemology

Epistemology is a theory of knowledge that investigates the rapport between the researcher and participant and co-creates insight through the inquirer-knowable interaction (Lee 2012:407). The researcher's goal was to obtain knowledge required for this study and to gain insight into what should be known. The researcher wanted to gain knowledge and insight about the participants` transition support needs. The researcher developed relationships with the participants through interaction during in-depth semi-structured interviews and obtained knowledge from the participants' descriptions of their transition support needs.

1.8.3 Methodological

Methodology refers to the process and procedures of the research (Ponterotto 2005:132). Constructivists mostly accept naturalistic designs (Guba & Lincoln 2005:191) in which the researcher is entrenched in the social setting and daily life and experiences of the research participants. Naturalistic inquiry leads to qualitative researchmethods such as in-depth face-to-face interviewing and participant observation (Ponterotto 2005:132). In this study, the researcher followed a multiple holistic case study approach and conducted individual in-depth semi-structured interviews and unstructured observation to allow the researcher access to the NQPNs' work environment and their experiences of transition support needs.

1.9 RESEARCH METHODOLOGY

The research design refers to the logical sequence or plan that connects empirical data to a study's initial research questions and to its conclusion (Yin 2014:28). A qualitative approach was followed with a holistic multiple case study research design (Yin 2014:62) and, specifically two case studies arranged within a multiple-case design (Yin 2014:57). The 'case' or primary unit of analysis (Yin 2014:31) for this study was the transition support needs of NQPNs who work in two

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private hospitals in Mpumalanga Province. Chapter 3 describes the research methodology in detail.

1.10 RIGOUR OF RESEARCH DESIGN

The quality of the design can be judged according to certain logical tests if a research design represents a logical set of statements. Four tests, namely construct validity, external validity, internal validity, and reliability are used to establish the quality of empirical social research. Since The four tests described by Yin (2014:45) were utilised. In qualitative research trustworthiness determines accuracy and quality and that the findings are worth paying attention to (Guba & Lincoln 2005:191). According to Guba and Lincoln`s (2005:191) data and design matrix, trustworthiness is assessed through five variables: credibility, transferability, dependability, confirmability and authenticity (Polit & Beck 2012:587). A full description of the rigour of the research design will be provided in Chapter 3.

1.11 ETHICAL CONSIDERATIONS

Stommel and Wills (2004:373) describe an ethical situation as having to do with "morality". In the research context, ethics focuses on recognising socially accepted and sanctioned professional and legal obligations. Ethical considerations are main features in nursing research (Polit & Beck 2008:167). A researcher has the duty to perform research in an ethical manner because, if not, it weakens the scientific process and may have negative implications (Brink, van der Walt & van Rensburg, 2006:30) since most research involves human beings or animals (Yin 2014:77). When research involves human subjects' special ethical considerations apply to assist the researcher in protecting human participants in case studies (see Chapter 3 Section 3.5). Conducting the current study, the researcher adhered to the ethical considerations contained in the *Belmont Report* (45 CFR 46). Before the study could commence it had to be approved by the Research Ethics Committee of the Faculty of Health Sciences (REC), University of Pretoria (75/2016) (see Annexure A1). Permission to conduct the study was obtained from the selected private hospitals in Mpumalanga Province (see Annexure A2 & A3), and informed consent was obtained from the participants (see Annexure B). Since the study involved human participants, the researcher observed the ethical principles of beneficence, respect for human dignity, justice, and right to confidentiality asset out in the Belmont report. These principles are discussed in detail next.

1.11.1 Beneficence

Beneficence requires the researcher to decrease harm and increase benefits for participants and others through the participants' right to protection from discomfort and harm (Polit & Beck 2012:152).

The right to protection from discomfort and harm covers the participants' well-being. The well-being of participants has various aspects which need to be protected. These aspects refer to namely physical harm such as injury and fatigue; emotional harm is stress and fear; social harm which is loss of support, and financial harm which is loss of income (Polit & Beck 2012:152). No unnecessary risks for harm or discomfort should be imposed on participants in a study since their participation is crucial in achieving the research objectives (Polit & Beck 2012:152). In this study there were no risks of physical, psychological or social harm. The participants might have experienced slight discomfort regarding the time required for the interview, but the researcher attempted to reduce this discomfort by complying with the scheduled time. The researcher did not need to extend the set time frame.

The risk for emotional harm (such as stress or fear) was minimised. The researcher informed the participants of the risks and benefits involved in the study. The participants were made aware that participation was voluntary and reassured that the data collected would be treated confidentially. Participants were reassured that none of the information shared by any participants would be used or held against them in any way but would be utilised to meet transition support needs of NQPNs. Arrangements were made with the health care facilities to offer counselling, if needed by participants. This service is freely available and is provided by the employee wellness centres available in selected private hospitals in the Mpumalanga province. None of the participants required or requested the use of this service. There were no risks for financial harm since the researcher was able to arrange with the management of the hospital that the interviews could be held during on-duty time with each session lasting for 45 minutes to 1 hour. The researcher supplied the participants with refreshments. The participants were informed of every step of the data-collection process.

1.11.2 Respect for human dignity

The second ethical principle described in the Belmont Report is respect for human dignity which is concerned with the right to self-determination and the right to full disclosure (Polit & Beck 2012:154). This principle was adhered to in the current study.

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1.11.2.1 Right to self- determination and full disclosure

The right to self-determination indicates the individuals' right to decide whether or not they want to participate in a study with no risk of penalty or prejudice (Polit & Beck 2012:152). The participants have the right to withdraw from the study at any time; to refuse to give information they are uncomfortable to give, or to ask for clarification of the purpose of the study if it is unclear. The participants were informed of their right of informed consent and gave informed consent before participating in the study. The researcher certified verbally and in writing that all the participants understood that their participation was voluntary; it was their own decision whether they wanted to participate or decline participation thus there was no coercion involved. The participants were assured that they could withdraw from the study at any time without stating a reason and without prejudice.

Full disclosure is required for participants to make informed voluntary decisions about participation in any study (Polit & Beck 2012:154). The researcher informed all the participants verbally and in the participant information and informed consent document of the nature of the study, the right to refuse participation, the researcher's responsibilities, and the possible risks and benefits (de Vos, Strydom, Fouche & Delport 2011:180). The participants were informed that it was a qualitative case study and in-depth semi-structured interviews would be conducted to obtain information to describe how NQPNs who upgraded from ENs described their transition support needs in selected private hospitals in Mpumalanga Province (see Annexure B).

1.11.3 Justice

The third principle in the Belmont Report is justice which includes the participants' right to fair treatment, and to privacy and dignity (Polit & Beck 2012:155).

1.11.3.1 Right to fair treatment

The right to fair treatment involves the fair treatment of people who decline to participate in the study or who choose to withdraw from the study (Polit & Beck 2012:155). Participation was voluntary and participants who refused to participate did not suffer any negative consequences. The participants were informed that no incentives were to be gained in participating in the study and all participants were treated fairly and courteously (see Annexure B).

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1.11.3.2 Right to privacy and dignity

Privacy indicates the participant's right to manage the time, extent, and general circumstances under which personal information will be shared with or withheld from others. This information consists of a person's 'attitudes, beliefs, behaviours, opinions, and records' (Burns & Grove 2009:195). The participants had the right to make informed voluntary decisions about their participation and divulging of information.

Data was collected from the participants in a private environment at the selected private hospital. The participants participated freely in the in-depth semi-structured interviews of an average of one hour at the agreed venues at the selected hospitals. The information was not utilised in any way that divulged the participants' identities but to describe the participants' transition support needs in the context of this study. The participants were referred to as A, B and so on on the transcripts. The study was not more intrusive than required to achieve the objectives of describing transition support needs of NQPNs who upgraded from ENs. The participants' privacy was respected and protected at all times during the study as well as afterwards. No information obtained from participants during the in-depth semi-structured interviews was shared without their consent as stipulated in the consent form (see Annexure B). Data was collected from the participants in a private environment at the selected private hospital.

1.11.4 Right to confidentiality

Confidentiality contracts the researcher to treat information from the participants as confidential and not to publicly display it in a way that exposes the participants' identity. The information from the participants is not to be made accessible to unauthorised people (Streubert & Carpenter 2007:66) that would put them in the undesirable position of being used in further studies (Yin 2014:78). During the study, the participants' confidentiality was maintained by addressing them in the transcripts as A, B etc (see Annexure C). Special precautions were taken to ensure that unauthorised people of the institutions did not have access to the data. The researcher asked the participants' permission to use direct quotes and ensured that the raw data and report did not reveal their identity. The researcher informed the participants about the use of information obtained from them during the interview. The information would be used to assist the transition support needs of future NQPNs and the use of the audio recording was to provide accurate information to the researcher only and not to any unauthorised officials. The participants' identities were protected at all times and would not be made available in the report or future articles to be

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published in academic research journals. All the data obtained during the study would be kept for 15 years after completion of the study (see Annexure B).

1.12 CONCEPT CLARIFICATION

For the purposes of this study, the following key terms were used as defined below.

- **Enrolled nurse**

An enrolled nurse is a person certified as such by the South African Nursing Council (SANC) as stated in Article 16 of the *Nursing Act, 50 of 1978*. The EN has successfully completed the prescribed two-year vocational education training programme (SANC 1993). By obtaining this qualification as stipulated by the SANC, the EN is registered to practise nursing according to the scope of practice (SANC 1984). The EN works under the supervision and delegation of the professional nurse. In this study, 'enrolled nurse' referred to a nurse who is qualified, registered and practising as an enrolled nurse according to the scope of practice.

- **Newly-Qualified Professional Nurse (NQPN)**

According to Article 16 of the *Nursing Act, 50 of 1978*, in South Africa, a professional nurse is a person certified as such by the South African Nursing Council (SANC). The professional nurse successfully completed the prescribed programme (SANC 1985 as amended) or as an EN completed the bridging programme (SANC 1989). The professional nurse has acquired the requisite qualifications to be registered to practise nursing. In this study, the NQPN referred to a nurse who had previously practised as an EN and successfully undergone the bridging programme (SANC 1989) to upgrade to a professional nurse and who is registered with SANC to practise as a professional nurse and has not more than four years' post registration clinical experience.

- **Transition**

Transition is defined as a process of changing from one state or condition to another (Madjar, McMillan, Sharkey, Cadd & Elwin 1997:4). Furthermore, transition is a passage and a development that occurs over a period and is supplemented by an adaption to roles, relationships and patterns of behaviour which is a significant component in modelling the new identity (MacLellan, Levett-Jones & Higgins 2015:393; Crafter & Mauder 2012:16). New professionals are confronted with the

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loss of previous social connections and supports; absence of known reference points; appearance of new needs; inability to meet old needs in new environments, and incongruence between previous and new expectations in work environment (Kumaran & Carney 2014:606; Laschinger, Cummings, Leiter & Wong 2016:91). In the current study, transition is a phase where NQPNs undergo a course of learning and change to acquire the skills, knowledge, attitudes and values required to become an effective member of the healthcare team and nursing practice as an NQPN. Duchscher (2001:428)

- **Transition support needs**

Transition support refers to giving approval, moral support, comfort, or encouragement to NQPNs as well as being actively interested in and concerned with the success of NQPNs during the transition period from ENs to professional nurses (Kramer 1974:4). Johnstone et al (2008:49) define transition support of NQPNs as 'clinical teaching availability and approachability, ability to ask questions, motivation to engage in best practices, benevolent surveillance, timely constructive feedback, reassurance, back-up support and debriefing opportunities'. Duchscher 2008 (cited in Lea & Cruickshank 2014:950) still supports the definition of transition support as defined initially by Kramer (1974:4). In this study NQPNs' transition support needs referred to the need for support that aids, encourages, and strengthens, gives courage and confidence to NQPNs to practise competently, safely, and effectively in the areas they have been educationally prepared to work (Johnstone et al 2008:52).

- **Bridging programme**

In an attempt to address the shortage of professional nurses, the SANC (1989) developed a conversion programme for ENs to upgrade to the professional nurse qualification which involves another two years of study.

1.13 LAYOUT OF THE STUDY

The layout of the study is illustrated in Figure 1.2.

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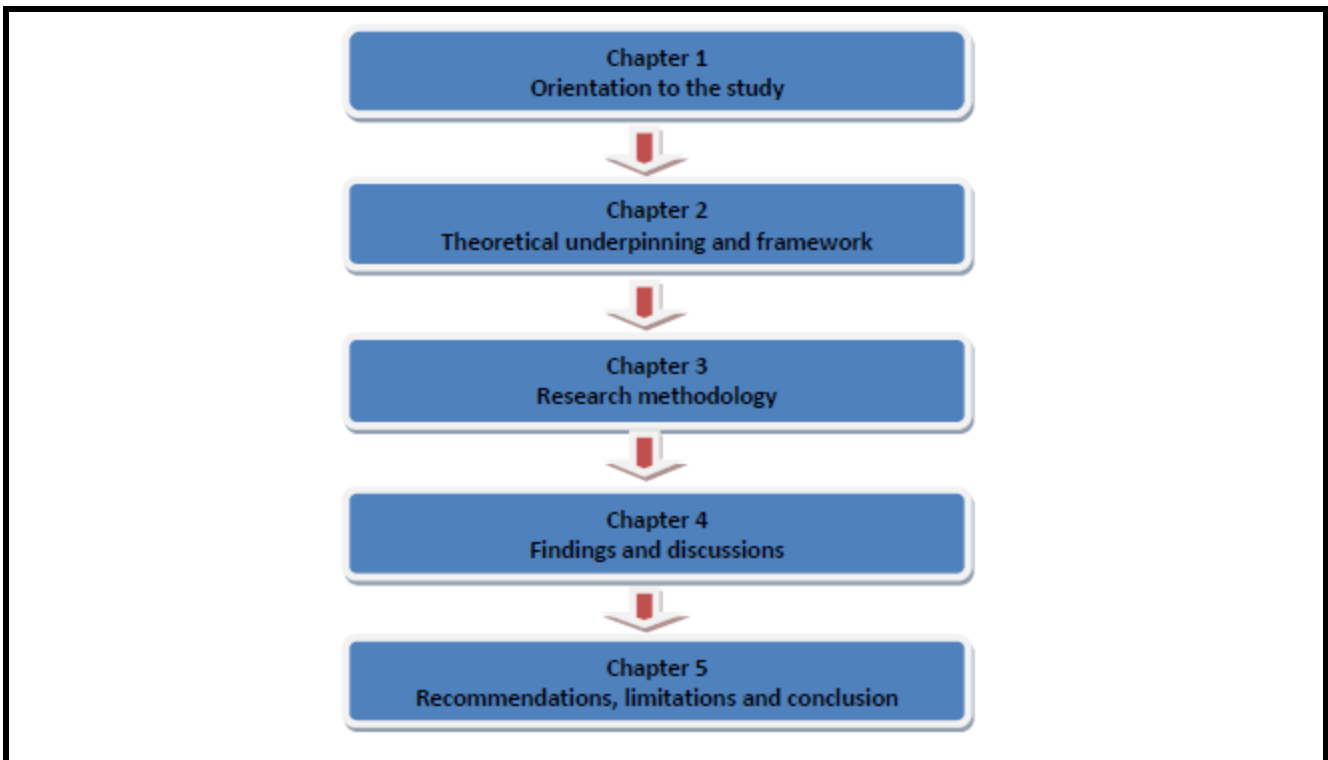
Figure 1.2 Overview of the chapter layout

1.14 SUMMARY

This chapter briefly outlined the background and aim of the study and the methodology for gathering the data to achieve the study aims and objectives. The researcher used a qualitative case study design to obtain data on the transition support needs of ENs who upgraded to NQPNs in private hospitals in Mpumalanga Province.

Chapter 2 discusses the theoretical underpinning and literature review conducted for the study.

CHAPTER 2

THEORETICAL UNDERPINNING AND FRAMEWORK

"Only in growth, reform, and change,
paradoxically enough,
is true security to be found."

-Anne Morrow Lindbergh-

2.1 INTRODUCTION

Chapter 1 provided an overview of the study. This chapter discusses Duchscher's (2008) stages of transition theory and the utilisation of underlying concepts to the preliminary conceptual framework of NQPNs transition as it formed the basis of this study. Reference is also made to some of the literature reviewed for the study.

2.2 THEORETICAL UNDERPINNING AND FRAMEWORK

The use of a theory in case studies contributes to describing the appropriate research design and data to be collected (Yin 2014:44). In addition to making it easier to design a case study, having some theory plays a critical role in assisting researchers to generalise the lessons learned from the case study. Yin (2014:40) typifies the function of a theory in a case study as 'analytical generalisation which contributes to external validity'. A case study should be considered an opportunity to shed empirical light on some theoretical concepts or principles which go beyond the setting for specific cases that have been studied (Yin 2014: 40). In this study, the researcher used Duchscher's (2008) stages of transition theory as the theoretical framework since the study focused on the transition experience of NQPNs during the transition period. The student nurse to professional nurse transition to practice has many challenges like new role adoption and professional socialisation. The stages of transition theory emerged from transitions (Schumacher & Meleis 1994 cited in Duchscher 2008:441) and includes Kramer's (1974 cited in Duchscher 2008:441) components of professional role socialisation.

According to Kramer (1974), the narrative of the stages of transition for newly professional nurses centres around their reaction during role transition's primary stages as being primarily

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about the theory-to-practice gap (Duchscher 2008:441). Kramer's work implies that new professional nurses experience reality shock during the initial stages of transition due to discrepancies between theory taught and nursing practice (Duchscher & Cowin 2006:498).

2.2.1 Stages of transition theory

In the stages of transition theory, Duchscher (2008:444) depicts the first 12 months of the transition to nursing practice as 'a process of becoming' which consists of a personal and professional journey for the new professional nurse. Duchscher's (2008:443) theory describes the three stages that the new professional nurse being the NQPN in this study have to go through during the initial 12 months of professional practice as doing, being, and knowing. In these stages are structured developments of anticipating, learning, performing, concealing, adjusting, questioning, revealing, separating, rediscovering, exploring and engaging. All three stages feature concepts experienced by the NPN at certain times during the transition process (Duchscher 2008:443).

These stages are not linear, prescriptive or progressive, but transformative and might be affected by factors such as new practice circumstances or contexts that may cause transitory deterioration in the field (Duchscher 2008:443). Duchscher's (2008:443) goal with this framework was to provide a precise general account of the NPN transition experience and processes involved as illustrated in Figure 2.1
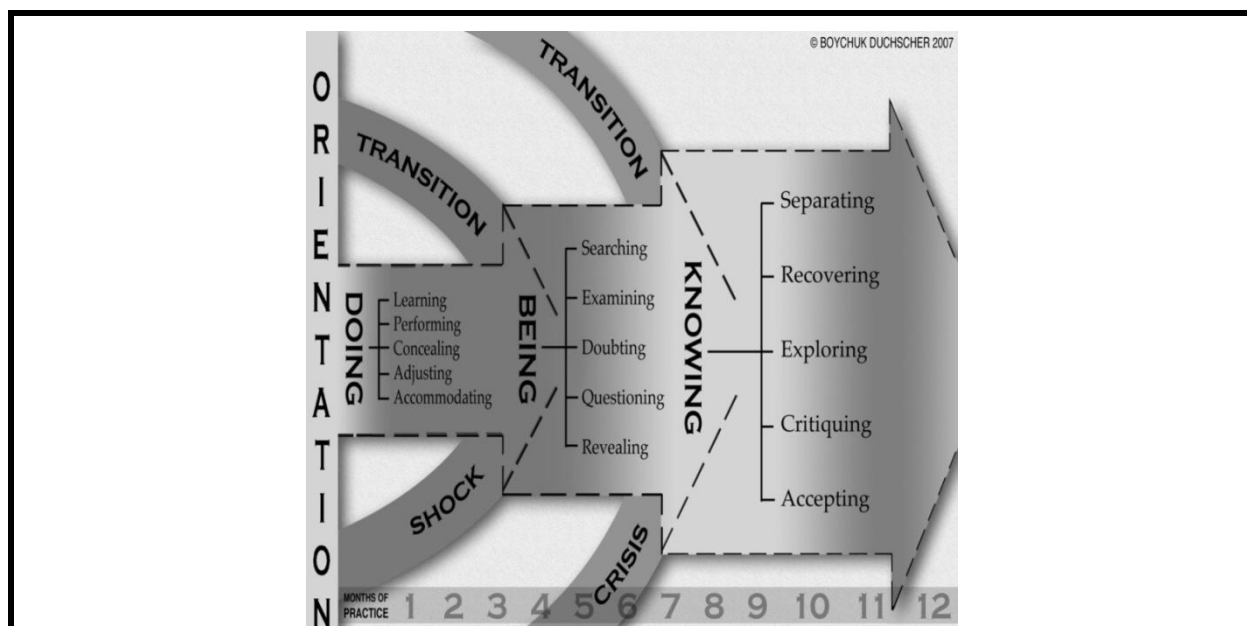
Figure 2.1 Stages of transition theory   Source: Duchscher (2008:443)

2.2.1.1 Doing

The doing stage consists of anticipating, learning, performing, concealing, adjusting and accommodating. This first stage of entry into professional practice is characterised by a wide range ofsevere intensity and rise and fall of emotions as NPNs go through the processes of discovering, learning, performing, concealing, adjusting, and accommodating (Duchscher 2008:444).

- *Anticipation*

The initial stage of the twelve-month role transition period for NPNs is considered the first three to four months after initial orientation. NPNs tend to work long hours and their fairly conventional life is transformed into expectations and responsibilities challenging their personal and professional identities. Most NPNs enter the transition process with idealistic views regarding expectations and anticipations. NPNs are unprepared for the workload demand and liability of the new role even though they were primarily excited about transition from student to professional nurse. NPNs often charge the disparities between idealistic role anticipation and the reality of practice to lack of educational preparation (Duchscher 2008:444).

- *Learning and performing*

The NPN at this stage is comfortable in a learning capacity and less comfortable with applying knowledge. NPNs quickly focus on learning and performing and feel insecure after discovering that the reality of nursing practice is different from their expectations (Duchscher 2008:444). Most NPNs feel comfortable managing eight patients but tend to manage double the number of patients with no or limited professional nurse support. Since NPNs were not prepared theoretically for so many variables, NPNs tend to find multi- tasking nursing and non-nursing duties, direct care of patients, caring for critical or terminal patients, dealing with difficult families, and the care of clinically unstable patients very stressful. The focus of NPNs is mostly on familiar details and theory. NPNs distance themselves from happenings in their surroundings to ignore the anxiety about harming patients due to ignorance or inexperience. There is much to be 'learned' in the NPNs' new professional environment: who's who; the institutional policies and regulations; their professional responsibilities; how to manage their workload; who they can trust; what skills they are required to do, and who they can turn to. Problem solving and clinical judgement is limited due to lack of exposure to situations in nursing practice. In most cases, NPNs are so focused on task management that they are unable to manage complicated clinical situations (Duchscher 2008:445).

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NPNs are most concerned with the ability to 'perform' the tasks and skills that are required. NPNs have an awareness of being 'watched' and 'judged' on how well they perform. Acceptance of themselves is often dependent upon the unit manager's acceptance of them and they take their cues regarding their practice from the unit manager. NPNs' growing professional self-concept is dependent on the healthy facilitation of their new roles and responsibilities. NPNs feel frightened and overwhelmed by decisions made and taking responsibility and accountability for these decisions regarding patients.

- *Concealing*

NPNs are insecure about their background knowledge and capabilities. NPNs have an intense need to belong and therefore hide their emotions and feelings of failure, inadequacy and incompetence from their co-workers and unit manager (Duchscher 2008:444). Due to exposure to new and unfamiliar experiences the learning requirements are high. The professional identity developed after educational preparation is dismantled by performance anxiety and self-doubt. NPNs may feel stressed about everything due to the conflict between adequate level of skill and knowledge and lack of confidence, limited exposure to application of skills and knowledge, and unfamiliarity with different clinical situations. NPNs may constantly be required to perform unfamiliar procedures that portray them as incompetent and affect their credibility which leads to anxiety. NPNs realise that non-compliance with required duties and routines may place the focus on them instead of blending into the nursing team. NPNs are expected to have the ability to delegate duties and responsibilities to older, senior, clinical experienced nursing staff (Duchscher 2008:445).

- *Adjusting*

NPNs are adjusting to many new roles, relationships and responsibilities. NPNs are torn between intense professional adaptations moving from student to professional nurse and socio-cultural and development alterations in their personal lives like changing residence and personal relationships which is exhausting. NPNs are forced to adjust to high levels of clinical responsibility, seeking acceptance from peers, adapting to working with other professional nurses, adjusting to the physical demands of the work schedule, and issues with personal relationships. During this period NPNs need to make clinical judgements and decisions themselves as the professional nurse for which they feel ill prepared and responsible. NPNs may blame themselves for wrong decisions made irrespective of situations that call for more than their practical abilities and knowledge (Duchscher 2008:445).

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- *Accommodating*

Many of the practices NPNs see in nursing, they have never seen or done before and need to decide in what way they need to accept and modify their own ways according to it. NPNs may be irritated by perceived senior peers' old-fashioned thinking regarding nursing and strict allocation of non-nursing duties. NPNs need a rationale for why nursing is done a certain way to decide whether to accommodate or reject it from their thinking. These thoughts may be accommodated without questioning only to be identified later as the main issue contributing to their lack of professional fulfilment in their nursing role (Duchscher 2008:445). NPNs are in a difficult professional adjustment process of finding themselves and developing a sense of belonging simultaneously.

2.2.1.2 Being

During the being stage NPNs progress through searching, examining, doubting, questioning and revealing. In the four to five months after orientation NPNs experience a fast and consistent progression in their thought, knowledge level and skill competency (Duchscher 2008:445).

- *Searching*

NPNs still experience a high degree of frustration constantly due to being a professional nurse for a short while, having some knowledge and some idea of what it means to be a professional nurse, but also the realisation that it might not be what they expected it to be. To escape this constant strain NPNs may engage in personal life activities escaping from the work setting and co-workers. NPNs may experience an enhanced awareness of their professional identity and consider the nursing role compared to other health professions and seek balance between their personal and professional life, trying to find meaning and reason in what they are doing at this point and what it means to be a professional nurse (Duchscher 2008:446). NPNs are no longer content with just doing without a rationale.

- *Examination*

In the first part of this stage NPNs become comfortable with the nurse roles and responsibilities and start to examine things for what they are. NPNs are very much aware of the differences of what actually happens in nursing practice and what they were educated to do. NPNs become more comfortable and do not focus only on doing anymore. This comfort initiates an examination of the fundamental motivation for nursing and medical interventions and the suitability and efficacy of health care. NPNs need to make decisions based on this

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examination which leads to the growth of their identity as professional nurses (Duchscher 2008:446).

- *Questioning*

NPNs are quickly advancing as they become more comfortable with the routines and tasks in the ward. NPNs may start to question why things are the way they are in nursing. During the evolution of this second stage, NPNs will disengage, question, search, reveal, recover, accept, and finally re engage in their selected career on their conditions. Some of the questioning may come from a sense of frustration and their own lack of knowledge and understanding about the underlying rationale for existing ways of being. NPNs may question the role of nurses, the function of certain aspects in the ward and the healthcare system itself. There is awareness that something is different, but NPNs will spend time wrestling with the changes caused by their commitment to become a 'real' nurse. NPNs question the choice of exchanging the comforts of undergraduate studies for exposure to the daily attacks of responsibilities that make them feel incompetent, unsure, exhausted, disappointed, depreciated, useless and powerless. The questioning stage is about adjusting and making sense of the environment they are passionate about. Irrespective of the inconsistencies NPNs observe and experience, questioning assists them to make sense of the nursing practice and where they fit in it. NPNs withdraw from the environment to regain a feeling of control over their life (Duchscher 2008:446).

- *Doubting*

This stage creates doubt regarding their professional identity by querying pre-graduate ideas of nursing and illumination of discrepancies and shortcomings in health care. NPNs doubt themselves and ask why did they go into nursing; will the other nurses ever respect them; will they ever be as knowledgeable as the experienced professional nurses in the ward, and will they ever be able to balance all that is required of professional nurses? The NPN may wish for stable clinical placement with stable clinical patient conditions to be surrounded by familiarity, consistency, and predictability since they are looking to escape the bombardment of learning, growing, and changing (Duchscher 2008:446). Many NPNs' sense of self-trust is fragile and they may seek the approval of senior colleagues they admire for clinical judgements, decision making and illumination and verification for their application of interventions. The knowledge that the decisions they make and the nursing interventions to be implemented are effective and safe, is vital to the NPN`s self confidence. During this stage NPNs may be placed in leadership positions that for which they feel ill-equipped.

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NPNs may consider this a vote of confidence in their abilities and therefore not raise their underlying concerns (Duchscher 2008:446). The initiation of this stage may be sensitive for NPNs as the tug-and-pull war between holding on and letting go is even. NPNs may deem attentive supervision as doubt in their abilities but also neglect when left without professional nurse support to assist in uncertain circumstances (Duchscher 2008:4450). The spike of this conflict occurs mostly from five to seven months when NPNs' confidence is affected through the junction of insecurities in terms of practice competency and their fear of failing themselves, patients and co-workers. This conflict stimulates a new commitment from NPNs to improve practice (Duchscher 2008:446).

- *Revealing*

NPNs find more middle ground and have more energy and develop a progressive positive view on their professional experience. The NPN is now more comfortable with what they do not know and their increasing confidence in what they do know (Duchscher 2008:447). NPNs see now more of the differences between what they expect and the reality of the nursing practice. The NPN experience a revelation through the experience of many new things they did not know as a student. The NPN is beginning to develop a sense of what reality in nursing is and that it needs to be accepted once it is revealed. During this period the NPNs familiarise themselves with personal aspirations that was put aside for professional growth. The NPN requires less energy to manage familiar nursing procedures and clinical circumstances. The new found liberation is appreciated since less time is spent on debriefing about work and more energy is deposited in adjustment to changes in their work schedule and personal lives. Within six to eight months after orientation NPNs may experience revitalisation and feel charged to look for challenges, new and unknown experiences, and future career opportunities (Duchscher 2008:447).

2.2.1.3 Knowing

The knowing stage consists of separating, recovering, exploring, critiquing and accepting (Duchscher 2008:447).

- *Separating*

NPNs may need some time alone and withdraw to adjust from surviving the first stage of the professional role transition and the experience of intense emotions and adjusting to the differences in nursing during the second stage. The last stage of the NPN`s original 12

months of practice is aimed on gaining a professional individuality that discerns them from other recognised professional nurses but also to be part of the bigger nurse professional culture. NPNs are scared of the transitioning from student to NPN due to the requirements and responsibility that accompanies it (Duchscher 2008:447).

- *Recovering*

NPNs sustain the process of recovery they initiate during the second stage in this last stage. NPNs require time to recover from the draining experience of making the initial transition to professional practice. They may separate themselves from the work environment to spend more time socially with family and friends and engage in more personal activities. A move of support structure from non-nursing relationships to nursing relationships may occur while others establish personal relationships like engagements. It may seem that the NPNs are focused on going to work, returning to their life and keeping their thoughts to themselves while developing a sense of balance in development, success and fulfilment (Duchscher 2008:447). Depending on the degree of adjustment the recovery time may vary in intensity and duration from NPN to NPN.

- *Exploring and critiquing*

NPNs tend to focus more on exploring and critiquing their new professional setting, socio-cultural and political environments towards the end of this stage. NPNs consider themselves somewhat stressed from nine to twelve months into transition and their stressors move from individual to frustration dealing with healthcare in general. NPNs suddenly realise that they are only at entry level in terms of power and authority and perceives this as being devalued professionally and start to think about their future. Most NPNs sees this as the initiation in their journey towards professional realisation outside their nursing care bedside role (Duchscher 2008:447).This may be about advancing their skills, knowledge, thinking, or may be about moving their actions forward, or it may mean literally changing roles, units, institutions or even geographical locations. NPNs start to critique their vision of nursing and how that fits with who they are to develop an understanding and reconstruct their vision if necessary. NPNs deconstruct and critique what exists in nursing practice to reconstruct it to match their aspirations and expectations of it.

- *Accepting*

NPNs start to distinguish between what they can accept and what they cannot accept in nursing practice. NPNs may either reconfigure their expectations regarding the nursing

environment or initiate a change. Input from other experienced professional nurses on how they adjusted and integrated their nursing standards into nursing workload may assist NPNs in developing their own strategies. NPNs may experience conflict as they work through the process of accepting the reality of nursing practice. NPNs will realise incompatibilities exists which is not an indication of failure on the NPN`s behalf. Most NPNs feel secure about their comfort, role confidence, responsibilities and routines at twelve months into transition and start to differentiate their clinical skills and cognitive expertise with new entry NPNs. This makes the NPNs recognise that they have changed and progressed from questioning to answering capacity without realising it (Duchscher 2008:447).

2.3 PRELIMINARY CONCEPTUAL FRAMEWORK

Miles and Huberman (1994:18) note that a conceptual framework serves several purposes by (1) identifying the inclusion and exclusion criteria of the study; (2) describing what relationships may be present based on logic, theory and/or experience, and (3) providing researchers with the opportunity to assemble common constructs into intellectual groups. A conceptual framework serves as an anchor for the study and is referred to at the stage of data interpretation. According to Baxter (2003:28), a conceptual framework does not illustrate links between the constructs. The framework should continue to expand and be concluded as the study develops and the links between the proposed constructs will surface as data are analysed. A final conceptual framework will include all the themes that surface from data analysis.

The intent of selecting this conceptual framework was to utilise underlying concepts of the stages of transition theory to provide an overall representation of the transition support needs NQPNs experienced during the stages of transition and the transition support processes encompassed within (Duchscher 2008:443). The underlying concepts utilised from the stages of transition theory were the knowing stage, being stage, doing stage, role adjustment, role conflict, role competence and transition shock which were the most predominant in Duchscher`s stages of Transition Theory. Figure 2.2 illustrates the preliminary conceptual framework.
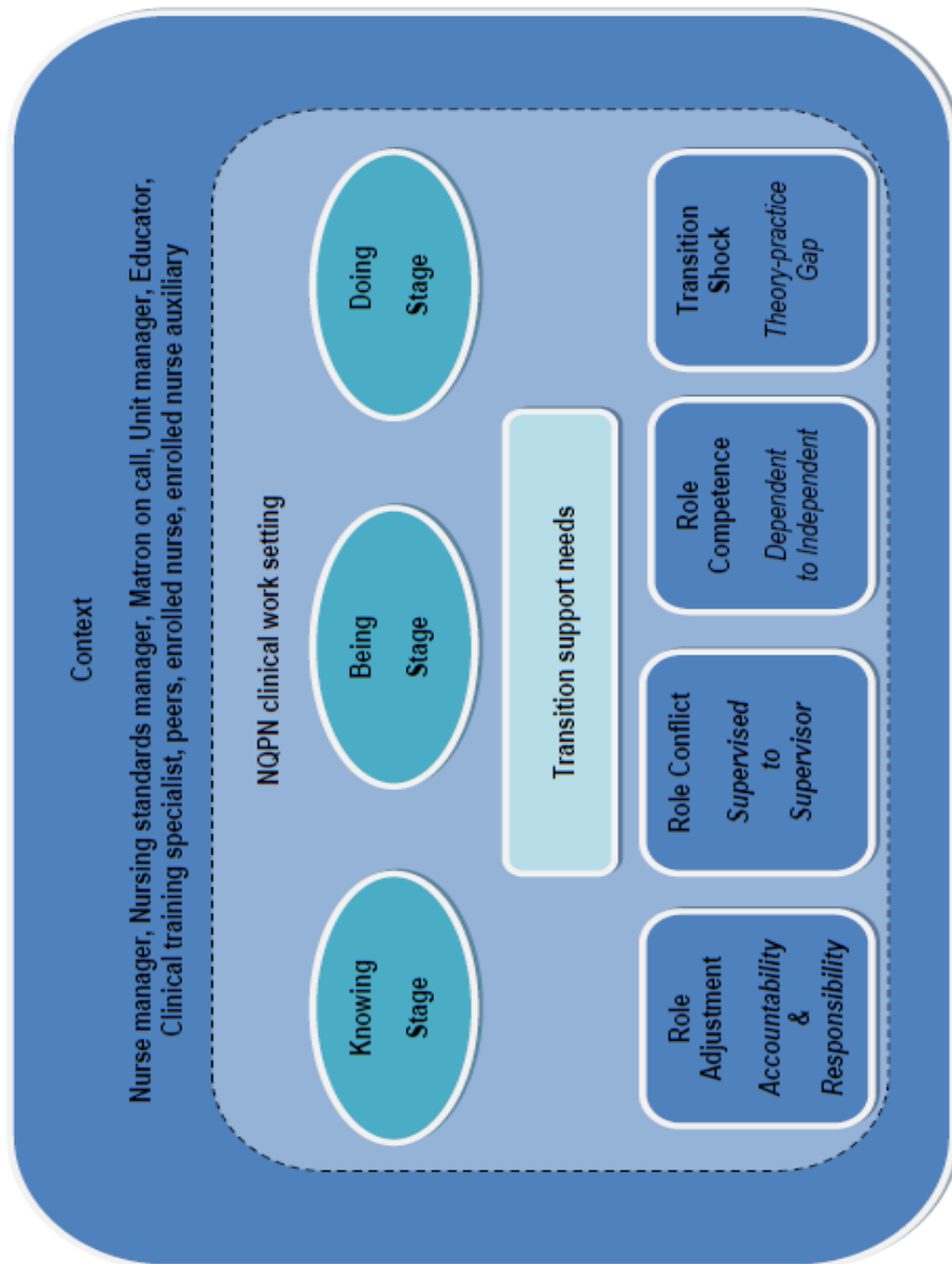
Figure 2.2 Preliminary conceptual framework   Adapted from Duchscher (2008:443)

2.4 SUMMARY

This chapter described the stages of transition theory NPNs experience during the transition period. The application of the stages of transition theory to the NQPNs' transition will be discussed in Chapter 4. The researcher illuminated the utilisation of concepts of the theory and the development of a preliminary conceptual framework.

Chapter 3 discusses the research design and methodology in detail.

CHAPTER 3
RESEARCH METHODOLOGY

"Every path to a new understanding

begins in confusion."

-Mason Cooley-

3.1 INTRODUCTION

In Chapter 2 an in-depth discussion was provided on the theoretical underpinning of this study. Chapter 3 discusses the case study methodology used to explore the transition support needs of NQPNs that upgraded from ENs during the transition period in private hospitals in Mpumalanga Province. The design, the context of the study, data collection and data analysis of this study will be discussed in this chapter.

3.2 RESEARCH DESIGN

The research design is considered the logical sequence or plan that connects empirical data to a study`s initial research questions and to its conclusion (Yin 2014:28). A case study is an empirical inquiry that looks in-depth at an existing phenomenon within real world context when the limitations between the phenomenon and the context may not be apparent (Yin 2014:16). A case study investigation deals with (1) precise distinguishing circumstances in which there will be numerous variables of interest compared to data points, (2) relies on multiple sources of evidence, with data needing convergence in a triangulation manner and as another result and (3) benefits from prior development of theoretical propositions, if any, to guide data collection and analysis (Yin 2014:18).

Three conditions lead the numerous variables in any case study: making an in-depth investigation, studying circumstances over time, and altering contextual conditions (Yin 2014:212). In-depth semi-structured interviews were conducted with ten NQPNs considering their verbalised transitions support needs during their transition period. The NQPNs contextual conditions were similar in terms of their work and peer environment in the selected two private hospitals in Mpumalanga Province.

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3.2.1 Holistic multiple case study design

A case study is considered holistic when the researcher examines the global nature of the phenomenon, which in this study was the transition support needs of NQPNs in private hospitals (Yin 2014:62). A holistic multiple-case study research design was utilised in this study. A multiple-case study has specific benefits and shortcomings in comparison to single-case designs. The reason for a multiple-case design is that the evidence from multiple cases is often considered more convincing and vigorous (Herriott & Firestone, 1983 cited in Yin 2014:57). The curious and acute cases, critical cases, and radical cases are mostly only single cases. Conducting a multiple-case study may be expensive and time consuming and beyond the means of one researcher. It is vital that the researcher deem multiple cases as one would consider multiple experiments that are to follow a replication design. Cases need to be selected carefully to ensure that they foresee replicating results or foresee contrasting results but for anticipatable rationales (Yin 2014:57).
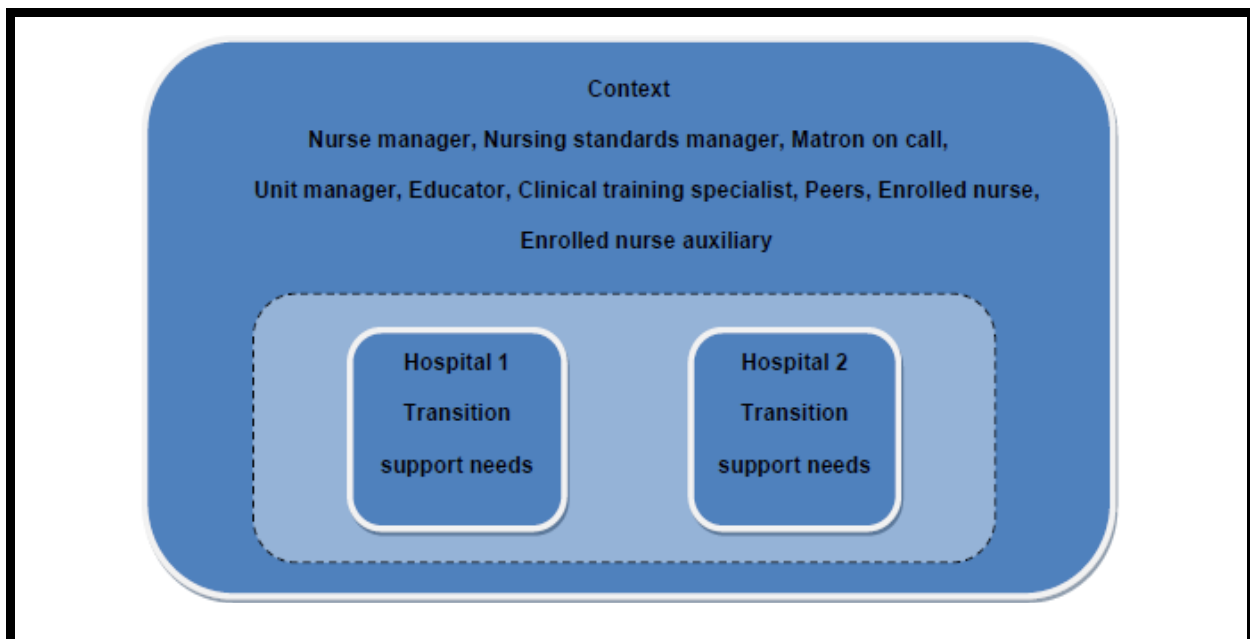
Figure 3.1 Holistic multiple case study research design   Adapted from Yin (2014:50)

3.2.1.1 Concerns of case study design

Since the case study has been viewed as not the ideal choice of inquiry, researchers have raised some concerns regarding the case study design (Yin 2014:19). The rigour of the case study design has been questioned because frequently case study researchers do not follow systematic procedures and get distracted by vague data that affect the direction of the

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findings and conclusions. There is also the possibility that the researcher may confuse case study research with case studies used in teaching that can be adapted to highlight certain points. This is not an acceptable practice in case study research. Case studies in general are considered time consuming and require hard work but Yin (2014:21) has proven the opposite. The belief that case study research has a comparative advantage to other research methods is embedded in the inability of case study research to measure effectiveness and ability to investigate 'how' and 'why' questions. The aim of this study was to explore and describe *how* NQPNs who upgraded from ENs described their transition support needs during the transition period in private hospitals in Mpumalanga Province.

3.2.1.2 Components of case study design

A case study research design consists of five components, namely case study questions; propositions, if any; unit of analysis; the logic linking data to the proposition, and the criteria for interpreting findings (Yin 2014:29). According to Yin (2014:29), the *how* case study question, 'How do NQPNs who upgraded from ENs describe their transition support needs during the transition period in private hospitals in Mpumalanga Province?' is the most appropriate for case study research. In this study, there were no propositions to link to data because the study was exploratory and the aim to explore and describe how NQPNs who upgraded from ENs described their transition support needs during the transition period in private hospitals in Mpumalanga Province was linked to the data. The 'case' or unit of analysis is a data source (Yin 2014:31) and in this study was the transition support needs of NQPNs who work in two private hospitals in Mpumalanga Province. The NQPNs working in these private hospitals were a distinct group compared to other professional nurses as their educational preparation to become professional nurses was different from others who work in these private hospitals. The findings were interpreted by working through the data, utilising an inductive strategy. Useful concepts and themes were identified. Chapter 4 discusses the interpretation of the findings.

3.2.1.3 Binding of case studies

Binding indicates what the case will not be; in other words, what will and will not be studied in the scope of the research study (Yin 2014:547). Binding refers to the small unit of analysis, namely the transition support needs of NQPNs, to be included in the group distinguished from the people and time boundaries outside the context of the case study (Yin 2014:33). Furthermore, placing boundaries on a case can prevent the researcher answering

a question that is too broad or a topic that has too many objectives for one study (Yin 2003 and Stake 1995 cited in Baxter & Jack 2008:546). A case can be bound by (a) time and place (Creswell, 2003); (b) time and activity (Stake), and (c) definition and context (Miles & Huberman, 1994 cited in Baxter & Jack 2008:547). Binding the case study will ensure it remains within reasonable scope (Baxter & Jack 2008:547) and therefore determines the scope of the data that need to be collected (Yin 2014:33-34). The placement of boundaries in a qualitative case study design is comparable to the inclusion and exclusion criteria for sample selection in a quantitative study, but also includes the breadth and depth of the study (Baxter & Jack 2008:547). The transition support needs of NQPNs formed the immediate topic of the case and were distinguished from those outside of the case, such as clinical training specialists, head nurses, nursing staff and unit managers who had experience of working with the NQPNs as well as policies and procedures in the hospitals associated with NPNs. The study was bound to the transition support needs of 60 NQPNs; ENs that upgraded to professional nurses in 2012-2015 and were working in the selected hospitals as their first permanent NQPN position.

3.3 METHODS

Polit and Beck (2012:765) describe research methodology as the steps, procedures and strategies utilised for gathering and analysing data in a research study. The research methods in this study included site selection; participant recruitment, data collection and analysis, and maintenance of the quality of the case study design throughout the study.

3.3.1 Site selection

According to Creswell (2003:185), a purposefully selected site forms part of the role in the steps of data collection. The goal behind qualitative research is to select sites and participants that will assist the researcher in understanding the problem and research question. Miles and Huberman (1994) (cited in Creswell 2003:185) refer to four aspects of site and participants; (1) the setting, meaning the place where the research will take place, (2) the participants who will be interviewed, (3) what the participants will be observed or interviewed doing, and (4) the developing nature of events undertaken by participants within the setting. The setting or site refers to the place where the study took place. The site chosen was two private hospitals in the Mpumalanga Province that have 235 (hospital 2) and 240 beds (hospital 1).

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Between the two hospitals 15-20 ENs are upgraded to NQPNs on an annual basis. The researcher works in this setting and therefore has an interest in the site.

3.3.2 Selection criteria

The aim of the study should be considered when deciding on who should be invited (Yin 2014:95) therefore participants meeting the selection criteria were recruited for the study to access rich information (Yin 2014:95). According to Polit and Beck (2012:338), researchers must consider the exact criteria on which to classify individuals as members of the population. Thus the researcher should specify characteristics that define the population through eligibility criteria (Polit & Beck 2012:338). To be included in this study, the participants had to

- Be newly-qualified professional nurses (NQPNs), both male and female, working in the two hospitals, registered with the SANC.
- Have graduated from the R683 bridging programme from 2012-2015.
- Be employed in a fulltime professional nurse position at the hospitals and available during the period of data collection.
- Be employed in this position for the first time and have a minimum of six months' experience.
- Consent to voluntarily participate in the study.

Exclusion criteria refer to specific characteristics that are not relevant to the study to be undertaken (Polit & Beck 2012:338). For this study, then, all newly-qualified professional nurses who did not graduate from the R683 bridging programme (SANC 1989); were not employed in a fulltime professional nurse position at the two hospitals; were not in this position as a first full-time professional nurse, and had less than six months' and more than 4 years'experience working as a professional nurse were excluded from the study.

3.3.3 Participant recruitment

The researcher made appointments with the hospital managers of the sites and explained the topic and aim of the study. Approval was obtained from the hospital managers (see Annexure A2 & A3) and submitted for final ethical approval from the University of Pretoria. After final ethical approval (see Annexure A) was communicated to the hospitals, the nurse managers of the two hospitals informed the unit managers of the research to be done at the hospitals. Appointments were made with the clinical training specialists of both the hospitals

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for meeting and introduction to the unit managers and recruitment of possible participants. Participant consent and information leaflets (see Annexure B) were handed out in person to 30 NQPNs that met the criteria.

Arrangements regarding the location, date, time and duration of the interviews were made with five eligible NQPNs who indicated immediately that they were willing to participate in the study. NQPNs that needed time to consider participation in the study were asked to contact the researcher at the cell phone number provided in the participant information leaflet. Five participants contacted the researcher via sms indicating their interest in participating in the study. The researcher contacted these participants via sms and finalised interview arrangements. NQPNs, seven from hospital 1 and three from hospital 2, were interviewed in either the clinical training specialists' or unit managers' offices. In-depth semi-structured interviews were conducted until data saturation was achieved through repetition of themes. Part of the preparation phase was the closing choice of cases that would be the focal point of this case study research. Data saturation was achieved after 10 in-depth semi-structured interviews even though 30 NQPNs met the selection criteria and received participant consent and information leaflets. Table 3.1 provides the participants' demographic data.

Table 3.1 Participants' demographic data

Nr	Participant	Gender	Age	EN years experience	Ward EN worked in	Year qualified as a NQPN	NQPN Years experience	Ward placed as NQPN
					Demographic data			
1	A	Female	29	6 months	Specialised unit	2012	4 years	Specialised unit
2	B	Female	41	6 months	Rotated	2015	13 months	Specialised unit
3	C	Female	32	3 years	Surgical	2014	2 years	Mixed
4	D	Female	30	14 months	Medical	2015	13 months	Medical
5	E	Female	46	10 years	Surgical	2014	2 years	Surgical
6	F	Female	35	1 year	Medical	2014	2 years	Mixed
7	G	Female	28	2 years	Surgical	2015	13 months	Surgical
8	H	Female	30	2 years	Specialised unit	2013	3 years	Surgical
9	I	Female	45	5 years	Medical	2014	2 years	Mixed
10	J	Female	35	5 years	Specialised unit	2014	2 years	Specialised unit

Source: NQPN participants

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3.3.4 Preparation for data collection

According to Yin (2014:71), good preparation for data collection begins with (1) the desired skill and values of the researcher of the study; (2) developing a protocol for the study including an interview guide; (3) screening participant cases; (4) preparation and training for the case study, and (5) conducting a pilot case study.

3.3.4.1 Researcher's desired skills and values

Asking good questions and probing, listening, paraphrasing and adaptability are desired skills and values required by the researcher of a study to conduct an interview (Yin 2014:72).

- *Asking good questions and probing*

According to Yin (2014:72), the researcher should have the ability to ask good questions and interpret the answers justly. Case study research requires an inquiring mind during data collection. The desired result is to generate a rich discourse with the data and activities that include it. The researcher should have a firm grasp of the issues being studied and must be able to interpret the information as it is being collected and to know instantly if this source of information may lead to more additional evidence (Yin 2014:76). The interview guide (see Annexure B) developed for the in-depth semi-structured interviews consisted of ten questions designed to obtain rich data on the participants' transition support needs. The purpose of probing is to extract more useful or detailed information from the participant in an interview (Polit & Beck, 2012:762). In this study, probing was applied with regard to what participants verbalised in the interviews about their transition support needs in order to gain clarity and meaning. An example of a probing question used during the study was: " *What do you mean when you say ...?"*

- *Listening*

For case studies, *listening* means receiving information through various methods like making good observations or sensing the underlying. Being a good listener means being able to incorporate a large amount of information without bias of preconceived ideas and concepts (Yin 2014:73). When a participant narrates an incident, a good listener hears the literal words used by the participant, detects the atmosphere and emotions, understands the context from which the participant is perceiving the world, and deduces the meaning intended by the participant (Yin 2014:74). In this study, the researcher listened attentively to what the participants said and used body language, such as nodding her head to show interest and using responses like "Okay" and "Please tell me".

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- *Paraphrasing*

Paraphrasing is a process of clearly expressing participants' ideas in the researcher's own words and connecting the meaning of these words in the study (Burns & Grove 2005:105). During paraphrasing, the researcher clustered information obtained and assigned meanings.

- *Adaptability*

Few case studies will conclude exactly as planned (Yin 2014:74). It is to be expected that the researcher of the case study will have to make small to key alterations ranging from following an unexpected lead to the need to identify a new case from the study. The researcher must consider the original aim of the case study and be prepared to adapt plans and processes in unexpected occurrences so that newly encountered situations can be seen as prospects and not threats (Yin 2014:73). The researcher needs to be able to balance adaptability with rigour (Yin 2014:75). The researcher adapted by elaborating and explaining the interview questions since some participants had difficulty understanding some of the terminology used.

3.3.4.2 Development of interview guide

The essence of a protocol is a set of essential questions reflecting the researcher's basic line of enquiry and a reminder of the data that needs to be collected and why (Yin 2014:89). In semi-structured interviews the researcher develops an interview guide which is a list of questions or areas to be covered with each participant (Polit & Beck 2012:537). The researcher's function is to encourage participants to talk unreservedly about all topics in the interview guide and give accounts in their own words. This method warrants the researcher obtaining all the data needed and allows participants to give many illustrations and explanations. The interview guide may include suggestions for probes to obtain more detailed information. Questions should allow participants a chance to present rich, detailed information about the phenomenon under study (Polit & Beck 2012:537).

The researcher prepared the interview guide questions in a rational order, from general to specific. The researcher developed the questions for the interview guide in collaboration with the supervisors to assist the researcher in obtaining rich data on how the participants described and experienced their transition support needs during the transition period (see Annexure B). The main focus of the interview questions was the transition support needs of NQPNs therefore the literature review assisted the researcher determine which questions to include in the interview guide.

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The interview guide was pre-tested on one participant one month before the main study. The goal of the exercise was for the researcher to familiarise herself with the equipment and to identify areas that might need elaboration and clarification. A participant that met the criteria for the study was asked if she would be willing to participate. The participant information leaflet was explained to her and informed consent to participate obtained. During the pilot study, the research questions and some probing questions were asked. The participant understood all the questions well. The interview lasted 20 minutes and indicated that more probing questions were needed to obtain more and richer data. The participant who participated in the pilot study was excluded from the main study.

3.3.5 Collecting case study evidence

Case studies are about phenomena within their real-world context (Yin 2014:88). This has significant inferences for defining and designing a case study. For data collection this feature of case studies focuses on the significance of properly designed field procedures. Data is collected from individuals and organisations in their everyday situations. In case studies, the researcher needs to learn to integrate real-world events with the needs of the data-collection plan (Yin 2014:88).

A case study protocol, the research proposal, guided data collection (Yin 2014:84). According to data collection principles, case study evidence can be collected from multiple sources (Yin 2014:103). In this study, the researcher collected data through in-depth semi-structured interviews and field notes (Yin 2014:106). The participants were observed and field notes made during the interviews.

3.3.5.1 Principles of data collection

Using data collection resources in collaboration with the four principles of data collection could be advantageous in establishing construct validity and reliability of data (Yin 2014:120). The principles of data collection are: (1) use multiple sources of evidence, (2) create a case study data base, (3) maintain a chain of evidence, and (4) exercise care when using data from electronic sources.

- *Use of multiple sources of evidence*

A major strength of case study data collection is the opportunity to utilise various sources of evidence following a similar convergence which contributes to the accuracy, triangulation and overall quality of the case study research (Yin 2014:120). In case study, data from

multiple sources of evidence are converged in the analysis process instead of managed independently this contributes to the strength of the results. Each data source forms part of the bigger picture which is multiple ways of the whole but same phenomenon (Baxter & Jack 2008:554; Yin 2014:122).

By developing convergent evidence, data triangulation helps to strengthen the construct validity of the case study. In this study semi-structured interview and field notes were utilised as multiple sources of evidence to provide the researcher with an understanding of the transition support needs of NQPNs. The data obtained from the semi-structured interviews and field notes were converged in the analysis process as discussed in Chapter 4.

- ### *Create a case study data base*

This second principle refers to the way of organising and documenting the data gathered for case studies (Yin 2014:123). The benefit of using a database to achieve organisation is that raw data are accessible for individual examination. The reliability of the case study is increased as it allows the researcher to trace, organise and retrieve stored data sources like field notes, documents, descriptions, photographs, and audio files from the database (Baxter & Jack 2008:554). The field notes of the researcher of this study were the most general aspect of the data base which were the result of the in-depth semi-structured interviews (Yin 2014:124). These field notes were handwritten and scanned and stored in pdf format together with the downloaded audio files of the recorded interviews electronically.

- ### *Maintain a chain of evidence*

Maintaining the chain of evidence increases the reliability of the data in a case study. The principle is to allow an outside party to the study to follow the source of the evidence from the research question to the case study conclusions. The supervisors were able to follow the steps from research question to conclusion and vice versa which increases construct validity and the overall quality of the case study (Yin 2014:127).

- ### *Exercise care when using data from electronic sources*

The sources of evidence can all be represented by electronic sources. Electronic sources include chat rooms, social media communications, retrieving a document on line, conducting an online interview or observing an event remotely. Great caution should be exercised when using electronic sources. The amount of electronic information can be daunting and time

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consuming in terms of cross-reference checking and authenticity (Yin 2014:129). In this study the researcher used electronic resources; internet, scientific articles from verified academic data bases and SANC regulations.

3.3.6 Data-collection methods

The following data collection methods were utilised in this study; (1) semi-structured interviews and (2) field notes.

3.3.6.1 Interviews

An interview is one of the most important sources of case study evidence. Interviews resemble guided conversations rather than structured queries. Researchers pursue a consistent line of inquiry with a fluid stream of questions (Yin 2014:110). This type of interview has alternatively been called in-depth interviews (Weiss 1994:207 cited in Yin 2014:110). In this study in-depth semi-structured interviews were conducted as described in the interview phase in this chapter.

The interview as a qualitative self-report data-collection method involved three phases, namely the preparatory, interview and post-interview phase.

- ### *Preparatory phase*

Yin (2014:88) states that to interview participants requires meeting the participants' schedule and availability. The preparatory phase consisted of obtaining permission from relevant parties to conduct the study at the setting (see Annexure A2 & A3) and audio-recording the interviews. An interview guide, with ten questions, focusing on participants' describing their transition support needs, was designed. Participants may not always cooperate in sticking to the line of questions. Therefore careful planning with regard to the participants, the environment and questions to be asked are vital to conducting effective interviews (Yin 2014:88). This phase also required organisation of logistics; audio recorder, batteries, note book, identification cards as well as recruitment of participants with a participant information and consent letter with the researcher`s contact details (see Annexure B)(see Section 3.3.1). Polit and Beck (2008:399) assert that a quiet place that offers privacy and protection from interruption is needed. De Vos et al (2009:316) emphasise that interview sessions should be held in a comfortable, non-threatening setting and encourage participants to freely share information away from influence or pressure. The location for the interviews had to meet the needs of both the researcher and the participants. The researcher negotiated with the

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management of the hospitals to allocate an office or a boardroom that was free from interruption and noise, with sufficient light supply and adequate ventilation. This venue was easily accessible to the participants and the researcher.

- ***Interview phase***

Interviews are essential sources of case study evidence because most case studies are about human affairs or behaviour. Well-informed participants can provide important information regarding such affairs or behaviours (Yin 2014:113). Case study interviews require the researcher to function on two levels at the same time: fulfilling the line of enquiry according to the case study proposal while simultaneously putting forth friendly and non-threatening questions in an unbiased manner (Yin 2014:110).

A semi-structured interview is an interview in which the researcher has a list of areas to cover rather than a specific set of enquiries (Polit & Beck 2012:742). Researchers mostly want to ensure that a specific set of areas is covered in their qualitative interviews. Researchers are clear on what they want to ask but cannot foresee what the answer will be. The participants' role in the process is unstructured compared to the fairly structured role of the researcher. Ten semi-structured, face-to-face, individual in-depth semi-structured interviews were conducted using an interview guide, communication techniques and taking of field notes over a four-week period until data saturation was reached through repetition of themes. The interview guide used in the interviews consisted of ten question focused on the participants' transition support needs. Informed consent was obtained from the participants. The duration of the in-depth semi-structured interviews was approximately 45 minutes to an hour. Yin (2014:110) states that the use of recording devices is a matter of personal choice. Audio recording provides a more accurate interpretation of an interview that taking notes (Yin 2014:110). A battery-operated tape-recorder was used to record information. The researcher obtained permission to use the audio recorder from the participants before the interviews. The recordings were only used for transcription purposes and did not replace listening during the interview. The researcher kept the audio recorder out of sight to prevent distracting participants during the interview. The interviews were conducted at times convenient to the participants in a quiet, private room in the hospital. The researcher ensured that services were not disrupted by the in-depth semi-structured interviews through prior arrangement with the nurse manager and participants' unit managers.

- *Post-interview phase*

On completion of each in-depth semi-structured interview, the researcher summarised the main points of the discussion and confirmed with the participants the accuracy of information generated. The participants were informed that the information was confidential. The researcher thanked the participants for their valuable time spent in the interview session. The participants were also informed when the interview session was complete. None of the participants needed counselling therefore the researcher did not need to refer any participants for counselling and support. As soon as participants had left, the researcher summarised and reflected on the in-depth semi-structured interview.

3.3.6.2 Field notes

According to Yin (2014:114), observational evidence is in many cases valuable in providing additional information about the topic under study. One of the most general forms of record-keeping in participant observation is field notes. Field notes are more comprehensive, analytic, and interpretive than a mere record of events. Field notes represent the participant observer's effort to record, fuse and understand data. Participant observer field notes consist of a detailed account of what is happening in the field, aimed at thick descriptions which serve as data for analysis. Most field notes are written after an observational session was completed in the field. Descriptive field notes refer to objective descriptions of document analysis regarding observations and interviews; information about actions, dialogue, and context are recorded as completely and objectively as possible. Occasionally descriptive field notes are recorded handwritten on additional forms similar to interview guides or audio recorded or typed to ensure that the vital data is captured (Polit & Beck 2012:548). Field notes should be stored in such a way to ensure easy retrieval later. It is suggested that the field notes be organised according to the major topics outlined by the case study protocol.

Field notes were made during the interviews with the participants. In this study, the field notes included personal, observational and methodological notes (see Chapter 4 Section 4.5 for full discussion). The researcher was able to record her personal feelings of frustration, anger, sorrow, empathy and being emotionally touched by the participants' experiences during their transition period. Special attention was paid to the participants' reactions during the interviews, such as nervousness; excessive twitching and body movements; hesitation to answer questions; discomfort with certain questions; emotional reactions like laughing, crying, excessive talking, and preoccupation with certain aspects of the interview. The participants had specific verbal and non-verbal reactions regarding subcategories like

nursing hostility, being the shift leader, and professional nurse and emotional support (see Chapter 4 Section 4.5 for full discussion). The researcher had to adjust the questions during the semi-structured interviews to ensure participants clearly understood and kept focused on the topic. Field notes were taken and written in the margin of the interview guide directly after the interviews. The interview guide with field notes and relevant documentation field notes were scanned in PDF format and stored electronically for later retrieval.

3.4 ANALYSING CASE STUDY EVIDENCE

According to Yin (20014:133), the data analysis of case study evidence is one of the least developed facets of performing case studies. Therefore the researcher utilised content analysis, which is a research method that makes replicable and valid inferences from data to their context, to provide knowledge, new insights, a representation of facts and a practical guide to action (Krippendorff 1980). An inductive approach (Elo & Kyngäs 2008:109) was used for content analysis of verbatim transcripts and observations noted in the field notes. According to Elo and Kyngäs (2008:109), content analysis consists of three phases: preparation, organisation and report (see Figure 3.2).
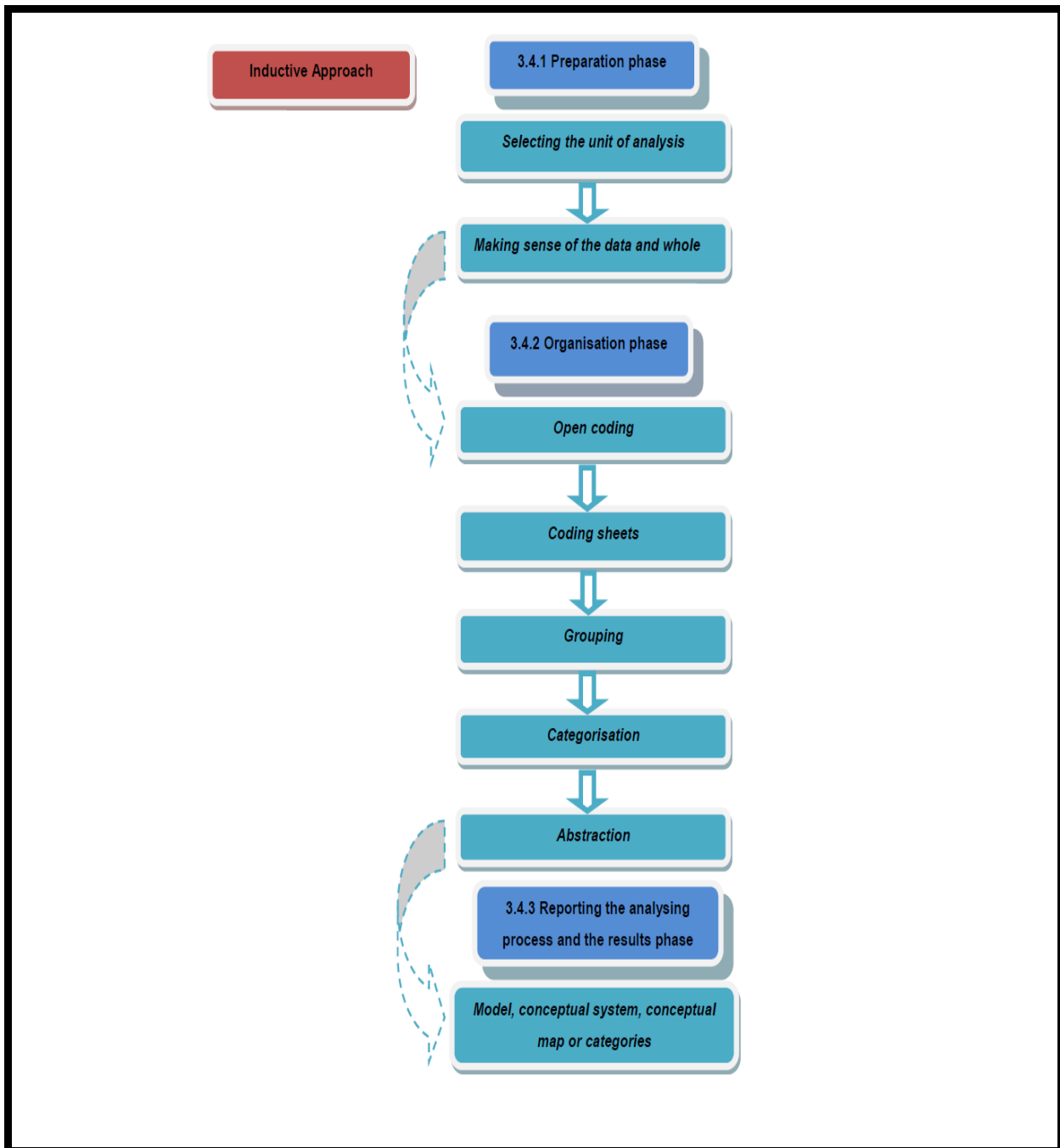
Figure 3.2 The content analysis process   Source: Elo and Kyngäs (2008:110)

3.4.1 Preparation phase

Even though content analysis consists of three phases, there are no guidelines for analysing data (Elo & Kyngäs 2008:109). The aim of the preparation phase is to become engrossed in the data, which is why the written material is read through numerous times (Burnard 1991, Polit & Beck 2004 cited in Elo & Kyngäs 2008:109). No insights or theories can be generated

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from the data without the researcher becoming completely familiar with them (Polit & Beck 2004). After 'making sense' of the data, analysis is conducted using an inductive approach (Kyngäs & Vanhanen 1999 cited in Elo & Kyngäs 2008:109). The process included transcribing interviews, scanning the material, making some notes during interviews. The main attribute of content analysis is that numerous words of text are categorised in smaller content categories (Weber 1990, Burnard 1996). A unit of data analysis was chosen (Guthrie, Yongvanich & Recceri 2004 cited in Elo & Kyngäs 2008:109) to extract significant statements, consisting of a word, sentences or theme which contains meaning (Polit & Beck 2012:562). Graneheim and Lundman (2004:106) point out that the most suitable unit of analysis is whole interviews or documents.

3.4.2 Organisation phase

Organisation is a process of thorough reading and interpretation of information (Elo & Kyngäs 2008:110). Verbatim transcripts were analysed by inductive content analysis and included playing the audio recordings several times. In this study the researcher read the entire text to obtain a sense of the whole and make memos of initial impressions. The researcher performed more careful, word-for-word reading, and highlighted significant statements that appeared to capture key concepts. Codes were attached to each statement and transferred to coding sheets. The codes were sorted into subcategories and abstracted into categories and were labelled and analysed for labels that appeared in several interviews. The labels were transformed into themes; a description of each theme was developed, to identify quotes that represented the themes to achieve abstraction. This iterative process occurred after each interview. In this study, the researcher used index cards to make themes out of the data gathered during the in-depth semi-structured interviews.

3.4.3 Reporting the analysing process and results phase

In a case study it is difficult to report the findings in a brief way, and therefore it is the researcher's responsibility to alter a difficult phenomenon into a plan that is readily understood by the reader. The objective of the report is to describe the study in such an all-inclusive manner as to facilitate readers' feeling as if they had been active participants in the research and can determine whether or not the study findings could be applied to their own situation. It is vital that the researcher depict the context within which the phenomenon

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occurs as well as the phenomenon itself. There is no one exact way to report a case study (Baxter & Jack 2008:555).

As the final phase of the interview data analysis, the researcher reported all the themes of all content areas in an integrated text (see Chapter 4).

3.4.4 Quality of data analysis

Irrespective of the analytic strategy chosen, the researcher needs to ensure that the data analysis of a study is of the highest quality. Four principles underlie all good social science research (Yin 1994a, 1994b:197, 199 cited in Yin 2014:168): (1) analysis attends to all evidence, (2) addresses all plausible rival interpretations, (3) addresses the most significant aspect of the case study, and (4) uses own prior expert knowledge in the case study.

3.4.4.2 Case study analysis addresses all plausible rival interpretations

If an outsider should have an alternative interpretation for one or more of the findings from the study, it should be considered as a plausible rival interpretation (Yin 2014:168). However, in this study no plausible rival interpretations were identified.

3.4.4.3 Case study analysis addresses most significant aspect of the case study

In single and multiple case studies researchers should be able to demonstrate that the analysis is directed at the most important issue to prevent possible contradicting findings diverting attention from the main issue (Yin 2014:168). The most significant aspect of the case study remained the participants' transition support needs.

3.4.4.4 Utilisation of the researcher's own prior expert knowledge in the case study

The expectation is for the researcher of the study to show an understanding of the current thinking and discourse of the topic under study (Yin 2014:168). The researcher kept abreast of the latest literature on the topic of the transition support of NQPNs throughout the study.

3.5 QUALITY OF CASE STUDY DESIGN

Case study research can comprise and may be limited to quantitative evidence (Yin 2014:19). In a case study, the use of qualitative data should be based on a weaker measure than those used in collecting quantitative data (Yin 2014:218). To ensure both the quality of the design and the trustworthiness of the data, the researcher felt that trustworthiness would

be more appropriate to explain the quality of the study. The researcher used Guba and Lincoln`s framework (see Sections 3.5.1).

3.5.1 Trustworthiness of case study design

The argument that the inquiry's findings are worth paying attention to is supported by trustworthiness in a qualitative inquiry and determines accuracy and quality in qualitative research. According to Guba and Lincoln (1985 cited in Polit & Beck 2012:587), trustworthiness is assessed through five variables: credibility, transferability, dependability, confirmability and authenticity.

3.5.1.1 Credibility

Credibility indicates the truthfulness of the findings as reviewed by participants and others within the discipline. The researcher ensured credibility of the study through prolonged engagement in the field, member checking, triangulation and peer debriefing (Guba & Lincoln, 1985 cited in Polit & Beck, 2012:589). The researcher conducted member checking and interviewing analysis with the participants to verify and clarify the truth of the matter and the researcher`s interpretation of the participants' transition support needs captured. Assessment of the data was used to allow experts to scrutinise the correctness of the methodology used to obtain and analyse data (Guba & Lincoln, 1985 cited in Polit & Beck 2012:584). To establish triangulation, multiple data sources and data types; ten semi-structured interviews and field notes contributed to construct validity of the case study (Yin 2014:121). The study supervisors are experienced researchers and were involved in all stages of the research. Prior to data collection, they gave feedback on the topic guides; during data collection, observational field notes were sent to the supervisors and, following data collection, they independently analysed a sample of transcripts.

3.5.1.2 Dependability

Dependability refers to the extent to which the findings are applicable if repeated in a different situation with similar characteristics to those of the original research (Polit & Beck 2012:175; Guba & Lincoln, 1985 cited in Polit & Beck, 2012:585). At the analysis stage, the consistency of the findings was promoted by having the supervisors and a co-coder code a set of data. During a meeting with the researcher and supervisors consensus was reached on the emerging codes and categories. The researcher implemented a process of double coding where a set of data was coded and then after a period the researcher returned and coded the same data set and compared the results (Krefting 1991:218). Should the researcher`s findings be consistent within the participants' interview data it would indicate

the dependability of the findings. The consistency and dependability of the findings are discussed in Chapter 4.

3.5.1.3 Confirmability

Confirmability refers to the degree to which the study results are derived from characteristics of participants and the study context, and not from the researcher's bias (Polit & Beck 2012:175). Additionally, this case study adopted a 'fair dealing' or 'fair go' technique by including different perspectives from ten participants rather than focusing on one viewpoint from one participant assuming that the accounts would represent the truth. Furthermore, to exclude researcher bias, reflexivity was adopted through every stage of the study. Reflexivity is an approach used in qualitative research referring to the researcher's awareness of the researcher of his/her role in the research and how this influences the research participants, process and findings (Yin 2014:112). In this study, the researcher was explicit about the study aim to participants.

3.5.1.4 Transferability

Transferability refers to the extent to which the findings are both generalizable and applicable to other settings (Polit & Beck 2012:585). Once the generalisability of the study is authenticated, the study can lay claim to valid and indisputable results. In this case study, rich thick description of the case (NQPN transition support needs), methods of data collection and analysis was provided to help make a decision about transferability of findings to another setting (Polit & Beck 2012:585). Even though this was a qualitative study and the goal was not to generalise but to gain a deeper understanding of the phenomenon understudy (Polit & Beck 2012:738), a theory and a 'how' research question was used which contributed to analytical generalisation (Yin 2014:40).

3.5.1.5 Authenticity

Polit and Beck (2012:585) refer to authenticity as the extent which researchers fairly and truthfully show a range of realities. A text has authenticity if it invites readers into vivid experiences of the lives being depicted and enables readers to develop insight into the issues being depicted (Polit & Beck 2012:585). The researcher conducted in-depth semi-structured interviews during data collection and used audio recordings in order to enhance the exactness and authenticity of data.

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3.6 ETHICAL CONSIDERATIONS

In the research context, ethics focuses on recognising socially accepted and sanctioned professional and legal obligations. A researcher has the responsibility to ensure the research is conducted in an ethical way to prevent weakening the scientific process and possible negative repercussions (Brink et al 2006:30) since most research involves human beings or animals (Yin 2014:77).

When research involves human subjects, special ethical considerations apply to assist the researcher in protecting the participants in case studies (Yin 2014:78). According to Yin (2014:78), protection involves conducting a case study with care and sensitivity by (1) obtaining informed consent from all participants involved in the study; (2) protecting the participants from any harm and deception; (3) protecting the participants' privacy and confidentiality; (4) protecting vulnerable groups like children, and (5) selecting participants equitably to ensure fair inclusion and exclusion of groups of people (National Research Council 2003:23-28 cited in Yin 2014:78).

3.6.1 Obtain informed consent from all participants involved in the study

The participants' right to informed consent and withdrawal were protected. The researcher certified verbally and in writing that all the participants understood that their participation was voluntary (see Annexure B). The participants were assured they could withdraw from the study at any time and could so without stating a reason or explanation (see Annexure B).

3.6.2 Protection of participants from any harm and deception

The participants were protected from unnecessary risks of harm, discomfort or deception. The researcher informed the participants of the risks and benefits involved in this study (see Annexure B). No physical, psychological, financial or social harm was experienced by participants. The researcher obtained permission and made arrangements with the unit managers in person for the participants to participate during on-duty time at the specific hospital. Risks of discomfort to participants were limited by staying within the set time frame of the in-depth semi-structured interview.

3.6.3 Protection of participants' privacy and confidentiality

The researcher ensured participants' strict privacy and confidentiality. The study was not more intrusive than required. The in-depth semi-structured interview questions focused only on the topic of the participants' transition and the information they were willing to divulge

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regarding transition support needs. The participants' privacy was respected and protected at all times during the study as well as afterwards. No information was shared about the participants without their consent. No access to participants' information by unauthorised people and use in further studies was allowed.

The participants' identities were protected by referring to them as Participant A, B etc in transcriptions (see Annexure C). Raw data and reports did not reveal the participants' identity, and the hospital and colleagues were referred to as hospital 1 and 2, and Sister X, Y & Z (see Annexure C). The participants gave permission for the researcher to use direct quotes from the in-depth semi-structured interviews. The participants were informed that the information obtained from the in-depth semi-structured interviews would be used to assist the transition support needs of future NQPNs (see Annexure B) and the use of the audio recorder was to provide accurate information to the researcher only and not to any unauthorised officials (see Annexure B). The recordings were not made available to any other parties except the researcher. Only the transcriptions were made available to the supervisors and co-coder (see Annexure D).

3.6.4 Protection of vulnerable groups

All the participants were of consenting age and therefore had the capacity to make their own decision to participate or not. The youngest participant was 28 years of age (see Table 3.1). NQPNs in South Africa are trained in private and public hospitals and therefore are not isolated minority groups.

3.6.5 Equitable selection of participants

Participants were selected equitably to ensure fair inclusion and exclusion of groups of people. The participants were selected on inclusion criteria (see Section 3.3.2). No participants were excluded because of age, race, culture and gender.

3.7 LIMITATIONS

The study was planned and conducted to determine the transition support needs of NQPNs that upgrade from ENs in private hospitals in Mpumalanga Province. The participants were selected from two selected private hospitals only. The researcher only conducted ten semi-structured interviews due to the limited number of NQPNs fitting the criteria still working in the setting. Therefore the small sample did not represent all NQPNs.

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3.8 SUMMARY

This chapter described the research design and methods used in the study in detail. The researcher selected a qualitative approach and collected data by means of in-depth semi-structured interviews. The data focused on the transition support needs of NQPNs working in private hospitals in Mpumalanga Province.

Chapter 4 discusses the research findings and the literature control.

CHAPTER 4
FINDINGS AND DISCUSSIONS

"However beautiful the strategy,
you should occasionally look at the results."

-Winston Churchill-

4.1 INTRODUCTION

Chapter 3 discussed the research design and methodology in detail. This chapter presents the data analysis and interpretation, and the findings. The study explored and described the transition support needs of NQPNs who upgraded from ENs in private hospitals in Mpumalanga Province. After the data analysis and interpretation the researcher relates the findings to the literature reviewed. Subsequently, the interpretations will be controlled with relevant literature.

4.2 DATA ANALYSIS PHASES

The researcher undertook content analysis that made replicable and valid inferences from the data to their context, which provided knowledge, new insights and a representation of facts. The researcher used Elo and Kyngäs's (2008:109) inductive approach for content analysis of the transcribed interviews and field notes. The preparation, organisation and report phases were followed.

During the preparation phase, the researcher became engrossed in the data, read through the written material numerous times and made sense of it as a whole. A unit of data analysis was chosen and significant statements were extracted; consisting of meaningful words, sentences or themes.

In the organisation phase, the data was further organised through open coding, creating categories and abstraction. The researcher performed careful, word-by-word readings, and highlighted significant statements that captured key concepts. Codes were attached to each statement and transferred to coding sheets (index cards) and sorted into subcategories and

abstracted into categories and then labelled. Labels were transformed into themes; each theme was described and quotes were identified that represented the themes to achieve abstraction. This process occurred after each interview. As the final phase of the data analysis, the researcher focused on the aim of the study and compared and weighed the findings against existing literature in order to position the new data in pre-existing data.

4.3 FINDINGS: THEMES, CATEGORIES AND SUBCATEGORIES

Data was collected in in-depth semi-structured interviews, which commenced in June 2016 and were completed in July 2016 with each lasting approximately 40-50 minutes. During the data analysis three main themes were identified, namely transition support challenges, transition support needs, and facilitation of transition support of NQPNs. The themes are discussed in Sections 4.3 to 4.5. The themes have categories and subcategories that assist with presenting the findings (see Table 4.1). The themes, categories and subcategories are discussed with representative quotes from participants and literature to demonstrate the contribution of this study to the existing body of knowledge for each theme, category and sub-category.

Table 4.1 Summary of subcategories, categories and themes

Subcategory	Category	Theme
a. Professional insecurity b. Theory-practice gap c. Professional socialisation	1. Role adjustment difficulties	Theme 1 Transition support challenges
a. Role competence b. Being the shift leader and the professional nurse	2. Role expectations	
a. Incivility b. Powerlessness c. No sense of belonging	3. Emotional strain	
a. Availability of support b. Emotional support	4. Limited support	

Subcategory	Category	Theme
a. Availability and accessibility of guidance	1. Guidance from the unit manager	Theme 2 Transition support Needs
b. Regular feedback		
a. Orientation	2. Support from an experienced professional nurse	
b. Buddy system		
a. Introduction to multi disciplinary team	3. Acknowledgement of NQPN status	
b. Opportunity to prove professional nurse competence		
a. Developing assertiveness	1. Continuous professional development	Theme 3 Facilitation of transition support
b. Managerial and administrative tasks		
a. Mentoring of NQPN	2. Mentorship programme	

4.4 THEME 1: TRANSITION SUPPORT CHALLENGES

During the transition period from EN to NQPN, the respondents experienced various challenges that contributed to them having specific needs pertaining to support during the transition period. The first theme identified was transition support challenges, which had four categories with various subcategories.

4.4.1 Category 1: Role adjustment difficulties

From the participants' responses it was evident that NQPNs experienced difficulties in role adjustment due to the challenges they experience during their transition period in the clinical work setting. Professional insecurity, theory-practice gap and professional socialisation difficulties were identified as subcategories.

4.4.1.1 Professional insecurity

The participants were all transparent about the unexpected hardship and difficulties experienced as NQPNs and indicated that this resulted in professional insecurity during the transition period. A participant (P10) remarked:

> *Being a sister is really hard. It's hard, it's not like easy.*

The participants also struggled to adapt from being supervised to becoming the supervisor as indicated by participant (6):

> *I was always used to reporting to someone [professional nurses] but now everything was being reported to me [NQPN].*

Retrospectively, after the transition period, seven participants indicated that they experienced professional insecurity regarding the magnitude and amount of responsibility and accountability an NQPN had as a professional nurse. Several participants agreed that they felt more insecure when faced with *"the challenges of adjusting to different personalities [nursing staff] in the unit and how to deal with different personalities"*.

Only one participant (P4) remarked on gaining professional confidence on a daily basis:

> *The confidence is something you [NQPN] gain day by day with the challenges that you get and experience and then you grow professional confidence.*

Participants also reported struggling with decision making and assertiveness, which aggravated their professional insecurity:

> *Why are they giving me [NQPN] so much responsibility? Now it is me who has to make this decision.*(P10)

> *I [NQPN] am not very assertive with my staff. I struggle to give orders and to delegate [to nursing staff].*(P1)

Furthermore, delegation and allocation of nursing staff also presented a challenge to the inexperienced participants:

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When you are a leader you must allocate your staff. So my problem was the allocation…I needed to learn at times that you had to look at the ward, how busy the ward was and the staff, and then allocate according to the ward.(P3)

Especially with delegation, because I[NQPN] was not used to giving orders [to nursing staff].(P6)

Smith (2014:89) found that NQPNs were professionally insecure in the beginning of the transition period but professional confidence grew with time, experience gained as a PN, training, and opportunities to observe the skills of more senior professional nurses in the ward. The professional insecurity level of NQPNs was supported by their own perceptions of their competency, knowledge, communication skills, expectations, and whether NQPNs view themselves as competent professional nurses or not (Smith 2014:89). Besides role adjustment, the NQPN role in the current study brought new challenges, responsibilities and uncertainties to the participants' lives which provoked anxiety and increased their stress during the transition period. Sources of stress for NQPNs included, but were not limited to, feeling unprepared and overwhelmed causing professional insecurity regarding the PN role at the beginning of placement.

Houghton (2014:2372) describes professional insecurity as a difficult multi-faceted concept confirmed by inefficiency which the current study also found had a negative effect on NQPNs' socialisation and inclusion in the nursing team. In contrast, some of the participants felt professionally confident from the beginning of their transition period. This concurred with Shipman's (2014:117) finding that some NQPNs did feel confident when transitioning to the professional nurse role, making decisions, and networking with colleagues.

The reality of professional accountability and responsibility had a significant effect on the participants' transition experience. Increasing accountability and changes in their scope of practice were issues identified as particularly challenging. This finding was consistent with Govender, Brysiewicz and Bengu's (2015:8) study in KwaZulu-Natal in which the need for accountability and responsibility was overwhelming. NQPNs experienced uncertainty about their coping capabilities, which intensified their stress levels and made them doubt the worthiness of their qualification considering the increased litigation in nursing care (Ndaba & Nkosi

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2015:1155). In Australia, Phillips, Esterman and Kenny (2015:118) found that NQPNs experienced work-related stress, multiple demands and tasks, and concern over workload, lack of professional nurses, and complex nursing care which was a major cause of frustration. Hezaveh, Rafii, Khosravi and Seyedfatemi (2014:205) found that new clinical nurses questioned their coping capabilities when there was not enough staff; they were in charge of a shift on a weekend; they commenced night shift, and when there was inappropriate allocation of staff. Moreover, NQPNs lacked the required competency in areas of performing and managing nursing and managerial tasks, which caused them to feel professionally insecure and unprepared. However, the NQPNs improved these skills with experience and time (Hezaveh, Rafii & Seyedfatemi 2014:219).

Allocation, prioritising, delegation, leading and managing nursing care were difficult for NQPNs who lacked experience in the specific tasks and prioritisation of work (Freeling & Parker 2015:e44; Blevins & Millen 2016:195). Prioritising, delegating, leading and managing nursing care were challenging for NQPNs who were inexperienced in prioritisation and delegation of work (Ekstrom & Idvall 2015:82; Shipman 2014:126). In this study, the participants as students did not have the opportunity to learn how to delegate nursing staff and their inexperience in these skills contributed to their feelings of professional insecurity. These findings indicated the need for NQPNs to frequently realign their thinking to deal with altering situations by refining skills such as adjustment, prioritising, and anticipatory planning. Smith (2014:89) emphasises that for NQPNs to learn how to prioritise requires starting a shift and asking questions about the acuity levels and needs of the patients and focusing on where priorities should be placed.

The participants stated that they were expected to lead others despite their inability to lead themselves. The responsibilities and the questioned leadership mandated due to lack of exposure acting in a leadership role in this study concurred with Mellor and Greenhill's (2014:55) findings. The findings of the current study supported Freeling and Parker (2015:e44) who found that NQPNs needed to be competent leaders and supervisors. However, many NQPNs lacked practical experience in nursing patients, and needed to learn ward management and staff management skills. Coordinating, supervising and managing the nursing team's work were challenging without previous leadership experience. Qualifications and professional nursing skills supported acceptance as a shift leader, but this competence was built on experience, which NQPNs lacked. The NQPN's position as a leader of nursing care was

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questioned and NQPNs were not considered the obvious team leaders (Ekstrom & Idvall 2015:80; Smith 2014:292). Similarly, the participants in this study found that working with a nursing team was challenging since it required new learning about workloads, leading, delegating tasks and trusting nursing staff in the ward.

Like the nurses in Ekstrom and Idvall's (2015:80) study in Sweden, the participants in this study felt challenged by managing nursing care and multi-tasking in the PN role. The participants felt unprepared and overwhelmed when asked to multi-task, with the focus on efficiency, as well as having to assume major responsibilities in this study. Although the participants had a general education in nursing, they were too inexperienced to be familiar with all situations in nursing. Consequently, because of their inexperience, the participants found these situations stressful and felt inadequate and insecure to carry out the dutiesfor which they were responsible efficiently and correctly in the fast-paced environment of nursing practice. Blevins and Millen (2016:195) emphasise that NQPNs need to adjust quickly to address patient needs and demonstrate effective time management skills to prevent a delay of care and patient safety.

The participants indicated that their lack of decision-making skills and being assertive further added to their professional insecurity. Sedgwick, Grigg and Dersch (2014:8) and Shipman (2014:125) found that lack of exposure to decision-making opportunities during training added to NQPNs' professional insecurity and difficulty with their responsibility to make decisions on behalf of patients and provide patient care which then had a negative effect on their ability to perform their duties and responsibilities. In their study in Canada, Sedgwick et al (2014:10) found further that NQPNs were hesitant to commit to decisions, despite being correct in their judgment of the situation. In addition, in this study, the participants pointed out that the tempo at which they had to make decisions in their wards did not allow them time for reflection on practice and self-correction. Freeling and Parker (2015:e44) also found that NQPNs needed to have more confidence in their clinical decision-making abilities.

In the initial or *doing* stage (Duchscher 2008:444-445), the participants quickly focused on *learning and performing* the new professional nurse role and felt insecure after discovering that the reality of nursing practice was different from their expectations. The participants found multi-tasking nursing and non-nursing duties, direct care of patients, caring for critical patients, dealing with difficult families and the care of clinically unstable patients very stressful since they

were not theoretically prepared for it. The participants' focus was mostly on familiar details and theory.

The participants found that there is much to be *learned* in the new professional environment: their professional responsibilities; how to manage their workload; who they can trust; what skills they are required to perform, or who they can turn to. Their problem-solving and clinical judgement was limited due to a lack of exposure to situations in the nursing practice. In this study, most of the participants were so focused on task management that they were unable to manage complicated clinical situations. The participants felt frightened and overwhelmed by decisions they had to make and taking responsibility and accountability for decisions regarding patients.

4.4.1.2 Subcategory b: Theory-practice gap
Some of the participants indicated that knowledge from their nursing education seemed inadequate:

> *When you get, practically, when it has to be done practically [nursing practice], you get this is what happens but the outcome might differ from the text book.*(P6)

Furthermore, the participants seemed to experience a discrepancy between what they experienced in nursing practice and what they were taught in theory during their nursing education:

> *We [NQPNs] are taught everything [nursing] in theory and in practical, but as soon as you get into the field [clinical setting] in the practical scene, it is quite a bit different.* (P5)

In addition, the participants were confused by the theory-practice gap they experienced, which left them feeling ill prepared:

> *I [NQPN] was prepared but then after you get into the ward you can see that I am not well prepared. Now you see things [nursing] happening in reality.* (P9)

The participants felt that their theoretical preparation was inadequate in preparing them for the reality of nursing practice. Freeling and Parker (2015:e48) found that nursing curricula were

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frequently blamed for focusing on teaching theory and failing to prepare nurses for the reality of nursing practice. In this study, the participants had difficulty integrating theory with nursing practice and experienced a big gap between the ideals and reality in nursing practice, which confirmed Mellor and Greenhill's (2014:54) finding in Australia. During the student education period the focus had been on ideals and high quality in nursing practice. The participants were excited about putting into practice good nursing care, but found it challenging to achieve this in the hospital setting. They described a big difference between what they had developed as their professional identity as a student, and what was required of them as professional nurses in hospital practice. The participants' professional behaviour reflected textbook knowledge, but they needed guidance to manage various circumstances and they found that clinical practice was far too complex to learn from textbooks. The theory-practice gap in this study had started during the participants' education and continued into practice once qualified, which supports Monaghan's (2015:e5) findings. The gap between what the participants were taught and what they could expect once qualified seemed to be most prominent in clinical skills capabilities.

According to Smith (2014:57), NQPNs expected clinical practice to reflect their theoretical knowledge obtained as students. NQPNs felt that they were given opportunities to acquire a strong foundation in nursing knowledge, excellent medical surgical skills, competence in critical thinking, and the ability to learn independently in their educational programme. However, the findings of this study support those of Batch-Wilson (2016:25) in America that newly qualified nurses experienced difficulty in the clinical work setting with actual completion of nursing care tasks on time and making suggestions to change the nursing care plans of patients for fear of harming a patient due to lack of knowledge and experience in the clinical work setting.

Voldberg, Gronkjaer, Sorensen and Hall (2016:1761) also found that the initial lack of confidence and support in utilising the knowledge sources NQPNs brought with them created less ideal conditions for critical thinking. NQPNs followed and learned from more experienced nurses but seemed to lack the ability to integrate their theoretical and personal knowledge for reflection on clinical practice. They performed the tasks by copying the methods of colleagues and written documents without further consideration. Like Batch-Wilson (2016:25), the current study found that there is a need to understand NQPNs' experience in order to deal with their distress related to the education-practice gap. The participants felt confused by the discrepancy between theory and practice. In an Australian study, Goodare (2016:41) found that the reality of

practice stirred feelings of uncertainty and anxiety, due to the pace of the ward, and being exposed to conflicting ways of practising clinical skills, which in turn forced NQPNs to replicate the skills seen in practice, to enhance the opportunity of being accepted in the ward.

In the *doing* stage (Duchscher 2008:445), the participants were insecure about their background knowledge and capabilities and were focused on *concealing* their shortcomings. The professional identity developed after educational preparation was dismantled by performance anxiety and self-doubt. The participants felt stressed about everything due to the conflict between adequate level of skill and knowledge and lack of confidence, limited exposure to application of skills and knowledge, and unfamiliarity with different clinical situations. The theory the participants were taught as students did not meet the practice in the clinical setting causing them to feel insecure in the theoretical knowledge they had. However, the gap in the theory-practice correlation further contributed to the participants' feeling confused and insecure about their preparedness for the roles of the professional nurse.

4.4.1.3 Subcategory c: Professional socialisation

Six participants verbalised experiencing a deficit of knowledge required for professional socialisation in their role within the organisation:

> *They [management and nursing staff] expect you [NQPN] from the moment you get your purple epaulettes that you know exactly what to do even though you just qualified and you may be unfamiliar with some of the procedures and things that must be done [in the ward].* (P1)

Lack of exposure to and understanding of managerial tasks featured prominently as indicated by a participant (P8):

> *It was just a quick-quick thing [training in managerial tasks]. But then as time goes on you [NQPN] really need to understand what the reason is that I am doing this [managerial tasks] for.*

According to a participant (P2), as students, they were not expected to manage nursing staff of a ward but now were required to be proficient in this task:

> *I [NQPN] don't know how to manage staff with personal problems.*

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Participants further admitted that being unfamiliar with the ward and its related procedures, and not having knowledge of all of the diagnoses patients were admitted with, made them feel ill-equipped and scared:

> *My [NQPN] biggest fear is to understand the diagnosis. Sometimes patients come in with weird diagnoses which you have never heard of.*(P8)

> *It is difficult [in a new ward] because you don't know, especially if you [NQPN] don't know the ward, you don't know how things are done.* (P9)

A participant (P8) also described having difficulty with managing nursing labour costs, a task that NQPNs were not exposed to as students:

> *Management related, labour hours, managing your [NQPN] staff, who must work agency staff. What happens if you flex and then the importance of saying we have five patients and we [nurses on duty] are ten?*

Professional socialisation into the professional nurse role had a significant effect on NQPNs' experience of the transition period (Lai & Lim 2012:32; Feng & Tsai 2012:2066). In this study, the participants had difficulty in professionally re-socialising to a new ward with new procedures and nursing staff personalities during their transition from student to PN. This concurred with Lea and Cruikshank's (2015:39) finding in Australia that the socialisation process allowed the newly qualified nurses to develop a role self-concept to obtain the behaviours needed to perform the PN role. For each role, re-socialisation occurred moving from a student to a PN with a nursing management role. In this study, the participants experienced difficulty re-socialising from an EN to PN as they learned to adjust to different scopes of practice, clinical areas, management styles and staff personalities. Like Marquis and Huston (2012:364), this study found that socialisation referred to the participants' learning behaviours that accompany the NP role by instruction, observation and trial and error which caused their role stress.

The participants' experience of lack of exposure to and inexperience in performing managerial tasks as challenging was consistent with the findings of Ekstrom and Idvall (2015:82). The participants had an 'experience gap' due to unfamiliarity with ward routines. They were expected to manage a nursing team even though they were inexperienced in this task. Furthermore the findings in this study indicate the need for NQPNs to practise assuming

responsibility for tasks and duties which are unfamiliar to them. Newly qualified nurses had to share administrative and organisational duties for which they were not prepared, especially during the holidays when several staff members were on leave (Houghton 2014:2374). This study found that the participants did not know much about organising hospital work and were untrained in many nursing management procedures which were overwhelming.

Difficulty in professional socialisation was aggravated by the NQPNs unfamiliarity with the ward and related procedures contributing to a challenging transition period (Zarshenas, Sharif, Molazem, Khayyer, Zare & Ebadi 2014:436). In Australia, Goodare (2016:41) and Phillips, Esterman and Kenny (2015:121) found that over and above being expected to provide competent patient care in multi-faceted and often erratic clinical practice settings, NQPNs had to manage shift work fatigue and heavy workloads. This study found that the participants needed to be socialised and learn the wards' formal and informal norms and find supportive nursing staff members. The participants were most sensitive to socialisation during an inception into the profession. The findings of this study support those of Houghton (2014:2372) and Tomietto, Rapagliosi, Sartori and Battistelli (2015:856) that the socialisation process was easier when the NQPN already had a level of knowledge about the workplace. Newly qualified nurses had a need to be socialised prior to entering the ward which contributed to their adjustment to understand what was expected of them and how to cope with work expectations. They needed to know the formal rules, guidelines, protocols, workforce, job performance proficiency, and language to enhance effective care and task mastery, and their credibility. However, understanding the informal rules could be confusing at first (Tomietto et al 2015:856).

During the *doing* stage (Duchscher 2008:445), the participants' focus was mostly on familiar details and theory. There was much to be *learned* in their new professional environment: the institutional policies and regulations; their professional responsibilities; managing their workload; what skills they were required to perform, or who they could ask for help in the organisation and their ward. The participants tended to *conceal* their inability to delegate duties and responsibilities to older, senior, clinical experienced nursing staff as expected due to lack of exposure as a student.

4.4.2 Category 2: Role expectations

From the participants' responses it was evident that various parties expected them to perform

in the role of professional nurse from commencing employment, have adequate skills and competence, as well as perform as a shift leader. This category consisted of two subcategories: role competence, and being the shift leader and the professional nurse.

4.4.2.1 Subcategory a: Role competence

The participants remarked that NQPNs were seen as people who knew nothing, and they had experienced lack of trust as well as doubt regarding their role competence:

> *They [nursing staff] just see you [NQPN] as somebody who knows nothing [about being a RN].*(P5)

> *They [nursing staff] take you [NQPN] like a newly qualified and you don't know anything.*(P7)

> *They [nursing staff] all wanted to know is she [NQPN] going to do it? Can she do it?*(P9)

The participants reported being measured and judged on their clinical competence by the doctor, irrespective of the difficulty or circumstances surrounding the clinical procedure. A participant remarked that a doctor came in and asked her why she could not put up an intra-venous infusion. According to the participant (P4) she said, *'Doctor if I can get a vein I can put a drip [intravenous infusion] without a problem, but if I don't get a drip in [vein] then that is why I called you. And then he [doctor] told me, 'You are not the right person to work here if you can't put up a drip.'*

Some patients also seemed hesitant in trusting that the NQPN was competent to assist them in problematic issues. A participant (P4) described the following encounter with a patient*:*

> *I [NQPN] came when they [nursing staff] called me. So he [patient] said 'Are you the sister in charge?' So I said 'Yes' to which the patient replied 'No, I [patient] want the super sister in charge. You [NQPN] are not the super sister in charge'.*

According to participants, the unit manager also had difficulty in trusting that NQPNs were competent and delayed going off duty and when she did, she kept on phoning the ward

checking up on them:

> *She [unit manager] wouldn't leave the ward.*(P8)

In addition, the participants also experienced that nursing staff questioned their clinical competence, for example:

> *As I say, you hear people behind you saying, 'She [NQPN] is a qualified RN [professional nurse] but then she [NQPN] can't do this [unspecified nursing competency] and this, and doesn't know this and this'.*(P2)

The participants experienced meeting company standards and the ability to manage situations and the ward, as an expectation of management. The participants therefore refrained from asking for support because *'if I [NQPN] can call the other sister or management, they'll think I'm stupid.'*(P9)

> *Asking someone [unit manager] to intervene, it would make me [NQPN] look like I could not control my staff or I am not in control, or I do not know what I am doing.* (P6)

One of the participants (P10) even felt that she would fail the company if she did not meet the expected standards:

> *You [NQPN] are failing the company; you are not skilled enough if you do not meet the standards [of being an RN].*

The participants indicated that they felt that they were being observed by the other PNs in the unit who wanted to ensure NQPNs were meeting the standards:

> *They want you [NQPN] to show the junior nurses that you can do this and build that trust [with nursing staff] you know and then also expect you to be in that level [competent]. The junior nurses, the management, all those people, they are looking at you to be at that level, you know.*(P10)

The participants experienced the most stress due to their role incompetence to manage difficult situations of practice at the beginning of their transition period. Hazaveh et al (2014:218) also indicated that the lack of competency was mostly seen early during NQPNs' transition period, but it could also present later in the transition period. The incompetence was due to insufficient opportunities to gain experience and practise as a student. Arrowsmith, Lau-Walker, Norman

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and Maben (2016:1745) found that 'knowing how' referred to applying nursing skills with competence and confidence in the ward and clinical work setting which NQPNs lacked during the initial stages of the transition period. In this study, the participants considered how to perform clinical nursing skills, such as assessment and intervention, communication, critical thinking, caring skills, management skills, and knowledge integration as vital. However, they tended to focus more on managerial competencies than critical thinking or caring skills.

The participants were well aware that competence and to "know how" required the ability to integrate theoretical with practical knowledge. As the participants' skills and competence developed, they gained confidence in their new professional nurse roles.

Management's, nurses' and patients' high expectations and lack of trust in the newly qualified nurses' role competence also presented a challenge to them during the transition period (Arrowsmith et al 2016:1745). There was a discrepancy between the expectations NQPNs had to meet when they first started their professional nurse career and how long it took before they had developed real competence to master such expectations (Deasy et al 2012:112). Kilstoff and Rochester (2003:13) found that management, however, expected this competence to be present when NQPNs commenced employment. Furthermore, Tomietto et al (2015:586) indicated that NQPNs needed to demonstrate their ability to master the required competencies to manage nursing care in the ward to enhance professional credibility with nursing staff and to perform effective and safe care. The findings of this study concurred with those of Smith (2014: 83) in Canada that the amount of time required for newly qualified nurses to be accepted and trusted by patients varied. In the beginning, patients were unsure about NQPNs' knowledge and skills. Patients queried the age, skills, and abilities of young-looking NQPNs, and asked for other senior professional nurses with whom they were familiar to provide nursing care or to answer questions. The news of the presence of NQPNs in the ward spread between patients and influenced whether NQPNs were trusted and accepted or not. Some patients were very helpful and supportive of NQPNs as they transitioned but others were very demanding.

In this study, the participants *adjusted* to many new roles, relationships and responsibilities during the *doing* stage (Duchscher 2008:444). The participants were forced to adjust to high levels of clinical responsibility, seek acceptance from peers, adapt to working with other experienced professional nurses and adjust to the physical demands of the work schedule. The

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participants felt insecure about their capabilities and aimed to *conceal* their role incompetence. The participants tended to disguise their emotions and feelings of failure, inadequacy and incompetence from their colleagues and unit manager. Due to exposure to new and unfamiliar experiences, the learning requirements were high. The participants felt stressed about everything; had an inadequate level of skill and knowledge; lacked confidence; had limited exposure to application of skills and knowledge, and were unfamiliar with different clinical situations. They were required to perform unfamiliar procedures that portrayed them as incompetent and affected their credibility, which led to anxiety. The participants realised that non-compliance with required duties and routines placed the focus on them instead of blending into the nursing team.

4.4.2.2 Subcategory b: Being the shift leader and the professional nurse

As NQPNs, half of the participants verbalised that they were the only professional nurse on duty with limited or no support:

> *I [NQPN] was the sister on the floor.*(P3)

Being the only professional nurse on duty and not having another professional nurse on duty to ask, was also something some participants were not prepared for during the transition period:

> *I [NQPN] was not prepared for... like being the only sister on duty.*(P1)

This had a negative support implication for the participants because having no other professional nurse on duty to ask for support meant that they were the shift leader working alone with only nursing staff support:

> *There is only one sister per shift...so the ENAs [enrolled nurse auxiliary] were the ones that I [NQPN] could rely on.*(P5)

The participants were fully aware of the magnitude of working alone and being responsible for patient care:

> *You [NQPN] have one RN per shift...Working alone [NQPN] with a lot of patients.*(P2)

A participant (P1) felt strongly about the importance of having a peer experienced professional nurse (buddy) with an NQPN on duty:

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> *There is not enough staff [professional nurses] so that you [NQPN]*
> *can have a buddy to work with that you can buddy with. There*
> *is nobody [professional nurse] to give you [NQPN] that support of just*
> *another sister being there; another person that is your peer that is on*
> *your level to give you the support you need.*

It was apparent that a preceptor would have been of value during the transition period to familiarise themselves with how things should be managed:

> *You [NQPN] didn't have somebody [professional nurse] with you that*
> *has been qualified for a while that you can just see how they do things.*(P1)

NQPNs were not prepared to be a shift leader during the transition period (Shipman 2014:126). In a study in America, Armendariz-Batiste (2016:6) indicated that NQPNs felt unsafe, unprepared and ill-equipped to provide safe patient care. Mellor and Greenhill (2014:56) reported that newly qualified nurses did not want to be shift leaders working and making decisions in other capacities when senior support was unavailable. In this study, the participants did not have the required skills or experience to be the shift leader and only professional nurse without supervision so early in their transition period. This created anxiety over the risk of making serious mistakes. The participants were eager to have experienced professional nurses working with them but were frustrated that this did not realise as promised. The participants questioned how experienced professional nurses could support them and give valuable feedback if they did not work with them. This concurred with Hezaveh et al's (2014:219) findings in an Iranian study that one of the major challenges of newly qualified nurses was the lack of the required ability to perform as the shift leader managing and coordinating the nursing staff and patient care. Moreover, due to nursing shortages, newly-qualified professional nurses were also forced to be shift leaders and because of their lack of required competency they made mistakes that about which other nursing staff mocked them.

Roziers et al (2014:96) found that not only did NQPNs work as shift leaders during the transition period but they had limited support. Furthermore, NQPNs described the clinical work setting climate as challenging and stressful in terms of rigid and inflexible rules and regulations, long working hours, working at night or holiday shifts, heavy work shifts, inappropriate relationships, and being the only professional nurse (Hazevah et al 2014:202). The findings in this study

indicated that the participants assumed a lot of responsibility to keep the ward going. NQPNs were expected to run the ward during night duty, weekends and festive seasons when there was a lack of nursing staff which was difficult and a serious responsibility. Being the shift leader required working alone with no other professional nurse in the ward, which implied the NQPN had to make all the decisions that affected the safety of the patients with no support (Smith 2014:97). The findings of this study supported those of Govender et al (2015:8) that NQPNs experienced difficulties with the workload and role expectations which included autonomy, increased responsibility and being left in charge of the ward. Nursing practice involved more than making decisions about patient care. Govender et al (2015:8) added further that NQPNs reported they made decisions about equipment issues, management of nursing staff, patient and family concerns, patient appointments, and staff assignments. Shift leaders oversaw everything that happened on the floor with no unit manager over the weekend. In college the clinical setting was described as ideal but in reality differed.

Being the shift leader left the NQPN with limited support and no one to ask (Smith 2014:98). Due to nursing staff shortages and experienced professional nurses being occupied with other issues in the ward, NQPNs were forced to improvise in the management of duties (Odland et al 2014: 540). In this study, the participants also had to perform as shift leaders due to the absence of an experienced professional nurse and were therefore responsible for various nursing and nursing management tasks in the ward. According to Ekstrom and Idvall (2015:82), not having an experienced professional nurse to talk to and learn from was a considerable disadvantage to NQPNs, which was confirmed in this study.

In South Africa, Roziers et al (2014:96) found the shortage of professional nurses in hospitals was common, which affected NQPNs in terms of increased workloads and professional nurse turnover rates, preventing adequate breaks, reducing the ability to attend educational sessions, shortening the length of orientations, being forced to work, and the cancellation of vacations. The current study added that the professional nurse shortages made the participants feel unsafe and lack of professional nurse skills was due to professional nurse attrition. Similar to Smith (2014:68), the current study indicated that the participants were expected to be the shift leader, mentor new nurses, and clinically accompany students all of which was expected of experienced professional nurses.

Having no buddy or being paired with an experienced professional nurse had a significant effect on the participants' transition experience. This finding supports Smith (2014:100), who found that NQPNs in smaller hospitals in Canada were immediately expected to assume the position of shift leader and to manage the responsibility of the ward without support from any other experienced professional nurse. They had to make rapid decisions in critical circumstances without having the experience of similar incidents to draw from which felt troublesome, but also exciting at the same time. Occasionally NQPNs felt inadequate in their shift leader role, because they were reprimanded by experienced professional nurses who disagreed with the decisions they made. Smith (2014:100) also found that NQPNs were often considered the shift leader on night shifts and were expected to manage the ward, but with very little support. NQPNs were afraid when making decisions about critical situations due to a lack of knowledge. In accordance with Smith (2014:100), the current study also found night shifts were particularly challenging because the pace in the wards varied from quiet to hectic, often without adequate professional nurse staffing to support times of heavy workloads.

In Australia, Mellor and Greenhill (2014:56) indicated NQPNs expected and needed a preceptor during their transition period. However, even though NQPNs were promised mentoring and workplace orientation, and feedback they had to work alone as the shift leader early in their transition period with inadequate matron-on-call support. Furthermore, NQPNs had to manage a dual responsibility; that of being the shift leader and professional nurse, even when other professional nurses or doctors were in the hospital (Smith 2014:98). In this study, the participants found that night shifts, in particular, were challenging and stressful. In some wards, the other professional nurses on duty were responsible for other facets of nursing care and were not always physically available to offer support. This made the participants feel helpless and anxious. In addition, a lack of support by some of the unit managers contributed to the participants feeling frustrated.

During the *being* stage, the participants were placed in leadership positions that they felt ill-equipped for. Some participants considered this a vote of confidence in their abilities and therefore did not raise their underlying concerns. The initiation of this stage was sensitive for the participants as the tug-and-pull war between holding on and letting go was even. Some of the participants deemed being left without professional nurse support to assist in uncertain circumstances neglect.

4.4.3 Category 3: Emotional strain

It was evident from the responses of the participants that during their transition period, they experienced emotional strain caused by incivility, among other things. This, in turn, led to feeling powerless and having a sense of not belonging.

4.4.3.1 Subcategory a: Incivility

The participants indicated that they were focused on providing quality nursing care to patients but that nursing staff were negative towards them and this could hinder them from reaching that goal. According to a participant (P6), nursing staff undermined them just because they were NQPNs:

> They [nursing staff] will just, maybe because you are newly qualified, they will undermine you [NQPN].

Eight participants verbalised experiencing incivility and being undermined by nursing staff in the workplace which had a negative effect on their self-esteem. For example, *'it becomes a challenge for you [NQPN] because how are you going to cope working with four staff members that don't really like you?'* (P8)

The participants described being adversely challenged by the incivility of the nursing staff that caused them to feel isolated due to the unfriendliness:

> J*ust the staff being unfriendly. Unfriendliness can hinder you [NQPN].* (P9)

In addition, participants commented that they commonly experienced professional jealousy and insubordination as indicated by the following participants:

> *At some point you experience some, how can I say, professional jealousy... maybe the people [nurses] working before with you [NQPN] have been a staff nurse and with these people [ENs] now you have to be a shift leader to them [ENs].*(P4)

> *Every time you [NQPN] delegate something to a person [nurse] and it is not done...you see that person is undermining you. The person is not respecting you professionally.*(P6)

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The participants also remarked that they were well aware that they had limited experience and exposure regarding allocation of nursing duties and delegation of staff. The participants were even exposed to nursing staff that did not hesitate to challenge them on allocation and delegation:

> When you [NQPN] give them [nursing staff] instructions they are reluctant to action [carry out] the order. (P5)

> When it comes to delegation they [nursing staff] have this thing, 'Ah, she [NQPN] is a friend. Ah, this one is always friendly or smiling' and that is undermining respect because they have to take you seriously.(P6)

In addition, the participants indicated that 'you can hear them [nursing staff] gossiping, 'Now that one [NQPN], that one came here yesterday and now she's an RN' ... and they [nursing staff] are still there.'(P4)

One participant (P5) added that because NQPNs were qualified and received a higher salary than the other nurses, the others would not assist them by showing them how things were done in the ward using their knowledge as a source of power over the NQPN:

> Others [from EN to NQPN] will tell you, you are sister, you are going to
> earn your salary alone. You are not going to share your salary with me, so I
> am not going to show you.

Another participant (P4) specifically referred to the enrolled nurses who were uncivil towards them, in particular the way the ENs spoke to the NQPNs:

> She [nurse] will just have an attitude. It will be, why don't you [NQPN] ask her [other nurse]? Why don't you ask this one? You don't ask her because she is your friend [EN to NQPN].'

Unwelcoming and negative attitudes as well as unhelpful behaviours exhibited by experienced nursing staff were identified as influencing NQPNs' experience of transition to practice (Lea et al 2015:859; Campana & Hammoud 2015:717). In a study in Iran, Ebrahimi, Hassankhani, Negarandeh, Gillespie and Azizi (2016:5) found that NQPNs were like guests during the first days, therefore, they felt like strangers in the ward and were exposed to resistance from more

experienced nursing staff, which was also found in the current study. The current study also supports Parker et al's (2014:153) finding in Australia that NQPNs regularly encountered workplace incivility during their transition period, which included intentional and unintentional undermining, disagreement about practices, and attitudes of apathy and hostility. However, in the current study some experienced professional nurses and nursing staff were also very supportive of the participants' transitions and notably contributed to ease the transition experience because they openly and immediately welcomed them, which was similar to Smith's (2014:77) findings.

NQPNs experienced unfriendliness and undermining behaviour of nursing staff as stressful during the transition period (Hezaveh et al 2014:219; Parker et al 2014:153). In this study, the participants described the behaviour of some nursing colleagues, especially experienced professional nurses, as unfriendly, unsupportive, humiliating, abusive and stressful. They were also excluded from discussions and bullied. This negative, unsupportive behaviour had an effect on the participants' ability to communicate with nursing staff. As in Smith's (2014:70), the participants recalled ward cultures where they were excluded from discussions by more experienced nursing staff that disliked them. The more experienced nursing staff also waited for them to fail, as well as intentionally or unintentionally undermined and belittled them. A few nurses in the wards were not supportive of the participants' transition period, which made them feel frustrated, undervalued, and unwelcome. Unsupportive conduct included disregard for the participants' knowledge, being unwilling to provide support, demonstrating professional jealousy, not working to full scope of practice and lacking in knowledge.

NQPNs were exposed to professional jealousy from previous peer nurses and experienced professional nurses which was a challenge to them during the transition period (Ndaba & Nkosi 2015:1157). In a study in Sweden, Andragand and Jangland (2015:11) found that it was difficult for NQPNs to return to previous colleagues and take a higher position among them also found in the current study. Furthermore, in the UK Draper et al (2014:5) found that NQPNs who were previously ENs confirmed that more was expected of them due to their previous nursing experience. Some NQPNs experienced incivility and were challenged by nurses who had been their peers before. However, in this study not all the participants experienced this.

As in a study by Ndaba and Nkosi (2015:1157), the current study also found that NQPNs' stress

levels were increased through competition, intimidation, and lack of respect from the lower categories of nurses who had been in the ward for a long time. Nurses in the lower category did not want to be delegated by the participants. Similar to Draper et al's (2014:4) findings, the participants experienced some challenges associated with this transition as a result of their previous status as enrolled nurses, including their acceptance as NQPNs by co-workers and the jealousy of peers. However,the participants may have had the advantage in their transition to NQPN through experience associated with their previous and concurrent enrolled nurse employment whilst a student. In addition, the participants felt that the experienced professional nurses were hesitant to recognise their professional nurse status which was consistent with Roziers et al's (2014:97) findings.

In Australia, Phillip et al (2014:109) reported that the lack of respect undermined NQPNs and their confidence. Some NQPNs were given a hard time, so much so that they did not like their wards because there was no support; nurses brushed them off, disrespected them and treated them as though they were stupid. The NQPNs experienced the lack of support and respect and internalised it as a lack of self-worth. In the current study, several of the participants indicated that they constantly felt they were unnecessarily being scrutinized by senior nursing staff, and feared that this pressure would contribute to mistakes. Consistent with the findings of Ndaba and Nkosi (2015:1158), the participants explained that they experienced a negative attitude from experienced nursing staff in their ward when they performed below expectation due to being newly qualified in the nursing profession. The participants were expected to know everything because they were fresh from college. Furthermore, the participants were ridiculed in front of their juniors by being reminded that they were fresh from training, and should know. The participants felt undermined sometimes as their opinions were not taken into consideration until there was a complication with the patient.

Colleagues and peer nurses' abuse of power by withholding knowledge, attitudes and unhelpful behaviours contributed to NQPNs' feeling unsupported in the work setting during the transition period (Lea et al 2015:859). In their study MacLellan, Levett-Jones and Higgins (2016:4) found that some NQPNs perceived the knowledge held by the experienced professional nurses and nursing staff as a source of power; and their reluctance to share knowledge as a misuse of power. NQPNs expected that senior experienced professional nurses would support and mentor them in their new professional nurse role. The current study found that in contrast to the

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participants' expectation, they experienced the intentional withholding of knowledge, information and insights as a conscious misuse of personal power from professional nurses and nursing staff and experienced it as being intentionally oppressed, undermined and sabotaged. Some of the participants attributed the abuse of power to professional jealousy.

In the current study, during the transition period, the participants frequently experienced negative behaviour, such as being gossiped about which, in turn, influenced the team atmosphere negatively, which concurred with the findings of Roziers et al (2014:97). Freeling and Parker (2015:e48) found that NQPNs frequently experienced negative behaviours from nursing staff in the ward, such as negative criticism, belittling and bullying where NQPNs were subjected to social isolation or exclusion, their work and efforts were devalued, they were threatened, disparaging comments were made about them behind their backs, or other negative behaviour aimed to distress, wear down, or frustrate them took place. In the current study, the participants were also exposed to workplace incivility which included negative comments, gossip, mockery and belittling. Similar to Batch-Wilson's (2016:32) findings, the participants reflected that clinical work settings and wards were not conducive to professional growth due to gossip among the nursing staff about them.

In conclusion, workplace incivility initiated by nursing staff, in particular experienced professional nurses, had a negative effect on NQPNs' mental health (Wing et al 2015:640). Therefore, the current study indicated that team atmosphere was very important for NQPNs' health and well-functioning and more attention should be paid to the team atmosphere and to tackling on-the-job gossiping about NQPNs. This also agreed with Ketelaar, Nieuwenhuijsen, Frings-Dresen and Sluiter's (2015:958) findings.

In this study, during the *doing* stage, the participants' transition shock experience was greatly affected by relationships with colleagues. The participants were self-critical and hypersensitive to any form of condemnation, disregard or distrust. Due to lack of formal feedback, the participants looked for other cues to measure competency, practising safely and progress in development of their professional nurse role. Similar to Duchscher's (2009:1108) findings, the participants developed and established personal professional identities during the first four months of the transition period and experienced unbearable psychological stress. Their emotional adjustment was intense due to the psychological impact of poor or lack of emotional

support, altered confidence levels due to insufficient clinical practice experience, lack of communication skills and fitting into the nursing culture. Factors like emotional fatigue, loss of autonomy, lack of support of professional practice values and anticipated roles and unrealistic performance expectations by the organisation, peers and NQPNs self also intensified the participants emotional responses. Some of the participants experienced being challenged by a senior colleague on purpose to shake their confidence.

4.4.3.2 Sub category b: Powerlessness

A participant (P9) described her excitement and anticipation about being a professional nurse but soon realised that she was not as prepared and competent as she thought. Furthermore, the participant was not prepared for the lack of support she experienced when faced with the new professional nurse role, which came as a shock and made her feel powerless:

> *When you are told you are an RN (professional nurse), now you are going to be a leader, you must be a good example, you think you will make it. You think it is easy. I thought I was prepared. I thought I was fully equipped but it was not like that. I needed support in a way that I nearly resigned. It is not easy. I felt powerless. I felt I'm not doing enough. I felt I'm lonely and I am overloaded.*

NQPNs felt powerless due to their lack of preparedness for role transition during the transition period (Hezaveh, Rafii & Seyedfatem 2014:219; Roziers et al 2014:95). The findings of the current study concurred with Voldberg, Gronkjaer, Sorensen and Hall's (2016:1761) finding that during the transition period NQPNs needed to take on new responsibilities for which they felt unprepared, overwhelmed, uncertain or frightened. Along with feelings of insecurity and powerlessness, the NQPNs needed acceptance from the nursing staff in the ward. Deasy et al (2012:112) found that NQPNs were not as ready for their professional role as they anticipated, even though the biggest part of their clinical training had taken place in acute clinical settings. This study found that the participants were frightened by their inexperience in a demanding and hectic working role compared to their structured vocational training as students. The participants faced multiple responsibilities and difficulties which did not accommodate their being new and inexperienced. The participants realised they had to manage on their own, irrespective of the big difference between student and NQPN. Their nursing student preparation did not prepare them for what professional nursing responsibilities entailed and left them feeling unprepared, shocked and powerless.

Furthermore, according to Cheng et al (2014:7), NQPNs felt powerless and overloaded due to heavy workloads during the transition period from time to time and were exposed to difficult workloads which led to NQPNs becoming unmotivated and not wanting to work anymore. When NQPNs have no social support from peer nursing colleagues they tend to resign (Hazevah et al 2014:203). The current study confirmed that the inappropriate clinical work setting and ward atmosphere caused stress, which was emotionally exhausting and caused the participants to lose hope. Like the NQPNs in Ndaba and Nkosi's (2015:1157) study, the participants felt engulfed by the work conditions that they were exposed to during transition. These conditions induced change that was uncontrollable and ambiguous, and led participants to describe the huge responsibility and accountability as 'horrible'. In contrast, some of the participants enjoyed the feeling of autonomy, while others found it unpleasant due to their views of having inadequate knowledge, skills, confidence, and intuition. The current study supported Smith (2014:90) who found that learning to plan was thrilling and empowering for some NQPNs but also stressful and scary because it required them to manage and deal with situations that lacked structure.

In this study, during the *doing* stage, the participants' professional role transition was experienced in varying intensity and fluctuating states of emotional, intellectual and physical well-being. The participants experienced moving fromthe known role of a student to the relatively less familiar role of the professional nurse. Important to this experience for the participants was the evident contrast between the relationships, roles, responsibilities, knowledge and performance expectations required in the more familiar academic environment to those required in the professional clinical work setting. The participants were exposed to a feeling of *anticipation* while their fairly predictable life was transformed into expectations and responsibilities challenging their personal and professional identities. Most of the participants entered the transition process with idealistic views regarding expectations and *anticipations*. The participants were unprepared for the workload demand and liability of the new role even though they were primarily excited about transition from student to professional nurse. The participants often described the disparities between idealistic role anticipation and the reality of practice.

4.4.3.3 Sub category c: No sense of Belonging

In this study, participants referred to not being accepted in the ward as an obstacle. Some participants explicitly verbalised not being accepted as a professional nurse and in the nursing team of the ward and experienced feelings of hostility, isolation and rejection from the nursing staff:

> *The staff were reluctant to receive me as their sister because they don't know me.* (P9)

> *The team [nursing staff] that you [NQPN] are working with, it is hard for them to accept you in their team."* (P8)

> *They [nursing staff] see you [NQPN] as that you don't know anything and you are not supposed to be there. I am new here but they don't accept that.* (P2)

A participant (P9) further described using various methods to win the nursing staff over to be accepted and to fit in:

> *I [NQPN] help them [nursing staff] in all angles with whatever [unspecified nursing task] so I win them with that. When they [nursing staff] are busy, I [NQPN]... do the observations. I will admit the patient; do everything from A to Z, I'll put up the drip [intravenous infusion]. They [nursing staff] start to see that she [NQPN] is this kind of a person. Then I [NQPN] win them [nursing staff] that way.*

The participant (P9) indicated further that if *'the unit manager doesn't accept you, then the whole staff is influenced'.*

Acceptance of the NQPN was often dependent upon the unit manager's acceptance of the NQPN during the transition period (Batch-Wilson 2016:31; Houghton 2014:2373; Roziers et al 2014:98). In their study in Canada, Laschinger, Zhu and Read (2016:663) indicated that there was a vital relationship between group unity and job satisfaction, intent to stay, and NQPNs' view on quality of care standards and job satisfaction. The current study supported this finding and also found that the participants needed to feel a sense of belonging. As the unity of a group was essential in the clinical work setting, understanding and continually trying to improve the clinical work setting to be conducive to the participants was a vital function of the unit manager.

The participants' fear of not belonging affected their view of group unity. The ability of the participants to have supportive, positive relationships with the unit manager and colleagues was essential for them to successfully adjust to the clinical work setting. The participants' feeling of being appreciated by their unit manager and colleagues and their acceptance into the clinical work setting was essential to successful transition and job satisfaction.

Like Mohamed, Newton and McKenna (2014:127), the current study found that the participants' sense of belonging was associated with the unit manager and focused on the acceptance of the unit manager. Therefore feeling accepted as well as maintaining acceptance was considered another important element of the participants' feeling of belonging. The participants wanted to be accepted and respected by the unit manager once they engaged in interpersonal interactions in the ward setting. The participants wanted to be perceived as having appropriate like-minded attitudes and competency and thus be liked and respected. The current study indicated that a sense of belonging and positive feelings protected the participants from burnout, stress, and anxiety. Furthermore, Bontrager (2014:41) identifies a supportive work environment that could assist the NQPN in overcoming feelings of frustration and inability to cope independently in practice during the initial transition period as an important priority for transition support.

Acceptance of peer and nursing colleagues had a significant influence on the participants' sense of belonging in the ward culture during the transition period. Previous research found that NQPNs had a need to feel a sense of belonging in the wards in which they were placed (Phillips, Kenny, Esterman & Smith 2014:110; Houghton 2014:2371; Batch-Wilson 2016:5). Furthermore, in the UK OL´uanaigh P´adraig (2012:152) added that welcoming and engaging nursing staff created a sense of belonging for NQPNs. The need to belong seemed to continue as a part of NQPNs transition period in their new clinical work setting and with colleagues. The participants described positive ward cultures as having friendly, welcoming nursing staff that supported them to feel as if they fit in, were valued, respected, trusted, and accepted while learning their new professional roles. Smith (2014:69) emphasises that NQPNs experience difficulty in transitioning due to difficult ward cultures that make them feel unwelcome and that they do not belong. This study supports these findings because the participants tended to have the ability to automatically grasp the advantage of creating stable social relationships and focusing on having at least some social ties with nursing staff in the ward. However, NQPN transition can be made difficult by negative ward cultures. Andragard and Jangland (2015:8)

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found that during the initial stage of the transition period it was difficult to find a place for any type of NQPN, irrespective of their role in any type of nursing team. In addition, the current study found that the nursing team needed time to adjust to the new situation and the new professional role of the NQPN. The introduction of the NQPN with new roles and functions in the ward and nursing team started a process for the unit manager, nurses and doctors which was long and complex. The NQPN felt alone and lost. When the process commenced, the objective was not clear, and there were various challenges regarding informing the ward and the organisation about the NQPNs and their role.

In agreement with Mohamed, Newton and McKenna's (2014:127) findings, the current study identified that belongingness was associated with colleagues and nursing staff and focused on acceptance and influenced the participants' sense of belonging. The participants used various methods to fit in: practising teamwork in everything; always being willing to help in performing nursing care to patients even if not requested, and compromising with and tolerating nursing staff to maintain a peaceful situation or environment. The findings from this study support Wing et al (2015:641) who emphasise that the personal aim of being accepted and respected was awakened when NQPNs felt threatened; in other words, perceived the risk of being disliked or disrespected and might cause them to become preoccupied with being accepted and respected. The desire to be accepted was also due to the nature of the nursing role since NQPNs relied heavily on teamwork from nursing staff and experienced professional nurses.

Wing et al (2015:641) indicate that NQPNs need to have relationships with experienced professional nurses and nursing staff to be able to rely on their colleagues for advice or encouragement during their transition into the profession. Furthermore, experienced professional nurses' expertise was precious to the professional development of NQPNs and essential in successful NQPN role transition.

In this study the participants were most concerned with the ability to *perform* the tasks and skills that were required during the *doing* stage (Duchscher: 2008:445). The participants had anawareness that they were being observed and evaluated on how well they performed. Acceptance of themselves often depended on the unit manager's acceptance of them and they took their cues regarding their practice from the unit manager. The participants' growing

professional self-concept was dependent on the healthy facilitation of their new roles and responsibilities.

4.4.4 Category 4: Limited support

The participants indicated that they experienced some support from various role players. Nevertheless, all the participants felt the support was insufficient, limited and/or lacking. Considering the emphasis all the participants placed on the importance of support, they experienced limited support as a challenge.

4.4.4.1 Subcategory a: Availability of support

Three participants made specific statements regarding the availability of support from other staff members and in particular the unit managers, clinical training specialist, mentor and professional nurse:

> S*omeone [mentor] who will always be there.* (P5)

Participants pointed out that support was not available over weekends:

> *But you are not getting them [unit manager, clinical training specialist] all the time; they go off and on the weekends we [NQPN] are all alone.* (P7)

Participants also added that support on night duty was limited to the assistance the night quality supervisor could provide:

> *We [hospital] had a night super when I[NQPN] would call sometimes though she also did not know the discipline well.*(P5)

Participants had no one to turn to and had to rely on themselves, which sometimes led to mistakes and incidents:

> *Sometimes she [unit manager] is not there but at least when she is there, she can tell you [NQPN].If they [unit manager, registered nurses] are not there you [NQPN] don`t know where or who to go to.*(P6)

In contrast, a participant (P10) remarked that always having support available could be dangerous and delayed the NQPN's growth, *'when I [NQPN] wake up knowing there will be*

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someone [registered nurse]. It makes me rely on them, which is dangerous because it delays growth.'

Another challenge NQPNs experienced during the transition period wasthe availability of support (Gardiner & Sheen 2016:11; Phillips et al 2015:1220; Odland et al 2014:541). This study found that the participants were confronted with complex medical work and challenges regarding providing and managing of nursing care and frequently struggled to find supervision and support. Similar to Hickson's (2015:44) findings, the participants in this study did not receive the required support to develop their comfort and confidence in the clinical work setting and ward, and the support from unit managers and experienced professional nurses was limited. The current study's finding that the availability of support had an effect on the participants' experience of the transition period concurred with Smith (2014:71) who indicated that lack of support had an effect on how NQPNs felt about their transition. NQPNs who were adequately supported during the transition, experienced it as good and for some the transition process was slow, but for those who were not adequately supported, the transition caused erratic emotions. Some NQPNs who were exposed to long orientations experienced professional nurse mentors, buddies, on-call back-up support felt they were supported during their transition. In this study, the participants considered some unit managers and colleagues as supportive or unsupportive during their transition period. The participants' experience that the clinical work setting, with inadequate unit manager support, was not conducive for them confirmed Batch-Wilson's (2016:32) findings.

One of the biggest challenges the participants experienced during the transition period was the availability of support after hours and during night duty. Although NQPNs acted as both professional nurse and shift leader, support from the on-call matron was unreliable (Mellor & Greenhill 2015:55). Lea et al (2015:958) and Henderson et al (2015:230) also demonstrated that NQPNs, who were shift leaders on night duty and over weekends, had limited support available. In this study, the participants were also exposed as shift leaders to limited, if any, support on night duty and over weekends.

The participants in this study made an emotional adjustment during the initial *doing stage* (Duchscher 2012:445) and experienced a severe loss of support as a student; intellectual counsel by fellow students and educators, emotional support, consultation and feedback that

contributed to their feelings of isolation and self-doubt. Duchscher (2008:444) found that during the transition period most NQPNs felt comfortable managing eight patients, but in this study the participants managed double the number of patients with no or limited professional nurse support. NQPNs had not seen most of the things they were seeing and doing during the *Doing stage* before and needed to decide what they could accept and needed to *accommodate* to their own way of doing things. It was normal and acceptable to seek support for "how to be" in this new role, why things were the way it were, and to make a better decision regarding accommodating something in the NQPN`s thinking in this case study.

4.4.4.2 Subcategory b: Emotional support

More than half of the participants reflected on the need for emotional support. The participants strongly focused on the need to be nurtured and encouraged by unit managers. Unit managers should focus on the positive during the transition process as verbalised by one of the participants (P6):

> *I [NQPN] feel like the unit managers must not only put the mistakes to light but also the good that we do because we also work hard.*

Encouragement should be provided to NQPNs by management, unit managers, tutors and clinical training specialists. According to a participant (P9), *'I [NQPN] needed my manager [unit manager] to ask me if I [NQPN] am okay. I wanted my management and CTS [clinical training specialist] to come to me. I just want the tutor to check me... I don't mean they must carry me, but they must know my need. They must do the follow-ups on me as the newly-qualified one.'*

One participant (P5) remarked that she just needed encouragement:

> *That is not just to say you [NQPN] want someone to hold your hand, but as a new sister you need somebody that encourages you.*

The participants also emphasised the need for designated follow-up visits with NQPNs to create a platform to determine the NQPNs' needs and challenges during the transition process:

> *I [NQPN] think there must be a follow up, like let's just say we [NQPNs] have started working two weeks, I think there must be a follow up done. Maybe a team, a CTS [clinical training specialist] or whoever will come and check, 'Okay*

guys [NQPNs], how are you doing? What are the challenges? What do you [NQPNs] think can be done?'(P4)

One participant (P7) indicated that *'the only thing that they [management] must do to help the new sister is the CTS [clinical training specialist] must make a follow up. Just see how they [NQPNs] are settling in after becoming a registered nurse...They [CTS] must just make a little bit of time for you [NQPN] to sit in and tell them [CTS] what your views and your suggestions are.'*

The participants' experience of emotional support was consistent with Batch-Wilson's (2016:31) findingon NQPNs' perceptions of limited supportive behaviours. Similar to Smith's (2014:113) findings, the participants' transition created an array of emotions that were interpreted as behaviours, events, or experiences considered as sudden and intense alterations. The fluctuation of emotions were intense for some participants compared to others and was related to what was occurring at the time or the amount of available work-related or social support available. Therefore it was circumstance and ward related. Those who experienced adequate support from the unit manager or colleagues and nursing staff experienced less intense emotions than those who did not. Some of the participants were dissatisfied with the lack of encouragement and feedback provided. This was consistent with Ebrahimi et al's (2015:5) finding that encouragement was an important influential factor in improving emotional support to NQPNs. NQPNs had a need for approval; had great knowledge but lacked self-confidence and tended to obsess about whether they performed tasks correctly.

Supportive behaviours included the provision of encouragement around the NQPNs performance of patient care, the creation of opportunities for autonomous performance, the availability for help where required, an environment encouraging inquisitiveness, colleagues responding to questions, providing an opportunity for debriefing, providing impartial guidance and creating a sense of worth (Smith 2014:113) and was supported by the current study. Similar to the findings of Shinners, Africa and Hawkes (2016:217), in the current study a debriefing experience provided the NQPN with an opportunity to share reactions of clinical situations from the ward in a safe environment and provided the NQPN with an emotional outlet. Shinners et al (2016:217) further indicated that allowing NQPNs to address their feelings could reduce stress and burnout and affect the NQPN`s ability to provide quality patient care.

Like Ketelaar et al (2015:957), the current study also recommends that NQPNs meet with their unit managers two weeks after commencing in the ward to provide the NQPNs with an opportunity to indicate their needs and how the NQPNs could be supported by the nursing staff or the unit manager. Monthly discussions should be planned for NQPNs to discuss job satisfaction and transition challenges experienced because discussions made it easier for them to ask for help.

The participants in this study found it difficult to emotionally adjust to the experience of loss, confusion, disorientation, and doubted that emotional support would be vital during the transition period. This corresponded with what NQPNs experience in the *doing* stage (Duchscher 2008:444) (see Chapter 2, Section 2.2.1.1).

4.5 THEME 2: TRANSITION SUPPORT NEEDS

The majority of the participants strongly emphasised the importance of being supported during the transition process and referred to their support and guidance needs.

4.5.1 Category 1: Guidance from the unit manager

From the participants' responses, it was evident that they needed guidance from their unit managers.

4.5.1.1 Subcategory a: Availability and accessibility of unit manager guidance

According to one of the participants (P6), *'it would help if there is that guideline or guidance to prevent the mistakes made by NQPNs.'*

The participants indicated that guidance from the unit manager should be available and accessible during the transition process and highlighted that the guidance should not only be in terms of clinical support but also in terms of general assistance:

> *If you [NQPN] are faced with whatever then at least you can call them [mentor, unit manager, experienced professional nurse] for assistance or guidance.*(P6)
>
> *I needed my manager to ask me if I [NQPN] am okay. I wanted my management [unit manager] to come to me.* (P9)

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NQPNs have transition support need for guidance especially from the unit manager during the transition period (Unruh & Zang 2014:303). This study agreed with Mellor and Greenhill's (2014:51) finding that the reality was that NQPNs found the transition to practice stressful and with limited, if any, clinical guidance provided patients could be at risk. This was also consistent with Gardiner and Sheen (2016:11) who indicated that the provision of inadequate guidance to NQPNs contributes to lower levels of confidence and job satisfaction. In this study the participants regarded the support from unit managers as limited since they did not receive the guidance necessary to develop their confidence in the clinical work setting and ward which supported Hickson's (2015:301) and Batch-Wilson's (2016:32) findings. In contrast, however, Smith (2014:471) and the current study found that some NQPNs did have adequate unit manager guidance and assistance which they experienced as very supportive during the transition period.

Unruh and Zang (2014:303) emphasise that NQPN job satisfaction can be improved through alterations in the clinical work setting that lessen nursing care difficulties and demands, and increase effective management of the ward. Furthermore, the need to focus on improving teamwork; providing reasonable and clear organisational procedures and instructions that ease the nursing practice; ensuring strong unit manager support, and promoting independent decision making and autonomy was also identified as a priority in the transition period in the current study.

Consistent with Duchscher's (2009:1103) *doing* stage, the participants' transition shock reinforced the need to prepare NQPNs when they were still students for the increasing demands of the clinical work setting and the discrepancy experienced between theory taught and the reality of nursing practice. The participants experienced emotional adjustment, which required access to a support network of peers and co-workers. In addition, the participants experienced guilt feelings due to their inability to perform practices they considered elemental to their professional role. To assist NQPNs with *learning and accommodating,* the participants emphasised the need to be assigned a mentor that could offer support and encouragement during the *doing* stage such as a senior experienced professional nurse that had an understanding of the scope of practice and role (see Chapter 2, Section 2.2.1.1).

4.5.1.2 Subcategory b: Regular feedback

Four participants indicated the need for regular feedback and according to one of them (P6),

'at least if you [NQPN] get that regular feedback [from unit manager] or that constant appraisal or appreciation then at least you know you are being supported.'

The participants explained that they constantly measured themselves against a self-set performance scale regarding their PN performance and feedback from the unit manager to determine where they were lacking and whether they were still doing things correctly:

> *Only to refer to them [unit manager], just to verify something. Is this thing still done this way? Am I still correct if I do things like that? And to tell me [NQPN], 'I [unit manager] see you are lacking there and there.' Supervise me, check where I'm lacking.*(P9)

Although the participants appreciated receiving both negative and positive feedback from the unit manager, they preferred to receive negative feedback in private and not in front of peers since it compromised their self-esteem:

> *I [NQPN] wanted them [unit manager] to maybe say, 'This we do like, this we don't do like this.' Why didn't you [unit manager] call me in the office and tell me I want you to do things like this and why did you tell me in front of the staff?* (P4)

> *I felt like if I made a mistake...the mistake was put out there for everyone [nursing staff] to see the mistake.* (P6)

The participants required constructive feedback regarding their performance to evaluate their growth in the professional nurse role and alleviate stress during the transition period. This finding was consistent with Ekstrom and Idvall (2015:83) and Laschinger, Zhu and Read (2016:663) who found that NQPNs needed continuous feedback regarding their performance as a professional nurse to alleviate their stress and fear. In addition, Parker et al (2014:154) indicate that, irrespective of the reluctance, discouragement and lack of interest from senior professional nurses, NQPNs considered it their responsibility and needed to ask for help and feedback. Not knowing how the nursing staff perceived their performance, increased NQPNs' stress levels. NQPNs needed constructive feedback about their performance to measure their growth as professional nurses. The current study supported this finding and also indicated although frequent feedback where no one complained about the NQPN or the NQPN was not

making any major errors was given, the participants valued encouragement and genuine interest in their performance more.

NQPNs had a need to be acknowledged and valued in the nursing team to improve their confidence levels during the transition period (Gardiner & Sheen 2016:10). Similar to the findings of Phillips et al (2014:109), the participants in this study felt valued in a supportive clinical work setting and experienced respect from experienced professional nurses,adequate feedback on performance, and recognition of work well done which was essential to their transition process. Remarks of appreciation from nursing staff were seen as support and respect which motivated the participants to continue despite the challenges and demands of the professional nurse role. This finding supported Ashton (2015:14), who indicates that if the NQPN was provided the opportunity to debrief at the end of a shift it was considered a form of support. It might also provide the time and structure required for NQPNs to raise their concerns and for the unit manager to provide feedback and encouragement. The investment of time and attention to debrief about a shift worked might assist NQPNs to feel nurtured in the new clinical work setting and ward.

The participants in the current study functioned in a hypersensitive and self-critical state and felt every hint of disapproval, disrespect or doubt, and likewise acceptance, praise or simple encouragement. During this stage almost all the participants spoke of wanting, but not adequately receiving, positive and negative feedback from their senior experienced professional nurses, the unit manager or clinical training specialist. In the absence of formal feedback, the participants looked for other cues to measure their safety, competence and progress as professional nurses. This corresponds with what Duchscher (2009:1108) describes NQPNs experience during the *doing* stage (see Chapter 2, Section 2.2.1.2).

4.5.2 Category 2: Support from an experienced professional nurse

The participants' responses clearly indicated the need for NQPNs to be supported during the transition period by allowing them to learn the professional nurse role from an experienced professional nurse and ensuring that this occurred. This category encompassed two subcategories, namely orientation and the 'buddy' system.

4.5.2.1 Subcategory a: Orientation

All the participants indicated the need for proper orientation by an experienced professional nurse from the ward when arriving there as an NQPN:

> *It still goes back to orientation. If I [NQPN] work with someone [professional nurse] closely and who shows me everything and ...drafting a little leaflet or maybe information... 'there is this form that they [company] use to orientate people'. I think that form would come in handy when a new person [NQPN] comes into the unit.* (P2)

> *I [NQPN] would have liked to have somebody [professional nurse] to just show you the ropes of the speciality. It would have been nice if somebody was there with me just to show me how to work with the ventilator the first time that I got there.*(P1)

The participants realised that the nursing management's expectation of them as a student differed from that of an NQPN as indicated:

> *This is what is expected of you [NQPN] because some of the things are not of the scope of practice; they are from the company who wants this from you.* (P10)

One participant (P5) further requested and described receiving ward orientation from a peer experienced professional nurse who was familiar with the ward:

> *I [NQPN] needed orientation from another RN and who was willing to help and to show me this is what we use. They [unit manager] buddy [pair] that person [NQPN] with somebody [professional nurse] who already works in the unit and then they [NQPN and professional nurse] go through that form together. Fill in at the end of the day; if they did something together they both sign.*

Participants not only indicated the need for ward orientation but also orientation and training regarding how to use ward equipment and doctors' protocols:

> *This doctor works like this; this one works like that, this one brings his own things and this one works the same as the other one. It was only to differentiate which one is done this way.* (P7)

Certain managerial tasks also presented a challenge to the participants due to limited exposure and experience when they were still students:

> *More time [for NQPN] to be exposed to the management side because uhm* (interjection) *it was only a month.* (P8)

Four participants suggested that *'it will be better for students [NQPNs] to go back to their wards; they know the surroundings, they know the doctors, they know the staff. Though there will be a few things; they are happy, they are back home. That will help.'*(P8)

Other studies found that NQPNs had a need and expectation to receive orientation during the transition period which had a significant effect on their role adjustment (Lea et al 2015:975; Ndaba & Nkosi 2015:1154) and that adequate orientation support had a positive effect on how the NQPNs perceived their transition experiences (Armandariz-Batiste 2016:4; Smith 2014:71). The current study supports these findings because some participants did have lengthy orientations; experienced professional nurse mentors, buddies and on-call, back-up support, and assistance in bridging the gap between them and nursing practice.

However, similar to Phillips et al's (2014:109) study, the participants who did not receive orientation or only received partial, short and superficial orientation, lacked specific detail associated with ward environment, staff, policies and procedures and consequently experienced increased stress levels and dissatisfaction due to feeling disorganised and unsafe in the wards. Unruh and Zang (2014:303) maintain that proper orientation could improve NQPNs' job satisfaction. In addition, this study concurred with Smith's (2014:84) finding that intensive clinical support at the ward level to assist with adjustment to the clinical work setting, with patient care practices, orientation, time management, and prioritising of workload, was also a priority during the first three months of the transition period.

Returning to the NQPNs' ward of origin would ease the orientation process and improve their confidence levels during the transition period (Gardiner & Sheen 2016:11). The introduction of the NQPN to the nursing staff of the ward was easier when the NQPN already knew the nursing staff, was experienced in the specific ward, and had confidence in the nursing staff and the ward (Andragand & Jangland 2015:11). The current study likewise found that the participants were mostly familiar with the wards in which they worked before, which decreased the need for

induction and orientation and increased the opportunities for learning in practice. In contrast to Draper et al's (2014:5) findings in the UK, some of the participants in the current study found that working in their ward of origin created challenges amongst the nursing staff in the ward as their working relationships changed. Most of the participants were able to work through these alterations and to create new relationships with colleagues.

According to Andragand and Jangland (2015:11), NQPNs realised that it was not always possible to be placed in the ward of their choice. Some NQPNs found that frustrating while others reported that they enjoyed the wards they did not request. Furthermore, new wards where NQPNs are placed might differ in the amount of support provided and the treatment NQPNs received in previous wards of origin (Gardiner & Sheen 2016:11). This study confirmed these findings because the participants placed in a ward they really disliked for an extended period of time indicated that they were unhappy and distressed.

This study confirmed that there was much to be learned during the *doing* stage (Duchscher 2012:165) in the participants' new work environment; for example, who's who, the organisational structure and functioning, the institutional policies and regulations and/or who they could turn to. In the current study the participants expected and required not only an introduction to the organisation, but also an orientation to the ward in their clinical work setting and the professional roles and responsibilities of the NQPN in the ward.

4.5.2.2 Subcategory b: Buddy system
Half of the participants verbalised that NQPNs needed to be 'buddied' or paired with an experienced professional nurse who was familiar with the ward and its processes during the transition period:

> They [NQPN] should be buddied [paired] that person with somebody [professional nurse] that knows the unit, who is the same rank and shows that person [NQPN] all the ropes of that unit. (P5)

> Preferably somebody [professional nurse] working in my unit that has been there before, that understands the unit and works, that works differently from any other ward. That can give you [NQPN] just a little bit of advice. (P1)

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The participants added that it was the responsibility of the unit manager to allocate the NQPN with an experienced professional nurse:

> *They [unit manager] can allocate you [NQPN] with a former sister that can lead you.* (P9)

In addition, the participants suggested:

> *I think it is really important for the newly qualified RN [registered nurse] to have support. Like they [unit manager] buddy [pair] them for about two months with someone [professional nurse].*(P1)

> *I was buddied with one of the sisters in the ward for.* (P10)

Furthermore, participants highlighted that the shortage of more than one professional nurse on duty created a barrier to this need:

> *There is not enough staff [professional nurses] so that you [NQPN] can have a buddy [to be paired] to work with that you can buddy with or sister.* (P1)

NQPNs had a need to be 'buddied' or paired with an experienced professional nurse, familiar with the ward which had a significant effect on the professional socialisation of the NQPN during the transition period (Odland et al 2014:540; Missen et al 2016a:112). Like Armendariz-Batiste (2016:6), the current study also found that the participants (NQPNs) felt unsafe and unprepared to provide safe patient care, and be a shift leader who worked and made decisions as the professional nurse in charge when senior professional nurse support was unavailable. Consistent Mellor and Greenhill (2014:56), the current study found that the participants felt ill-equipped and inexperienced, being the shift leader and only professional nurse, without supervision so early in their transition period. This created anxiety about the risk of making serious mistakes. The participants were eager to have experienced professional nurses working with them and were frustrated that this did not realise as promised. The participants remarked on how could experienced professional nurses support NQPNs and give valuable feedback if they did not work with them.

The current study supports Houghton's (2014:2370) recommendation that the unit manager have an organised method in assisting NQPNs to adjust to the clinical work setting. The utilisation of role models like experienced professional nurses is essential for a positive

socialisation and learning process. In addition, Gardiner and Sheen (2016:11) emphasise the importance of experienced professional nurses having adequate knowledge, skill and time to spend with NQPNs in order to supervise and assess them.

The shortage of senior nurses had an impact on the availability of a 'buddy' or being paired with an experienced professional nurse during the transition period (Smith 2014:68; Roziers et al 2014:96). Due to nursing shortages, the participants in this study were forced to be shift leaders and because of their lack of required competency were prone to make mistakes, which concurred with Hezaveh et al (2014:219). According to Odland et al (2014:540), due to shortage of nursing staff and experienced professional nurses being occupied with other issues in the ward, NQPNs in the absence of experienced professional nurses were forced to improvise the management of duties. In this study as well, the participants were held responsible for various nursing tasks in the ward. The participants had increased workloads, inadequate breaks, shortened orientations, were forced to work, and their vacations were cancelled. Not having an experienced professional nurse to talk and learn from was found to be a considerable disadvantage to the participants, which confirmed Ekstrom & Idvall's (2015:82) findings.

Like Ketelaar et al (2015:957), the current study supports the notion of supernumerary. NQPNs should be over and above regular staffing for the first two months which allows them to observe and work alongside experienced professional nurses and settle into the work place.

NQPNs were therefore dependent on help and guidance from the experienced professional nurses as role models, easing the process of transitioning (Missen et al 2016a:112; Faulkner 2015:43). NQPNs turned to experienced professional nurses as a source of help, guidance and knowledge (Voldberg et al 2016:1761; Wing et al 2015:640). The current study found that the participants relied on experienced professional nurses for support to adjust and be socialised to their ward and the organisation, and with clinical decision in new situations as professional nurses. Professional nurse support regarding decision-making was therefore significant to the participants' professional development. The participants who did not have a relationship with the unit manager, experienced professional nurses, and nursing staff were exposed to high levels of stress and fear since there was no advice and encouragement they could rely on during their transition period. Like Houghton (2014:2370) and Shipman (2014:118), the current study found that the participants learned most from the professional nurse they worked with and participants

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who worked on a daily basis alongside experienced professional nurses gained insight into professional nurse responsibilities, how to perform tasks like a professional nurse, and how a professional nurse should behave.

The findings of this study support those of O L´uanaigh P´adraig (2012:158) in the UK that experienced professional nurses had an important influence as role models in creating the image of nursing to NQPNs. NQPNs admired good professional nurses and viewed them as good communicators who taught their skills through paying attention to detail. Houghton (2014:2371) emphasises that NQPNs gain emotional support from the example set and knowledge of experienced professional nurses which enhances confidence levels and learning and decreases stress. In this study, the participants appreciated support through clinical guidance from experienced professional nurses and had a need for a sense of belonging in their ward. In addition, unit managers need to invest in resources to encourage and support relationships between experienced professional nurses and NQPNs in the ward, which supports Wing's (2015:641) findings.

In the *doing* stage *(*Duchscher 2012:80), the participants in the current study needed a mentor, preferably a professional nurse who understood the scope of practice and the role of the NQPN. The participants also had a responsibility to provide the experienced professional nurse with their needs regarding *learning, performing, concealing, adjusting* and *accommodating.* Being paired or 'buddied' with a professional nurse is valuable because the NQPN can observe the difference between doing things and seeing things from a distance (see Chapter 2, Section 2.2.1.1). According to one of the participants, by working with an experienced professional nurse, the NQPNs were taught how to practise within the scope of practice of a professional nurse.

4.5.3 Category 3: Acknowledgement of NQPN status

The data indicated that the participants (NQPNs) had a need to be acknowledged by various health care role players involved in a new clinical work setting to ensure that they became role players in caring for patients. Although the participants had a need to be acknowledged, they also realised that they were at the beginning of their career and needed the clinical work setting to acknowledge that too. This category had two subcategories, namely introduction to the multi disciplinary team and the opportunity to prove [their] professional nurse competence.

4.5.3.1 Subcategory a: Introduction to multi-disciplinary team

According to a participant, being qualified did not mean an NQPN could automatically do everything and knew everything:

> It was people's [nursing staff] attitude and mindset that if you wrote that paper and passed that means you are competent.(P2)

Therefore, it became essential to the participants to be introduced as NQPNs to the role players in the clinical work setting. Four participants clearly stated the need to be introduced to unit managers who then introduced them to the nursing staff as an NQPN who was still learning and needed support from all the nurses in the ward:

> Take me [NQPN] straight to my new unit manager. She [CTS] has been with me two years and she knows me better now. She can elaborate on who I am. She [NQPN] is the type of person; she [CTS] mentions my good reputation in that way maybe she [unit manager] will be influenced. They [the company] must acknowledge that we [NQPN] need support and without support you feel neglected. There will be a new sister. Support her. (P9)

The unit manager's communication further contributed to the nursing staff supporting the NQPN as stated by a participant:

> This thing [supporting NQPN] must be injected in the juniors [nursing staff] from the unit manager to the juniors. (P9)

One of the participants indicated that the understanding of the nursing staff could further be enhanced through the unit manager's support:

> Inform them [nursing staff], "This is a newly-qualified professional nurse. She is new in the ward. She is willing to learn....we [NQPN] are qualified but it doesn't mean we automatically know everything [being a PN], automatically can do everything." They [nursing staff] must just put themselves in your [NQPN] shoes and remember back when they also came. (P2)

According to the participants, an additional introduction to multi-disciplinary team members like doctors might also ease the further integration of the NQPN into the clinical work setting:

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Introduction to the doctors and then inform them, 'This is a newly-qualified professional nurse, she is new in the ward, she is willing to learn.' (P2)

According to the participants, their introduction had a significant effect on the support of the multi-disciplinary team and their understanding of the participants' learning process during the transition period. This finding was consistent with Gardiner and Sheen (2016:11) who found that NQPNs were found to be more positive when welcomed and supported by the nursing staff of the ward and other multidisciplinary team members. According to Andragand and Jangland (2015:11), information and discussion before the introduction of the NQPN was beneficial in preventing conflicts since the nursing staff of the ward might need time to adjust and find ways to work with the NQPN. The current study supports Andragand and Jangland's (2015:11) finding that introducing a new staff member, like an NQPN, to nursing staff in a ward created change in the ward's structure and induced reaction from the nursing staff towards this change.

This study found that the participants' many new roles, relationships and responsibilities required an *adjustment* in their role; therefore, the participants were mostly concerned about their ability to *perform* the task required of them during the *doing stage* (Duchscher 2012:153,154). The participants' reported feelings of being watched and judged by other nurses on how well they performed. The nursing staff expected the participants to perform certain roles and skills, which they were not prepared for during their training or had the opportunity to perform while still students. Therefore the participants *concealed* their feelings of inadequacy or their concerns about their competence from the experienced professional nurses and nursing staff for fear of being seen as incompetent. The participants had to decide what they needed from their friends, family and nursing colleagues to assist them since their professional nursing identities' growth relied on a proper facilitation of their new roles and responsibilities (see Chapter 2, Section 2.2.1.1).

4.5.3.2 Subcategory b: Opportunity to prove professional nurse competence

According to one of the participants, the unit manager needed to provide them with opportunities to perform tasks to ensure that the nursing staff respect and acknowledge them as professional nurses. This, in turn, would contribute to the development of their professional confidence:

> *You [NQPN] need the unit manager to support you in terms of giving you tasks that will make the junior nurses to respect you and to recognise you as a RN [registered nurse] now, to acknowledge your position so that you build that trust, responsibility and accountability for your position.*(P10)

Four participants verbalised that the unit manager should trust their competence as professional nurses:

> *She [unit manager] also must be able to trust you [NQPN], she is on her own, she is running the ward.*(P6)

Some participants remarked that their unit managers found it difficult to trust them and constantly checked on them, which prohibited them from proving their professional nurse competence, which frustrated them:

> *No, will you [unit manager] please stop phoning. We [NQPN] will phone you when there is a problem.*(P8)

In addition, a participant stated that NQPNs needed an opportunity to prove their professional competence but with adequate support:

> *Today you are the shift leader ... to give me [NQPN] that opportunity, but to know that she [professional nurse] is there.*(P10)

A participant further described that some doctors found it difficult to acknowledge the NQPNs and preferred doing rounds with the familiar professional nurses in the ward:

> *He [doctor] told me [NQPN] you are not the right person to work here...where is who and who? She [professional nurse] is the one who is supposed to work here.*(P2)

NQPNs' sense of professional competence was dependent on the unit manager allowing them an opportunity for clinical performance and the experience of being trusted to perform tasks during the transition period (Roziers et al 2014:98). Consistent with Tomietto et al's (2015:856) findings, the participants in the current study also needed to prove their competencies to manage nursing care in the ward to enhance their professional credibility and to perform effective and safe nursing care. Like Wing et al (2015:639), this study found that the participants had limited opportunities to prove their professional nurse competence. In this study, the participants had EN level of empowerment in the clinical work setting and their wards, and

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needed to identify opportunities to learn and advance. The participants were exposed to countless new experiences early in their training; therefore, they felt empowered by opportunities to learn new skills and experiences. Through obtaining knowledge and experience from new opportunities, the participants were able to build clinical competence and confidence in their professional practice.

The current study concurred with O L´uanaigh P´adraig (2012:135) on the significance of responsibility of trust in allowing NQPNs to have a sense of belonging when given responsibility. It contributed to participants feeling trusted and supported by nursing staffand further enlarged learning during the transition period. Consistent with Laschinger, Zhu and Read's (2016:663) findings the current study confirmed that unit managers influenced NQPNs' job satisfaction by establishing empowering work environments with opportunities, trust and adequate support structures which encouraged autonomy over the nursing tasks and clinical work setting.

In the current study the participants experienced an intense learning period during the first stage, the *doing* stage of transition (Duchscher 2008:445), which took longer to process. The participants transitioned from the *doing* stage to the second stage, the *being* stage which was about the transferring of the participants' dependence on others to a reliance on themselves. The participants in this study were typical adult learners who did best when given the opportunity to apply what they had learned shortly after being taught how to do the skill or theory. The participants had a need to demonstrate what they had learned but had limited opportunities to display their new skills. Therefore the participants needed to arrange with the mentor, experienced professional nurse or unit manager for opportunities in the clinical work setting to immediately apply what had been learned. The participants needed to know they could trust their own competency, assessment abilities and skills. However, some of the participants interpreted attentive supervision as a doubt of their abilities as professional nurses.

4.6 THEME 3: FACILITATION OF TRANSITION SUPPORT

In this theme, two categories and three subcategories were identified. The findings revealed that the participants believed that transition support could be facilitated for NQPNs in the future. The

participants made a number of proposals pertaining to facilitation of transition support that might improve NQPNs' transition support experience during the transition period.

4.6.1 Category 1: Continuous professional development

From participants responses it was evident that due to lack of experience and exposure to various clinical and managerial situations in the clinical work environment, the participants had a need for continuous professional development. In this category, two subcategories were identified, namely assertiveness and managerial and administrative skills. Some specific training needs were identified which the participants experienced during the transition period which might assist future NQPNs in their continuous professional development as professional nurses.

4.6.1.1 Sub category a: Developing assertiveness

Some of the participants revealed that they lacked self-confidence, a vital trait in assertiveness for the professional nurse in the clinical work setting. The participants realised that they needed support to improve their self-confidence:

> *Maybe I [NQPN] lacked confidence in myself; maybe to help us [NQPNs] improve our self-confidence.*(P5)

Half of the participants reported that *'it became challenging in the initial stages [of the transition period] because you are not use to being assertive.'*(P4)

A participant further described having specific issues regarding lack of assertiveness with nursing staff:

> *The other thing that I am still struggling with, I am not very assertive with my staff.*(P1)

The participants' being new led nursing staff to challenge their authority, which forced them to become more assertive:

> *They will just, maybe because you are newly qualified, they will undermine you so you have to be assertive, you have to be firm.* (P6)

The participants also described that being an NQPN meant being responsible for the whole nursing team and also being confronted with managing nursing staff issues which required them to be objective and assertive:

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Their [nursing staff] attitude, the fights amongst them, it requires someone [NQPN] assertive, someone who needs to be impartial not to be taking sides or anything like that. (P6)

Participants suggested that workshops might be helpful in improving their ability to be assertive:

Maybe if there could be workshops now and then to teach the NQPN about assertiveness, confidence things like that. It can help. (P6)

Another participant added that training on various topics might be valuable:

Give specific training, maybe of different topics to develop them in independency and to develop them on standing alone.(P8)

During the transition period, NQPNs' assertiveness and confidence levels had an effect on their ability to manage patient care and nursing staff (Armendariz-Batiste 2016:5; Batch-Wilson 2016:32). Furthermore, NQPNs' assertiveness also had an effect on their ability to manage conflict situations (Hezaveh et al 2014:219) since NQPNs experience uncertainty, hesitation and confusion regarding role relationships and dealing with nursing staff in the clinical work setting (Mellor& Greenhill 2014:57). The current study supports these findings.

Hezaveh et al (2014:219) maintain that there should be a focus on how to increase NQPNs' self-confidence and assertiveness, and the need to explore how socialisation can be utilised to create a clinical environment to enhance NQPNs' self-confidence levels and assertiveness. In this study, the participants suggested that training and workshops on various topics, such as self-confidence, assertiveness and independence, were a priority to assist them in developing these required skills.

In the first three to four months of the participants' professional role transition, they experienced an adjustment process that was developmental, intellectual, socio-cultural and physical in nature. Therefore the participants were still adjusting and still in the *doing* stage that was supported by changing roles, responsibilities, relationships and levels of knowledge from the role of an EN to a PN that contained within it experiences, meanings, and expectations that formed part of the their personal and professional lives. The experience of transition was affected by previous EN developmental experiences, situations and settings that both

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prescribed and encouraged expectations about professional roles and responsibilities, work ethics and ward culture as a PN. The participants' professional role transition included idealistic views and feelings of *anticipation,* feeling prepared for the PN role while their fairly predictable life was transformed into expectations and responsibilities challenging their personal and professional identities which differed from the reality of the PN role. Instead the participants experienced varying intensity and fluctuating states of emotional, intellectual and physical well-being and were exposed to fear of the unknown, professional insecurity, lack of assertiveness and exhaustion due to workload.

4.6.1.2 Sub category b: Managerial and administrative skills

The participants did not specifically suggest how transition support could be facilitated in terms of managerial and administrative skills since these skills were taught while they were students during their management month module. However,the participants did specify with which managerial and administrative tasks they needed facilitation since they still found some of the skills expected from them difficult. To be able to facilitate transition support it was essential to isolate the managerial and administrative tasks the participants needed facilitation with.

The participants reported that they found prioritising the nursing tasks in a busy ward, with numerous variables, and the responsibility of making decisions regarding patient nursing care overwhelming and challenging:

> *So it was difficult for me; doctors rounds, dressings, when they [enrolled nurses] can't find a drip [initiate intravenous infusion] it's me [NQPN], and when there are problems in the wards it is you and you must go sort it out.* (P4)

Prioritisation did not present the only challenge because delegation of nursing tasks to nursing staff also caused distress to the participants. For example, *'I struggle to give orders and to delegate.'* (P1)

> *Sometimes your [NQPN] delegating was also challenging on its own, because now you have to try to manoeuvre that [delegating].*(P6)

One participant (P1) remarked that she would rather do things herself than delegate:

> *Because I really struggle sometimes, I would rather do something myself and know it's done than delegate it to somebody.*

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The participants felt frightened and overwhelmed by the decisions they had to make regarding patient care, in conjunction with the accompanying responsibility and accountability for these decisions:

> *Now it is me [NQPN] who must solve the problems. You panic, you don't know what to do next when this [making decisions] happens.* (P2)

Since most managerial and administrative tasks in the clinical work setting required the participants to be computer literate and have the ability to capture the findings electronically, this presented a challenge to the participants who were not computer literate:

> *No, I don't know how to use a computer.* (P4)

Furthermore, the participants reported that computer literacy was not a requirement for or a module in their educational training:

> *I think that they expected we all know how to use computers.*(P4)

The participants identified computer literacy as a definite area of development for NQPNs:

> *Being computer literate would also help while you [NQPN] are doing your management.* (P8)

> *I [NQPN] think there must also be continuous developed about their studies, about maybe doing like computer.*(P7)

> *Maybe if we [NQPNs] can get some training, because not all of us have been exposed to IT [information technology] programs.* (P4)

Planning, prioritisation and delegation was thrilling and empowering for some NQPNs, but at the same time also unpleasant due to their feelings of not having adequate skills, confidence, and intuition since it required the inexperienced NQPNs to manage and deal with delegation situations (Smith 2014:90). In the current study, the participants also felt they lacked practical experience due to the limited practice they had as students in terms of managerial and administrative skills required. NQPNs found that the role expectation for professional nurses was different, prioritisation of patient care was intricate, time management, multi-tasking and

managing a ward of patients simultaneously was difficult, and all the other aspects of the professional nurse role were less familiar during their transition period (Mellor & Greenhill 2014:57; Awasi, Cooke & Pryjmachuk 2015:1729).

In their study in America, Johansen and O'Brien (2016:46) found that decision-making required critical thinking which had an effect on the NQPNs' decision-making competencies. NQPNs were supposed to have the necessary clinical decision-making skills to provide safe patient care. However, NQPNs struggled with the theory-practice gap (Al-Dossary, Kitsantas & Maddox 2016:25). Decision-making is multifaceted and decisions in nursing are of a clinical, administrative, ethical, and moral nature and are influenced by contextual factors, the level of clinical nursing practice, theoretical training and influence, and patient outcomes and safety. Decision-making includes acquiring subjective and objective data about a patient's situation and the assessment of that data to execute actions to achieve the preferred outcome (American Association of Colleges of Nursing [AACN] 2014:45). In this study, the participants considered nurses' knowledge, experience, and ability to manage with altering situations were also important for decision-making in clinical practice.

Like Hazevah et al (2014:219), the current study found that when NQPNs worked alone, development of good clinical skills and pattern recognition was crucial for positive patient outcome. Joint partnerships were needed among nurse educators, NQPNs, hospital management, and educational institutions for the development of programmes that focus on critical thinking and decision making. Acknowledging that the need to work together and engage others in sound reasoning and decision-making could be supported through the use of scenarios, simulation, workshops and feedback during debriefing sessions was also identified as a priority in the current study.

NQPNs should focus on the need to know what to do and learn about tasks and technology, and find comfort in the new professional nurse role (Voldberg et al 2016:1761). This was illustrated in the current study as the participants indicated that they had limited computer literacy. Hence, they found it challenging to capture managerial and administrative tasks electronically. They realised they urgently needed training to assist them in this regard.

The current study also found that during the *doing* stage (Duchscher 2008:444), the participants had limited experience and exposure to managerial and administrative tasks. There was much to be *learned* and therefore a need for facilitation of transition support arose in the participants' new professional environment; their professional responsibilities; how to manage their workload and who they could trust; what skills they were required to do, or who they could turn to. The participants quickly focused on *learning and performing* the new professional nurse role and felt insecure after discovering the reality of nursing practice differed from their expectations. The participants found multi-tasking nursing, non-nursing duties, direct care of patients, caring for critical patients, dealing with difficult families, and the care of clinically unstable patients very stressful since they were not prepared theoretically for so many variables. In most cases the participants were so focused on task management that they were unable to manage complicated clinical situations. Since Duchscher's stages of transition theory does not specify how to facilitate transition support regarding managerial and administrative tasks, the current study made recommendations (see Chapter 5).

4.6.2 Category 2: Mentorship programme

It is evident from the findings that the participants believed that future NQPNs would benefit from a mentorship programme during the transition period. A need for a mentor for a period of time to assist the NQPN during the transition period was identified as a method to facilitate future NQPNs.

4.6.2.1 Sub category a: Mentoring of NQPN

Half of the participants indicated that they had needed guidance from 'someone' during their transition period. 'Someone' referred to a mentor who could be asked or called when the NQPN was unsure on how to handle a clinical situation:

> *It would help if there is that guideline or guidance... having an RN [registered nurse] speed dial number on line if you [NQPN] are faced with whatever, then at least you can call them [mentor, unit manager, experienced professional nurse] for assistance or guidance.*(P6)

The guidance included not only the NQPN seeking advice when struggling with challenges and obtaining assistance when needed from 'someone', but also the availability and accessibility of the proposed mentor:

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> *By being there for that person [NQPN], for me that is the only support. Then you go and talk to that mentor and it is somebody that when you need her she is there.* (P3)

The participants referred to a mentor, a teacher, a tutor, a clinical training specialist, a professional nurse or someone, but were not always clear on who should provide the guidance to the NQPN. However, the participants were adamant that they had needed support from a mentor during the transition period:

> *I [NQPN] would have like to have somebody, I don't know exactly who, but just to have a mentor to tell "I am struggling with this..." especially when I started I would like to have had somebody to encourage more or just give me tips on how to do it or something like that.*(P1)

The participants were clear on the fact that NQPNs did not want to be 'policed' or 'babied' by the person providing the guidance:

> *We [NQPN] need mentors. Not someone to mamma them or baby them but somebody, I don't know if you understand, but somebody that...not a police or bodyguard or security.*(P5)

A participant emphasised the importance of support and of having a mentor:

> *Support is very important. Especially if you [NQPN] don't know that there is somebody you can count on. Somebody, maybe like a mentor, you can always go back to seek advice from that person.*(P5)

In addition, the participants also had a need to share their experiences in the clinical setting therefore they needed an opportunity to share with a mentor who was available and willing to listen:

> *And it is if you [NQPN] want to tell them something they can...make...for you to be free and let out everything that you have inside.* (P7)

Guidance and support from a mentor had an impact on the professional socialisation of the NQPN during the transition period (Smith 2014:77). Consistent with Goodare (2015:41) findings, in the current study supervision and support was also invaluable to NQPNs transition

experience. Like Ashton (2015:13), this study indicated that it is vital for NQPNs to have the support of peers and nursing staff during their transition period. It is possible to support NQPNs on a ward level. Unit managers, mentors, experienced professional nurses and nursing staff could create an environment conducive for NQPNs to ask questions, to admit they did not know something, or to describe a situation that made them feel anxious.

Ketelaar et al (2015:957) suggest specific methods that unit managers could utilise, including formal and informal support to NQPNs, promoting autonomy with mentoring from experienced professional nurses. In this study, the participants emphasised that it was a priority that the experienced professional nurse needed to be from the NQPN's ward and not their unit manager, but who would create workplace standards and teamwork and to whom the NQPN could turn when in need of help.

The participants preferred not to be left alone in difficult situations, to be able to ask questions, and receive help from peer professional nurses and nursing staff as it promoted their sense of security and leadership, which concurred with Ekstrom and Idvall's (2015:81) findings. The findings from the current study support Odland et al (2014:541) who indicate that nursing care involves humans and theoretical knowledge alone did not describe the skills required. NQPNs required mentoring from experienced professional nurses, and time to acquire the practical knowledge and insight to carry out good quality nursing care as also indicated in the current study.

Mentors need to nurture NQPNs. Even though NQPNs have passed their exams and are considered competent professional nurses they are not yet experienced and could not manage complex patient situations. Mentors, therefore, socialise NQPNs to the norms of the profession and the routine of the ward (Blozen 2016:2). Like Ekstrom and Idvall (2015:81), this study indicated that reflection and discussions with a mentor might help NQPNs to obtain different views on leadership and team work. The mentor could be a role model and a resource for the NQPN during the transition period. According to Blozen (2016:2), motivation, approachability, confidence, and having a positive attitude are important qualities to effectively support NQPNs. In this study, the participants stated that to be a successful mentor requires the necessary knowledge and skills to support and teach NQPNs in the clinical work setting.

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This study found that during the *doing* stage (Duchscher 2008:444) the participants experienced emotional adjustment which required access to a support network of peers and colleagues, such as a mentor, and were considered an important link to their on-going professional development. Many of the participants battled with maintaining their beliefs, intentions and aspirations for providing nursing care. The participants experienced feelings of guilt due to their inability to perform the practice beliefs they considered elemental to their professional role.

4.7 SUMMARY OF MAIN FINDINGS

There were three main findings from this study:

- There was minimal understanding and recognition at the private health care level of the transition support needs of the NQPNs who upgraded from ENS who were making the transition to clinical healthcare practice in private hospitals. The participants (NQPNs) experienced transition support challenges and transition support needs.

  o NQPNs experienced role adjustment difficulties in terms of professional insecurity, theory-practice gap and professional socialisation.
  o NQPNs experienced difficulty with role expectations regarding role competence, and being the shift leader and the professional nurse.
  o NQPNs experienced emotional strain due to incivility, feelings of powerlessness and no sense of belonging
  o NQPNS experienced limited support in terms of availability of support and emotional support.
  o NQPNs had a need for guidance from the unit manager in terms of availability and accessibility of the unit manager and the regular provision of feedback.
  o NQPNS needed support from an experienced professional nurse that entailed orientation and being 'buddied'.
  o NQPNs needed acknowledgement of their NQPN status which required an introduction to the multi-disciplinary team and an opportunity to prove their professional nurse competence.

- There is currently no transition support programme during the transition period for NQPNs that upgraded from ENs in private hospitals in Mpumalanga Province. Since the transitions support needs of NQPNs in private hospitals in Mpumalanga Province have not been explored before the need for a transition support programme has not been identified. The participants (NQPNs) in this study voiced the need for transition support. The study identified the need for the facilitation of transition support regarding:
  - NQPNs needed continuous professional support in developing assertiveness and performing managerial and administrative tasks.
  - NQPNs needed a mentorship programme with mentoring by a mentor.

The different stages of the NQPN transition to professional practice illustrated in Duchscher's model of the stages of transition theory as discussed in Chapter 2 are not clearly understood or recognised. Consequently, the different learning and support needs of the NQPN during the transition period are not met.

- NQPNs need transition support mostly during the first two stages of the transition period since the findings support and confirm the *doing* and *being* stages in Duchscher's (2008) stages of transition theory as a representation of NQPNs' transition period in the selected private hospitals. However, in this study the participants did not refer to transition experiences related to the *knowing* stage but focused specifically on their transition support challenges and transition support needs during the *doing* and *being* stages.

4.8 CONCEPTUAL FRAMEWORK

The stages of transition theory was utilised to describe how NQPNs experience transition support during the transition period in private hospitals in Mpumalanga Province. The findings of the current study support and confirm the stages of transition theory presented by Duchscher (2008) as an accurate representation of the transition period experienced by NQPNs in private hospitals in Mpumalanga Province. NQPNs [participants] reported being prepared and ready for practice after three to four months into the transition period and there for only focussed in the Doing and Being stage of the transition period as demonstrated in Table 4.2.

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Table 4.2 Doing, Being and Knowing stage of Transition

Author	Duchscher	Du Toit	Themes of current study applied
Date	2008	2016	
Method	Qualitative interpretive inquiry	Qualitative case study	
Country	Canada	South Africa	
Setting	2 major cities	2 cities	
Doing stage — Disparity between expectations and real world / **Anticipation**	• Orientation • Disparities in education/ responsibility & practice support	• Introduction to organisation & orientation to ward • Idealistic role anticipation differ from reality of practice • Inadequate PN availability for practice • No formal mentoring • Want but not receiving feedback	Transition support needs • *Orientation* • *Buddy system* • *Regular feedback* Transition support challenges • *Powerlessness* Facilitation of transition support • *Assertiveness* • *Mentoring*
Learning, Performing & Concealing	Significant stress related to: • Multi-tasking • Speak with physicians • Processing orders • Managing patient & family issues • Anxiety & self doubt • Worried about missing something	Significant stress related to: • Task management • Delegating & speaking to nursing staff • Adequate exposure level and familiarity versus level of skill & knowledge • Professional self-concept • Unprepared to manage situations	Transition support challenges • *Theory-practice gap* • *Professional insecurity* • *No sense of belonging* • *Professional socialisation* Transition support needs • *Accessibility & availability of unit manager guidance* • *Introduction to multidisciplinary team* Facilitation of transition support • *Managerial & administrative tasks*
Adjusting & Accommodating	• Advance judgments/ practice decisions • Clinical responsibility • Wavering confidence • Delegation • Socio-cultural change to personal life	• Clinical responsibility • Altered confidence levels • Lack of communication skills • Isolation & self concept • Emotional adjustment	Transition support challenges • *Role competence* • *Incivility* • *Emotional support* • *Availability of support*

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Author		Duchscher	Du Toit	Themes of current study applied
Date		2008	2016	
Method		Qualitative interpretive inquiry	Qualitative case study	
Country		Canada	South Africa	
Setting		2 major cities	2 cities	
Being stage *Doubt, Frustration, Stress, Disengage, begin to recover*	**Doubting & Examining**	• Personal identity • Confidence/ awareness • Gaining comfort in roles • Able to scrutinise practice content	• Vote of confidence in ability • Tug & pull war-holding on letting go • Disappointment with provision of support	Transition support challenges • Being the shift leader and professional nurse
	Questioning & Searching	• Feeling exhausted, inadequate, disappointed, devalued, frustrated , powerless • Seeking validation for decisions & clinical judgements	• Powerless • Increasing trust in abilities	Transition support challenges • *Powerlessness* Transition support needs • *Opportunity to proof professional nurse competence*
Knowing stage *Stable level of comfort*				

After the application of the conceptual framework adapted from Duchscher's stages of transition theory and themes identified, concepts were interlinked in the current study as demonstrated in Figure 4.1.

The current study established that the participants (NQPNs) had a need to be *provided with transition support* from role players that were part of their context during the transition period in private hospitals in Mpumalanga Province. The role players included the *nurse manager, nursing standards manager, educator, clinical training specialist, peers, enrolled nurses and enrolled nurse auxiliaries.* The transition process consisted of three stages as described by Duchscher (2008), namely the *doing, being* and *knowing* stage. During the *doing* stage, the NQPNs [participants] *entered into nursing practice* as professional nurses. The NQPNs [participants] *experienced disparity between their expectations of nursing practice and the reality experienced in the real world* of nursing. The NQPNs [participants] further transitioned to

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the second stage; the *being* stage. During this stage, the NQPNs [participants] were exposed to feelings of *doubt, frustration* and *increased stress levels*. As this stage progressed, the NQPNs [participants] began to *disengage* from being dependent on support and *began to recover* from the transition shock and role adjustment difficulties. The NQPNs [participants] finally moved into the *knowing* stage where they experienced a *stable level of comfort* in the professional nurse role.
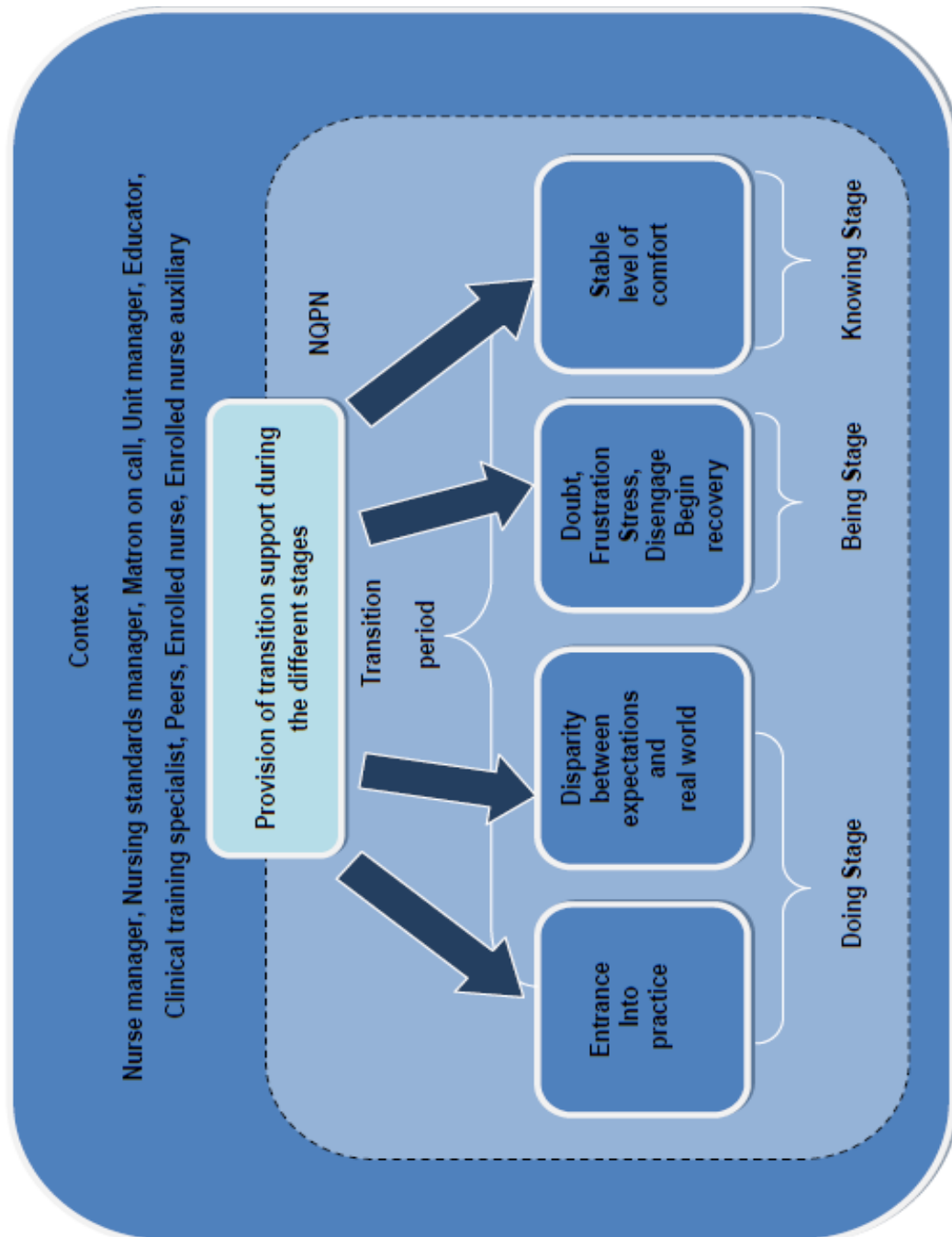
Figure 4.1 Conceptual framework   Adapted from Duchscher (2008:443)

4.9 SUMMARY

The transition support challenges of the NQPN transition process as well as the transition support needs have been established (Parker et al 2014; Lea et al 2015). To achieve the aim of the study, the researcher selected a qualitative case study design. The study explored and described how the participants (NQPNs who upgraded from ENs) described their transition support needs during the transition period in private hospitals in Mpumalanga Province. The participants' successful transition process to practice was dependent on several factors which included availability and accessibility of guidance and support from experienced professional nurses in the ward as well as the understanding of the unit manager and nursing staff. The study found that to improve the transition period experience of NQPNs, attention must be given to the needs and inputs of the NQPNs. It was further discovered that most of the participants desired to have guidance and orientation from an experienced professional nurse in the ward, follow-up visits with the clinical training specialist, and encouragement from all in the clinical setting. NQPNs needed frequent feedback from the unit manager and wanted to be trusted with opportunities to take ownership of the ward to improve their decision-making skills Recommendations were made in Chapter 5 based on the study findings and how to possibly address the problem identified in the study.

Chapter 5 discusses the recommendations, limitations and conclusion in detail.

CHAPTER 5

RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

*"Only the open-minded get to
experience the world
from many perspectives."*

-Anonymous-

5.1 INTRODUCTION

Chapter 4 discussed the study findings with reference to relevant literature. The major conclusions drawn relating to the aim of the study, the limitations of the study, and study findings are also discussed. Furthermore, recommendations are made for the nursing educator, nursing manager, unit manager and the NQPN. This chapter concludes with implications and recommendations for nursing education, nursing management and clinical practice regarding future research into this field of study.

5.2 AIM OF THE STUDY

The aim of this study was to explore and describe how NQPNs who upgraded from ENs described their transition support needs during the transition period in private hospitals in Mpumalanga Province.

5.3 SUMMARY OF MAIN FINDINGS

Three major findings arose from this case study. First, that there is minimal understanding and recognition at the private health care level of the transition support needs of the NQPN who has upgraded from an EN and is making the transition to clinical healthcare practice in private hospitals. The different stages of the NQPN transition to professional practice illustrated in the model of the stages of transition theory as discussed in Chapter 2 are not clearly understood or recognised and, as a result, the different learning and support needs of the NQPN during the transition period are not met.

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Secondly, that there is no transition support programme during the transition period for NQPNs that upgraded from ENs in private hospitals even though the NQPNs in this study voiced the need for a transition support. Since the transition support needs of the NQPN in private hospitals have not been explored before, the need for a transition support programme has not been identified. Whilst Duchscher`s (2008) study was conducted in a metropolitan setting with a sample of graduate nurses from two major city hospitals who were not employed on a formal transition support programme, the current study was conducted utilising NQPNs in private hospitals in Mpumalanga Province in South Africa with no transition support programme.

Thirdly, that the NQPNs need transition support mostly during the first two stages of the transition period since the findings support and confirm the *doing* and *being* stages in Duchscher's stages of transition theory (2008) as a representation of the NQPNs' transition period in private hospitals in this case study. However, in this study the NQPNs did not refer to transition experiences related to the *knowing* stage but focused specifically on their transition support challenges and transition support needs during the *doing* and *being* stages.

5.4 RECOMMENDATIONS

Recommendations are made to ease the NQPNs' experience regarding the transition support challenges, transition support needs and the facilitation of transition support during the transition period. The researcher makes the following recommendations for the nursing manager, nursing educator, unit manager and the NQPN in Sections 5.4.1 to 5.4.4.

5.4.1 Recommendation 1: Facilitate the role adjustment of the NQPN during the first three months of the transition period.

The role adjustment from student to NQPN requires a 'psychological shift' and the realisation that the key distinction between being a student and becoming a PN is the responsibility and accountability for decision making in practice (Maben & Clark 1998:150). The professional practice role of PNs consists of the responsibility and accountability for providing care and managing clinical situations for multiple patients simultaneously (Kramer et al 2013:692). According to the findings from the current study NQPNs can be facilitated in role adjustment by

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being made aware of the role adjustment that will occur and having adequate support as suggested.

Nursing educator to:

- Create awareness with NQPNs during their final year as students regarding the difficulties (transition support challenges as identified in the current study) they will face during the transition period to alleviate the fear of the unknown.

Nursing manager to:

- Send all experienced professional nurses for mentorship training provided by the healthcare institution twice a year continuously to be able to mentor NQPNs.

Unit manager to:

- Create opportunities for the NQPNs while still students to be the shift leader, prioritise nursing care and delegate nursing duties under the direct supervision of the unit manager to develop the required skills during the month of the curriculum stipulated management module.
- Allocate a mentor such as an experienced professional nurse working in the ward to the NQPN to learn from the role of a professional nurse on a daily basis during the first four months of the transition period.
- Assign the NQPN to the same shift roster as the experienced professional nurse to ensure the NQPN has the opportunity to observe and learn from the experienced professional nurse for the first three months of the transition period.

Newly-qualified professional nurse to:

- Collaborate and engage with the experienced professional nurse in decision-making aspects regarding patient and nursing care during the first three months of the transition period.

5.4.2 Recommendation 2: Enhance professional socialisation in the ward during the first three months of the transition period

The professional socialisation process centres on the learning of norms, attitudes, behaviour, skills, roles and values of the nursing profession. For the NQPN to become professionally socialised, integration of values and norms of the profession into personal behaviour and self-concept needs to occur (Lai & Lim 2012:32). Findings from the current study suggested professional socialisation can be enhanced through introduction, clarification of expectations and feedback to the NQPN as follow:

Nursing manager to:

- Design a formal feedback system to document feedback sessions between the NQPN and the unit manager on a monthly basis.
- Introduce the NQPN formally to the doctor, unit manager and nursing staff in ward allocated as an NQPN.
- Allow the allocation of NQPNs as supernumerary to enable NQPNs to learn and observe how to act within the scope of practice of a professional nurse during the first three months of placement.
- Incorporate the NQPN in the continuous professional development programme to ensure the development of clinical skills and professional development of the NQPN as a professional nurse during the first three months of the transition period.

Unit manager to:

- Introduce the NQPN formally to the nursing staff when commencing in the ward. This will indicate the endorsement of the NQPN by the unit manager and will further contribute to support and acknowledgement of the NQPN's status by the nursing staff.
- Initiate a discussion regarding expectations and outcomes from the unit manager and NQPN for the first three months of the transition period role expectations of the NQPN on entry of placement in the ward.
- Allocate NQPNs as supernumerary to allow NQPNs to learn and observe how to act in the scope of practice of a professional nurse and not be distracted by duties, ward management and workload during the pre-registration period.

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- Supervise the socialisation of the NQPN on how the ward functions by the allocated mentor and experienced professional nurse during the first three months post registration.

- Provide at least monthly formal feedback to NQPNs to ensure the improvement of the NQPNs' nursing practice and self-esteem during the remainder of the transition period.

- Utilise the formal feedback journal to document weekly and monthly feedback sessions with the NQPN to monitor the NQPN's progress and growth during the transition period.

- Arrange informal feedback sessions between NQPNs and allocated mentors and/or experienced professional nurses after every set of shifts for the first three months of the transition period and thereafter as needed.

- Provide feedback whether positive or negative in a professional and confidential way to maintain the dignity and motivation of the NQPN during the transition period.

- Perform a joint performance management discussion with the NQPN to provide formal feedback and evaluate the NQPN's performance after the first three months of the transition period post-registration.

Newly-qualified professional nurse to:
- Attend initial weekly and thereafter monthly formal feedback sessions with unit manager as scheduled during the first three months of the transition period and thereafter as needed.

- Attend the informal feedback sessions with allocated mentor and/or experienced professional nurse after every set of shifts for the first three months of the transition period and thereafter as needed.

5.4.3 Recommendation 3: Assist the NQPN in developing a sense of belonging during the transition period

A supportive work environment could assist the NQPN in overcoming feelings of inability to cope independently in practice during the transition period (Bontrager 2014:41). The ability of NQPNs to have supportive, positive relationships with the unit manager and colleagues is essential for the NQPN to feel accepted and to adjust to the work setting. Findings from the current study indicate NQPNs need assistance in developing s sense of belonging during the transition period and can be supported as follow:

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Nursing educator to:

- Educate NQPNs while still students on possibility of experiencing incivility and bullying from nursing staff and the process to be followed should it occur.

Nursing manager to:

- Develop a zero tolerance approach towards incivility and bullying.
- Establish the parameters of workplace incivility or bullying and a process that can be followed by the NQPN in case of experiencing incivility or bullying from nursing staff.

Unit manager to:

- Inform the nursing staff about the NQPN joining the nursing team to allow the nursing staff time to adjust to the new situation and addition of the NQPN to the nursing team before the NQPN commences in the ward.
- Explain the role and function of the NQPN to nursing staff of the ward with the NQPN present at the beginning of placement of the NQPN.
- Implement a zero tolerance towards gossip and rumours among nursing staff.
- Create a platform for the NQPN and nursing staff to ask questions and discuss problems in a safe environment on a weekly basis.
- Facilitate conflict management between nursing staff and the NQPN to discourage the blame game and encourage a solution orientation to problems should such a situation arise.
- Establish a set standard of behaviour of nursing staff towards each other to encourage respecting each other and the NQPNs continuously.
- Motivate NQPNs to report incivility during the initial weekly and monthly feedback sessions during the transition period.
- Initiate teambuilding activities to integrate the NQPN into the nursing team.

Newly-qualified professional nurse to:

- Report incivility to the unit manager during the transition period.

5.4.4 Recommendation 4: Provide and facilitate structured support to the NQPN during the transition period

NQPNs from the current study made a number of proposals pertaining to the facilitation of transition support that might improve NQPNs` transition support experience during the transition period. Suggestions were made regarding orientation, the provision of support structures and training and there for this recommendation are made as discussed.

Nursing educator to:

- Motivate for a computer literacy course to the educational nursing student programmes to ensure NQPNs are competent in the basic use of computers.
- Add electronic capturing of managerial tasks and findings as an outcome to the student management module to ensure the NQPNs are familiar and comfortable with the use of the electronic gateway.

Nursing manager to:

- Add electronic capturing of managerial tasks and findings as a refresher outcome to the pre-registration period to ensure the NQPNs are familiar and comfortable with the use of the electronic gateway.
- Collaborate and facilitate between the clinical work setting, clinical training specialist and the NQPN regarding the design of the transition support programme to ensure both parties' needs are met prior to commencement of the programme.
- Assess and take into consideration the NQPN's transition support needs in collaboration with the clinical training specialist when designing a transition support programme.
- Specify specific outcomes and support structures for the NQPN in the transition support programme to ensure adequate guidance is provided prior to commencement of transition support programme.
- Establish a transition support programme to support NQPNs during the transition period prior to commencement of the transition period.
- Schedule designated monthly follow-up visits during the first three months of the transition period with the NQPN and clinical training specialist to create a platform to determine the NQPN's needs and challenges.

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- Schedule quarterly visits thereafter with clinical training specialist at a designated time and private place to ensure the NQPNs' are provided with an opportunity to openly discuss the issues they experience after the first three months of the transition period.

Unit manager to:
- Allocate an experienced professional nurse who is familiar with the ward and procedures to perform the ward orientation with the NQPN for the first three months of the transition period.
- Follow up on the NQPN's progress regarding ward orientation during weekly and monthly formal feedback sessions during the first three months of the transition period.
- Add specific protocols and equipment used in the ward to the ward orientation to ensure the NQPNs are familiar and know how to use or apply it before the NQPNs commence ward specific orientation in the ward.
- Buddy or pair NQPNs with an experienced professional nurse on the same shift to ensure the observation and demonstration of professional nurse role modelling during the first three months of the transition period.
- Allocate NQPNs as shift leaders only when their clinical workbook is completed.
- Establish adequate support structures such as being able to phone the mentor, unit manager, matron on call or night supervisor for assistance prior to when NQPNs work alone and are the shift leader.
- Develop a flow diagram with the relevant support structures and contact details that the NQPN can utilise when working alone and as a shift leader when in need of assistance before NQPNs start leading shifts.
- Inform all the role players in the support structure about their function regarding providing the NQPN with assistance when needed before the NQPN starts working as a shift leader.
- Inform matrons on call and night supervisors when NQPNs are working alone and being the shift leader to ensure that extra support and supervision are provided.
- Establish a designated line of communication for decision making with the NQPN before the NQPN begins working alone and as shift leader.

Newly qualified professional nurse to:

- Participate in ward orientation conducted by the experienced professional nurse who is familiar with the ward and procedures for the first three months of the transition period.
- Complete the ward orientation with the experienced professional nurse as stipulated within the first three months of the transition period.
- Hand in the completed ward orientation proof to the unit manager at the end of the first three months of the transition period.

5.5 IMPLICATIONS FOR FUTURE RESEARCH

The researcher believes that this study has explored the phenomenon of transition support needs of NQPNs who upgraded from ENs making the role transition to professional nurse within the private healthcare settings, and will make a valuable contribution to the nursing literature as it has identified transition support needs specific to NQPNs in the private healthcare setting. The implications for future research for nursing education, nursing management and clinical practice are presented in relation to the provision and enhancement of a safe and supported transition to acute nursing practice. The recommendations that arose from this study are to 1) facilitate the role adjustment of the NQPN during the first three months of the transition period, 2) enhance professional socialisation in the ward during the first three months of the transition period, 3) assist the NQPN in developing a sense of belonging during the transition period, and 4) provide and facilitate structured support to the NQPN during the transition period. These recommendations will form the basis of future research recommended.

The intention of the researcher was not to generalise the findings from the study to the NQPN population in general. The intention was to identify and explore how NQPN experience transition support in private hospitals in Mpumalanga Province so that the findings may create an awareness on transition support needs specific to NQPNs in private hospitals in Mpumalanga Province. It is hoped that the research findings will assist nurse educators, nurse managers and unit managers to provide more sufficient and structured transition support during the transition period for NQPNs, which in the long term, could have a major impact on the recruitment and retention of NQPNs in private hospitals in Mpumalanga Province.

It is important to consider that some of the findings from this study relate not only to nursing in private hospitals but to NQPNs in general. The researcher believes that the NQPNs may had unrealistic expectations regarding their first year as an NQPN and lacked knowledge regarding the work setting organisation as well as the process of role transitioning. NQPNs experience fear of the unknown and the role adjustment from student to NQPN during the transition period. This was apparent by NQPNs stating they felt well prepared for their role as an NQPN. However, the researcher believes that nurse education, nursing management and clinical practice can attend to these matters to improve transition support during the role adjustment process for NQPNs. Thus, the study has illuminated a number of areas that require further investigation.

The study explored how NQPNs experience transition support as they made the transition from student to NQPN in private hospitals in Mpumalanga Province. It provided further evidence to support Duchscher`s (2008) Stages of Transition theory, as a model applicable to NQPN making the role adjustment to private hospitals. It also provide insight into the level and timing and length of support of transition support to ease the process of transitioning to private nursing practice and explores who is best placed to be involved in transition support for NQPNs in private hospitals in Mpumalanga Province. The study also identified transition support challenges in terms of receiving transition support in private hospital settings. Even though this study provides valuable insights into the transition support needs of NQPNs in private hospitals in Mpumalanga Province it also raises questions regarding the work setting as a professional socialisation environment for NQPNs. In particular, further research in order to extend the knowledge regarding the provision of transition support and the enhancement professional socialisation during the transition from student to NQPN.

How private hospitals overcome transition support challenges in terms of the provision and implementation of support identified in the current study lends itself to an organisational action research project as suggested by Lea et al (2014:955). Levett-Jones and Fitzgerald (2005:43) stated that there is limited collaboration between the nursing management and nursing education regarding NQPN transition. An action research project may involve nursing educators, private hospital nursing management and unit managers from clinical practice is required to promote strategies for the provision of transition support for NQPNs in private hospitals in Mpumalanga province. Lea et al (2014:957) also recommended that this type of

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study would assist to define and create transition support strategies that match the context and would assist in bridging the gap between clinical practice, nursing management and nursing education.

This study also identified transition support challenges experienced by NQPN during the transition period that had an effect on how they experienced transition support. The findings require further investigation into the adequate professional socialisation of the NQPN into clinical practice during the transition period. Such a research study would also assist to further explore and investigate strategies for fostering and further development of the NQPN`s sense of belonging in nursing practice.

In summary, the implications for clinical practice, nursing education and nursing management have been identified and recommendations for improving transition support for NQPNs during the transition period in private hospitals in Mpumalanga province have been proposed. Finally, the findings and recommendations have been used as a basis for further research.

5.6 LIMITATIONS

The study was planned and conducted to explore and describe the transition support needs of NQPNs that upgraded from ENs in private hospitals in Mpumalanga Province. The participants were selected from the acute clinical setting in two selected hospitals only. The unit of analysis was small because of the limited number of NQPNs working in the setting. Due to these facts, the transferability of the study findings is marginalised and findings of the study should be implemented with caution.

5.7 PERSONAL REFLECTION

Over the last two years my involvement in this study rejuvenated my passion for nursing education. My interest in the transition support needs of NQPNs in the private health care sector stems from my role as a clinical training specialist working with nursing students in our hospital group. In my current role, I have the opportunity to observe and reflect upon the adjustment of NQPNs in the clinical work setting. As a provider of clinical education, I had the opportunity to

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do research within the field of nursing education related to the training of ENs to become NQPNs.

The past two years were a journey of personal and professional growth. In the planning phase of the study my aim was to do a descriptive qualitative study but later, after many months of reading about the descriptive qualitative study and input from my supervisors, I realised that the use of a case study research design would be more valuable. However, the months I used to read, study and write about the descriptive qualitative design were still valuable since they taught me the value of the individual's subjective experience. It reminded me that there are always two sides to any case and that the aim is not to point fingers but to get perspectives from all the different role players involved. I found that the NQPN's perspective was missing and therefore I advocated for them to have a voice and raise their perspective. I realised as soon as all perspectives are raised collaboration can be initiated to meet the needs of all the role players involved. Initially I expected that I would encounter disinterest or even resistance from the NQPNs when asked to participate in the study – but I found that the contrary was true. All the NQPNs who participated in the study were eager to be part of this journey and this led me to the realisation that the NQPNs really have a need to voice their perspective and experience of transition support during their transition period.

I observed and realised that some of the transition support needs were elementary and could be met easily with minor adjustments. It was only by conducting this study that I truly came to understand the importance of communication, working together, and that being valued as a professional nurse as part of the nursing team cannot be underestimated. The NQPNs did not raise their transition support needs because no one asked for their input and they felt that their input was not valued. If the NQPNs' feelings, opinions and suggestions were asked for and considered and attended to by the all the different role players, it would make them feel more worthy and increase their sense of being valued. Support with transition support needs during their transition support period would not only empower NQPNs in their process of becoming professional nurses, but would also bring about positive change in clinical practice and the NQPNs' intent to stay.

Undertaking and completing this study filled me with an overwhelming sense of achievement and pride, both in my personal and professional life. The completion of this study was made

possible by the selfless efforts of all the NQPNs who willingly participated in the study. I acknowledge the contribution of every participant and thank all those who were involved in this study.

5.8 CONCLUSION

In the South African nursing context, all NQPNs are exposed to the transition experience from student to professional nurse in private and government hospitals. Recognising that there are various transition support challenges and transition support needs with regard to the transition period, the researcher opted to explore the transition support experienced by NQPNs who upgraded from ENs. A qualitative case study design was used to guide the study and the semi-structured interviews were used to collect the data. Inputs from all the participants were included and consensus among the participants was reached on the transition support of NQPNs who upgraded from ENs experienced during their transition period in private hospitals in Mpumalanga Province. The conclusions made in this study were guided by the identified themes, namely 1) transition support challenges, 2) transition support needs, and 3) facilitation of transition support needs.

The findings identified particular but necessarily unique transition support challenges and transition support needs for which NQPNs required additional learning and clinical support within a proposed transition support mentorship programme to facilitate an effective and safe transition to professional acute private nursing practice.

The transition experiences of the NQPN in conjunction with the predicted stages of transition theory were taken into account. According to the data obtained it was found that the NQPNs experienced most transition needs and transition challenges during the *doing* stage of Stages of Transition Theory. NQPNs experienced learning, performing, concealing, adjusting and accommodating during the first four months of the transition period in a non- linear way. In the Being stage participants only indicated experiencing the transferring of the NQPNs dependence on others to a reliance on themselves. NQPNs also non-linearly experienced role conflict, role adjustment, and role competence and transition shock during the *doing* stage of the Stages of Transition Theory. This study has shown that the NQPN is moving from the known role of the student to the less familiar role of the NQPN, it is important that a facilitation of transition

support mentorship programme are developed to improve the NQPNs role adjustment, sense of belonging, socialisation in the clinical work setting and provide structured support.

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Annexure A

ETHICS APPROVAL

Annexure A.1

UNIVERSITY OF PRETORIA

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

27/06/2016

Approval Certificate
New Application

Ethics Reference No: 75/2016

Title: TRANSITION SUPPORT NEEDS OF NEWLY-QUALIFIED PROFESSIONAL NURSES WHO UPGRADED FROM ENROLLED NURSES, IN PRIVATE HOSPITALS IN MPUMALANGA PROVINCE

Dear Annelie du Toit

The **New Application** as supported by documents specified in your cover letter dated 22/03/2016 for your research received on the 29/03/2016, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 30/03/2016.

Please note the following about your ethics approval:
- Ethics Approval is valid for 1 year
- Please remember to use your protocol number (**75/2016**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed,PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

☎ 012 356 3085   ✉ fhsethics@up.ac.za   🖳 http://www.up.ac.za/healthethics
✉ Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4-59, Gezina, Pretoria

Annexure A

ETHICS APPROVAL

Annexure A.2

THE HOSPITAL (1)

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

TOPIC: *TRANSITION SUPPORT NEEDS OF NEWLY-QUALIFIED PROFESSIONAL NURSES WHO UPGRADED FROM ENROLLED NURSES IN PRIVATE HOSPITALS IN MPUMALANGA PROVINCE*

Dear Sir/Madam

I hereby apply for permission to conduct a research study at   Hospital. I am a registered nurse, presently studying for a Masters Degree with the University of Pretoria, majoring in Advanced Nursing Education. The research topic is: "Transition support needs of newly-qualified profession nurses who upgraded from enrolled nurses, in private hospitals in Mpumalanga Province"

Participation in this study is entirely voluntary. The newly-qualified professional nurses who upgraded from enrolled nurses, in private hospitals can refuse to participate or stop at any time during the interviews without giving any reason. Their withdrawal from the study will not affect them in any way.

This study is awaiting approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria. The study will only be granted preliminary approval on the condition of receiving permission from the   Research and Scientific Committee and hospital managers from participating hospitals.

The contact person for this study is Annelie du Toit. If there any questions about this study she can be contacted on 084 510 1977

All information collected will benefit the   group and will be kept strictly confidential by the researcher. Once the information has been analysed no one will be able to identify individual participants. Research reports and articles in scientific journals will not include any information that may identify participants or the health facility. Attached herewith please find the consent to participate in the study which the researcher aims to utilise for the study.

Hope my application will receive your utmost consideration.

Yours Faithfully

A du Toit   Signature   Date: 19 May 2016

Permission to do the research study at these hospitals and access to information as requested, is hereby approved

Hospital Manager

Signature of Hospital Manager   May 2016

Signature of Nurse Manager

Date: 19 May 2016

Annexure A

ETHICS APPROVAL

Annexure A.3

THE HOSPITAL (2)

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

TOPIC: *TRANSITION SUPPORT NEEDS OF NEWLY-QUALIFIED PROFESSIONAL NURSES WHO UPGRADED FROM ENROLLED NURSES IN PRIVATE HOSPITALS IN MPUMALANGA PROVINCE*

Dear Sir/Madam

I hereby apply for permission to conduct a research study at   I am a registered nurse, presently studying for a Masters Degree with the University of Pretoria, majoring in Advanced Nursing Education. The research topic is: "Transition support needs of newly-qualified profession nurses who upgraded from enrolled nurses in private hospitals in Mpumalanga Province"

Participation in this study is entirely voluntary. The newly-qualified professional nurses who upgraded from enrolled nurses, in private hospitals can refuse to participate or stop at any time during the interviews without giving any reason. Their withdrawal from the study will not affect them in any way.

This study is awaiting approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria. The study will only be granted preliminary approval on the condition of receiving permission from the   Research and Scientific Committee and hospital managers from participating hospitals.

The contact person for this study is Annelie du Toit. If there any questions about this study she can be contacted on 084 510 1977

All information collected will benefit the Life Healthcare group and will be kept strictly confidential by the researcher. Once the information has been analysed no one will be able to identify individual participants. Research reports and articles in scientific journals will not include any information that may identify participants or the health facility. Attached herewith please find the consent to participate in the study which the researcher aims to utilise for the study.

Hope my application will receive your utmost consideration.

Yours Faithfully

A du Toit   Signature   Date: 24 May 2016

Hospital Manager

Signature of Hospital Manager

24 May 2016

Signature of Nurse Manager:

24 May 2016

Annexure B

PARTICIPANTION DOCUMENT, INFORMATION CONSENT AND INTERVIEW GUIDE

PICD 2

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT

STUDY TITLE: Transition support needs of newly-qualified professional nurses who upgraded from enrolled nurses.

Supervisor: Dr. R. Leech

Principal Investigators: Annelie du Toit

Student number: 29616973

Institution: University of Pretoria

Department: Department of Nursing Science

DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):

Daytime numbers: (013) 653 8048

Afterhours: 084 510 1977

Supervisor contact number: (012) 354 2134 / 082 441 4576.

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

				:
dd	mmm	ivy		Time

Dear Participant

Dear Mr. / Mrs. .... date of consent procedure …....../….....…/….......

1) **INTRODUCTION**

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved.

2) THE NATURE AND PURPOSE OF THIS STUDY

The purpose of the study is to describe your transition support needs as a newly-qualified professional nurse who upgraded from an enrolled nurse, working in a private hospital in Mpumalanga Province.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves individual interviews which will be scheduled at a time that will suit you. You will be asked about transition support needs of newly qualified professional nurses who upgraded from enrolled nurses. *If you agree to participate, you will be interviewed individually and with your permission be audio recorded for transcribing purposes. The audio recordings will be kept for 15 years by the department of Health Sciences of the University of Pretoria.*

4) RISK AND DISCOMFORT INVOLVED.

Minimum physical, emotional or social discomfort may be experienced as the study involves your transition support needs as a newly-qualified professional nurse. The interview sessions will last for about 45 minutes to 1 hour.

5) POSSIBLE BENEFITS OF THIS STUDY.

Although you will not benefit directly from the study, the results of the study will be utilised to make recommendations for the development of a program to meet transition support needs of new graduate nurses and improve quality of nursing care of patients in private hospitals in Mpumalanga Province.

6) WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal from the study will not affect you in any way.

Page 2 of 5

7) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, telephone numbers 012 3541677 / 012 3541330 and is awaiting granting of written approval by that committee. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding research involving human/subjects. A copy of the Declaration may be obtained from the investigator should you wish to review it.

8) INFORMATION

The contact person for this study is Annelie du Toit. If you have any questions about this study she can be contacted on 084 510 1977 or (013) 653 8048. Alternatively you may contact my supervisor Dr. R. Leech on office number (012) 354 2134 and cell number 082 441 4576.

9) COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10) CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analyzed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your institution.

11) CONSENT TO PARTICIPATE IN THIS STUDY.

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

....
Participant name   Date

....
Participant signature   Date

....
Investigator's name   Date

Page 3 of 5

....
Investigator's signature   Date

....
Witness name and signature   Date

Interview guide

The main research question supported by the following interview research questions will direct the study:

- _How do NQPNs who upgraded from enrolled nurses describe their transition support needs during the transition period in private hospitals in Mpumalanga Province?_

1. _Describe your experiences in adjusting to the new role of professional nurse?_

2. _How do you feel about your preparedness for the role of new qualified professional nurse?_

3. _How important is support to you during your transition period?_

4. _When did you feel ready for independent practice?_

5. _Did you have any transition preparation before becoming a professional nurse?_

6. _What type of support was available during your transition period?_

7. _Who provided this support?_

8. _What type of barriers to appropriate support did you experience?_

9. _What were your needs with regards to support during your transition period?_

10. _How can transition support be facilitated in future?_

Annexure C-
EXAMPLE OF TRANSCRIBED INTERVIEW AND THEME, CATEGORY AND SUBCATEGORY DEVELOPMENT

Interview transcription: Hospital 2 Participant 1   **Duration: 40 min 21 sec**

Researcher	Participant 1, thank you for participating.
Participant 1	Pleasure.
Researcher	I would like to clarify if there are any questions before we start the interview, something you would like to ask me before we start?
Participant 1	Nothing that I can think of. No.
Researcher	So let's start with the main question. How do newly-qualified professional nurses who upgraded from enrolled nurses (EN) experience transition support during the transition period in private hospitals in Mpumalanga Province? This will be the main directive question. Can you describe your experience adjusting to the new role of a professional nurse?
Participant 1	Well since starting as an EN, uhm (interjection) I was working... I come from Mosselbay. I worked already in an ICU so I already learned what is expected of an RN (registered nurse) the process that you gonna (going to) go through uhm (interjection) as a uhm (interjection) in adjusting to the role of RN. We as bridging students we were already exposed from day 1 to what is expected from a RN. Okay, so the adjustment that we made were through the whole course of the bridging. So from the first day of working as a RN I knew exactly what was expected from me. So I was already adjusted into my role while struggling as a bridging student
r Researcher	You said you were basically prepared throughout your course for this. Can you clarify; was this just in the course or when you were actually a RN in the unit? What was your experience there? I am not talking about during your training. You are finished now .What was your experience in adjusting to your new role as a professional nurse?
Participant 1	Uhm (interjection) you had more responsibilities as a RN. As a RN you have definitely more responsibility than a RN. You are responsible for taking care of patients, everything falls on you. If something goes wrong it also falls on you. Whether you were involved with that

Comment [A1]: P1 CHALLENGE
Adjusted to new role P1
Role adjustment

Comment [A2]: P1 CHALLENGE
responsibilities p1
Role adjustment- prof.confidence

1

	patient or not. So that is a big change to be made from EN. Because as an EN you still have that umbrella of the sister above you but as the sister in charge in a speciality unit you don't have the umbrella you are the umbrella for everybody else. So that is a big adjustment to be made and then also working in as specialised unit is different from the other units. Uhm (interjection) you, you have (pause) immediately you practice more independently than in other wards. Uhm (interjection) you`ve got a doctor that works there uhm (interjection) permanently .We've got specialised doctors that work permanently with us. They expect you from the moment you get your purple epaulettes that you know exactly what to do even though you just qualified and you may be unfamiliar with some of the procedures and things that must be done. You must immediately know what is going on in your unit whether you know or not. So that is a big change to be made.
Researcher	You spoke about two changes, being an umbrella for the unit and the doctor that has expectations (interrupted)
Participant 1	Are massive from the moment that you start.
Researcher	Can you elaborate on the expectations of the doctors?
Participant 1	They expect you when you get big trauma patients P1 patients uhm (interjection) to know exactly how to manage the patient. Uhm (interjection) which you don't learn during your bridging course .You don't exactly learn how to manage trauma patients' cases. So you have to know exactly what to give and when to give it, fluid ratios you have to work out understand the physiology and patho-physiology immediately which you learn but did not learn in a depth in your bridging course. And they expect of you to know exactly what is going on with your trauma patient. Uhm (interjection) intubation for example is something that you don't learn in the bridging course. They expect you to know exactly how to help them to intubate and to ventilate on a ventilator. You have never worked on before .So that is skills that you have to learn in practice while you go on. And that is what is expected of you the moment that you start.
Researcher	You also referred being the umbrella in the unit?
Participant 1	Ja (yes).
Researcher	Can you elaborate on that?

Comment [A3]: Good quote

Comment [A4]: Good quote

Comment [A5]: P1 CHALLENGE dr expectations p2
Role expectations- role competence

Comment [A6]: P1 CHALLENGE-dr expectations
Role expectation-role competence

2

Participant 1	Uhm (interjection) sometimes it is busy in the unit especially if we get two to three P1s. You are the only sister that is working on your shift and you've got only junior staff working under you. So all the P1s falls automatically on you. You are the one lacking rather than... you cannot expect of an EN to look after a ventilated patient, she know nothing about. She doesn't know how the ventilator works. So that automatically becomes your responsibility. But now I have the rest of the unit that is still functioning .I've got patients in the other cubicles on beds that I don't know about because I am busy with P1's keeping them alive. And then if something goes wrong with one of the other patients you are expected to take responsibility for that even though you were not involved at that time of the care of the patient. And especially some of our doctors they want you to be able to take care of the patients even though they know you are suppose to take care of the patients and the rest of the unit must function on their own without you. They expect you to be hands on with everybody. Already that is quite a big adjustment to be made. To learn to manage your staff to know who you can trust who you must still keep an eye on things like that.
Researcher	You talk about getting to know the staff managing the staff?
Participant 1	Getting to know especially your permanent staff that you work with. Some of them cope well in a specialised unit especially in a busy unit like ours. And some of them still need a lot of guidance even though they have worked there longer than you have been a sister. So you still have to learn when you get to the unit who is the stronger hands in your unit and who you can depend on and who are the ones in need of some support and assistance.
Researcher	Is that expected of you?
Participant 1	And that is expected of you the moment you start as a sister. You must know exactly which person goes where who you can trust and who you can't trust.
Researcher	How do you feel about your preparedness for the role of a newly-qualified professional nurse?
Participant 1	Uhm (interjection) I have been working in this specialised unit as a bridging student from my second year of bridging. So I barely rotated in my second year. So I was quite prepare when I walked into the unit and I knew exactly what was going on I knew already the staff because I have been working there for so long. Uh (interjection) my unit manager she's chosen me since my bridging year.

Comment [A7]: P1 CHALLENGE – ward expectations
Role expectations- role competence

Comment [A8]: P1 CHALLENGE managing &know staff P3
Role adjustment - prof. confidence

Comment [A9]: P1 CHALLENGE role adjustment P2
must know the staff and ward p3

Comment [A10]: P1 Prepared while student P3

3

	So in the second year I have already there long enough to know what was going on in the unit .So I was more or less prepared. There are some things you will never be prepared for. Like doctors what they expect of you because if you are a student they still know you are a student you get excused from some things but the moment you have the qualifications behind your name then you don't qualify as someone still being in the process of learning. You must already know although you are just newly qualified . I would say I was more or less prepared but there were some things I was not prepared for.
Researcher	Like what?
Participant 1	Like being the only sister on duty. Sunday when you have five P1's and a unit full of patients and still get 50 patients waiting outside for you. You are not prepared for that if you are still a student. Because if you are a student you still have your sister above you just there to help you but the moment that you are qualified you don't have that anymore. You are the one are suppose to take charge and there is nobody else to help you at that stage.
Researcher	What about it was difficult?
Participant 1	Uhm (interjection) it is difficult sometimes to run a full unit and then to manage patients that are outside and that are getting anxious and are getting difficult. At some stage you just lose your patience with the little bit that you had. So it is difficult maintain your professionalism when the ward is that busy and you get people that are anxious outside and getting angry at you which is something you don't have control over . I don't have control over the amount of P1's I get from the road. I don't have control over that. How long it will take to manage them I also don't have control over because I don't know what the injuries are gonna be and people don't always understand why they are waiting for long to be helped so that part is difficult for me. That part is difficult for me to deal with .Difficult patients because you can be nice up to a point and then you are not nice anymore and you are not being professional anymore and that is a difficult part for me.
Researcher	How important was support tot you during your transition period?
Participant 1	Very. It was very important for me to know I've got somebody that can support me. Uhm (interjection) at home I've got my husband. He is a very good listener so he will listen to my ranting and venting and actually he will sit and ask questions, he is very interested in medicine. So he will ask me questions to get me to talk about the day that I had at work. Uhm (interjection) at work it is also important to have somebody uhm (interjection)

Comment [A11]: P1 Need Acknowledge NQPN still learning p4

Comment [A12]: P1 CHALLENGE Not prepared to be only RN on duty P4 Role expectation- being shift leader

Comment [A13]: Good quote

Comment [A14]: P1 CHALLENGE Difficult multi tasking P4 Role adjustment- prof confidence

Comment [A15]: P1 NEED Support NB family P4 Support- emotional need

4

	like our unit manager is very supportive. If you call her during the day and say *"Listen I have a crisis. I cannot cope anymore"* she will make a plan for you even if it means she will have to come herself. Uhm (interjection) and I have known some of the sisters working with me for a long time since I started working there. So their support just to tell me *"We have all been through it"* uhm (interjection) *"Just hang in there, it gets better"* uh(interjection) just to give you a little bit perspective on how it's been since they have worked. It is important to have somebody to talk to that can say it gets better with time that can listen to your venting because to build up everything will not help at all.
Participant 1	When did you feel ready for independent practice?
Researcher	Uhm (interjection) when I didn't need anybody to help me anymore?! Uhm (interjection) (laugh). Sometimes I don't feel ready for it. I have been a sister for a long time now. Uhm (interjection) I must say during my second year of bridging course I have been working then long in the unit. You either swim or you sink. So then I started feeling ready so you learn more or less what is going on in the units. You learn how to handle your staff and how to handle your doctors. So by the end of my bridging I was already ready to work on my own to take charge of the unit.
Participant 1	I would like to clarify; you were ready to take charge of the unit on your own?
Researcher	I was taking charge of the unit from my first year of bridging. So (laugh) you learn on the fly it is not something that you are taught. You are either ready for it or not. I think for us we were thrown in the deep end. *"There you go my angel, either you swim or you don't make it."* So I learned you learn on the fly how things work. Uhm (interjection) if you are still a student and you are put in charge of a unit uhm (interjection) that is when you learn. For me that is when you learn best and to sort problems on your own because if there is nobody else then you make a plan to sort out the crisis that you got. Uhm (interjection) that's how I learned the best. If I can learn things when there is pressure on me I can learn the best. So that's why by the end of my second year I was ready. So I have been doing it for a while and I have been pressured to do it.
Researcher	Did you have any transition preparation before becoming a professional nurse?
Participant 1	I just want to make sure about the question; did somebody tell me there is going to be problems when I transition?

Comment [A16]: P1NEED- Support UM p4

Comment [A17]: P1NEED Support peer sister words of encouragement p5

Comment [A18]: P1 Ready Independent practice END 2ND YEAR BRIDGING

5

Researcher	It doesn't have to be telling. Was there any preparation, guidance or training on it?
Participant 1	Not really that I can think of. Uhm (interjection) as I said we were training on the deep side and that is where you learn to swim. So there was not really training on you are now going to transition from EN to RN so there is going to be a change in responsibility. It is something that I knew the moment that I take of the white epaulettes and put on the red epaulettes. It is going to be a change for me. That is something you see in everyday practice. So there was not somebody that told me this and this is going to change when you are a sister from an EN. That is something you see in everyday practice and it was something I knew from the day I started. There is something that gonna be different from the day you became an RN.
Researcher	What type of support was available during your transition period when you became a newly-qualified professional nurse? What transition support was available?
Participant 1	I did not have a mentor at all. Uhm (interjection) mentorship is not something that I have seen at all uhm (interjection) in the bridging course that I have experienced of. Uhm (interjection) so the moment in that transition the moment I became a sister there wasn't really any support from the hospital side. So if I can put it that way .The support I usually get from home, my husband and my family. If you come home crying, it was a difficult day then my husband will usually ask me what is going on or I'll talk to him or phone my mother. She was a nurse many moons ago so she more or less gets what I am going through. So that is more the support you get. It's difficult it's hard. It's not something that you really complain about at work that it is difficult or hard. Uhm (interjection) or I don't because I feel everybody that is qualified has all gone through something that is hard or difficult and coped with it or made a plan to cope with it .That is more or less it.
Researcher	You refer to not getting really support from the hospital side. Who exactly is the hospital side?
Participant 1	Uhm (interjection) if I think of the hospital side I think of the management. Uhm (interjection) my unit manager is supportive, you can… she is open all the time. You can go to her and tell her *"I've got a problem"* or *"This is what I experience is difficult"* especially if we have problems with the doctors or wit some of the staff.

Comment [A19]: P1 No preparation – No just knew

Comment [A20]: P1 CHALLENGE Mentoring P6

Comment [A21]: P1 CHALLENGE No support hospital side

Comment [A22]: P1 CHALLENGE – limited support - Type of support – did not speak about it at work everybody has problems P6

Comment [A23]: P1 NEED Type of support –UM available open

6

	Then you can really go to her and tell her this is the problem that I have. And she will try and sort it out for you. But with the little small things I don't feel to burden her with it. Ill rather try and suppress or sort it out myself. When you are newly qualified you don't run to the unit manager anger for every little thing because it looks like you can't handle what is going on with you. The transition that you made. But, ja. I really think mentorship for new sister. That you can trust, buddy with somebody not necessarily a buddy but just somebody that is there for you that you can talk to. And this is what I find hard. When I became a new sister I am newly qualified new all of a sudden there is all this responsibility on me. Just want to know how you are handling it, what you did or something like that. It would be nice to have something like that.
Researcher	You spoke about the support of your family, husband and hospital side. Was there anybody else who also provided you with support?
Participant 1	Not that I can really think of .No.
Researcher	In terms of management you referred to your unit manager. Anybody else?
Participant 1	Uhm (interjection) your peers, your fellow sisters. They also support you the best they could uhm (interjection) at this stage. When I finished we were very understaffed so we didn't have a lot of people working fellow sisters working there. You usually worked alone on a shift and uhm (interjection) you can't really talk to the juniors because they don't really understand what you are going through. Uhm (interjection) sometimes because we all work together we call friends. You'll phone somebody or whatsapp somebody that works with you. The other sister who qualified just before you or a little while before you and you will ask them "Listen I'm struggling with this" or "This is the problem that I'm having" or whatever the crisis is and they will give you support the best they could. But most of them are still struggling with it just before you, the year before you. So they are also struggling with it or never experienced the problem you've experienced you have. So they will listen but there is not always help to be given.
Researcher	What type of barriers did you experience to appropriate support?
Participant 1	Just explain barrier to me what hindered you from getting support?
Researcher	You spoke about areas that you did get support but there might have been areas where you struggled getting support. What was hindering that support?

Comment [A24]: P1 CHALLENGE
Type of support –did not ask for help with small things cant handle things P7

Comment [A25]: P1NEED
mentoring p7

Comment [A26]: P1 NEED
buddy –support from RN-p7

Comment [A27]: P1 NEED
support from RN p7

Comment [A28]: P1NEED
Support from fellow NQPN p7

7

Participant 1	Staffing, staff understaffe . If I think about working when we came into the units then you are working a shift with four people working in a ward with 30 to 40 patients. There is not enough staff so that you can have a buddy to work with that you can buddy with or sister. Then you work on your own whether or not you a are ready for it or not. So staff numbers is always a problem.
Researcher	I would like to clarify; this is now the unit you were placed in as a newly-qualified professional nurse?
Participant 1	Ja, also yes when we were rotated as well. You mean more when we were done?
Researcher	Yes looking at the newly-qualified professional nurse.
Participant 1	Uhm (interjection) that was also a problem with us cause we are always understaffed at our unit. So that was a problem that you didn't have somebody with you that has been qualified for a while that you can just see how they do things. You had to lean either on yourself or by asking the doctor what he want or how he wants it.
Researcher	You talked about the numbers of staff and you talked about qualified staff. Is it really about the amount of staff working with you or are you referring to qualified staff being on duty with you?
Participant 1	Both of them. Uhm (interjection) qualified staff there is not a . If I think of qualified staff I think of specialised trained staff that has been qualified into this specific speciality we are working in. Currently we are only three specialised trained sisters in the unit. When I started in the unit it was only the unit manager that was trained. So she was the one that can give you the specialised support when you are working in the unit. Uhm (interjection) the numbers of staff on a shift when I started you were lucky if we were 3 people on duty. You had one sister that was usually you, an EN and an ENA which means that even though you are and your unit manager is there over the week on a weekend, you are still alone. There is nobody to give you that support of just another sister being there another person that is your peer that is on your level to give you the support you need. That was the biggest barrier for . Uhm(interjection) can't think of another barrier at the moment.
Researcher	What were your needs with regards to support during your transition period? You were the newly-qualified professional nurse who recently qualified in your unit.

Comment [A29]: P1 CHALLENGE - understaff-no buddy – need buddy P7

Comment [A30]: Good quote

Comment [A31]: P1 CHALLENGE no other RN on duty to ask P8

Comment [A32]: Good quote

Comment [A33]: P1 CHALLENGE understaffed & qualified RN staff P8

Comment [A34]: P1-NEED Need a RN to ask- p8

8

Chapter 3

Participant 1	What would I want for support?
	Uhm (interjection) I would have liked to have somebody to just show you the ropes in the speciality.
	If I think of support that I needed, P1. The P2, P3 cases they are the cold cases normal things I can handle. You need support with you P1 trauma patients because they are the ones that can easily die .So I would have like.
	My needs would have been somebody just to help me just to work through one or two cases that you know what is expected of you with trauma patients. Because their management is much different from a normal patient that comes in a stomach or a broken finger.
	Uhm (interjection) there is multiple things to think of when you are managing a trauma patient and would like to have somebody to work with that knows what is going on and shows me this is how the ventilator works. This is how you ventilate a patient. Cause that something you never officially learn It is something that you had to learn either by yourself, reading or by asking. So I would have like to have somebody that shows me this is how it works. This is what is expected of you when you look after this patient.
	Uhm(interjection) ja, to have a buddy to with...
Researcher	You said you would have like to have that. Did you have an experience with a patient like that?
Participant 1	When I was just qualified. Quite a lot, yes. In the unit I am the one that gets all the trauma cases that come to me I don't know why.
	So you can... so the first day that you start the first trauma patient that you get that you have to ventilate .Now you stand in front of the ventilator you are not sure at all how it works. The one that we have is different from the one in ICU than you are used to more or less.
	Then you must tell the doctor you don't know how it works and then they shout at you because you are supposed to know how it works because you are mos now the sister and then you maar ask then to set it the way they want it and then it goes from there and that's how you learn. You ask them why do you put it like this why do you use this setting.
	So it could have been nice if somebody was there with me just to show me how to work with the ventilator the first time that I get there.
	The other thing that I am still struggling with, I am not very assertive with my staff. I struggle to give orders and to delegate
	So even now but especially when I started I would like to have somebody to encourage more or just give me tips on how to do it or something like that. Cause I really struggle sometimes. I would rather do something myself and know it's done than to delegate it to somebody.
	Now I have learned you cannot do everything yourself because you will not survive So now I have learned to, to ma ask very politely and nicely .If they say no I still feel bad but I know by now I actually have the authority to tell you this is what you have to do.
	But that is the support I would have liked.
	I would have like to have somebody, I don't know exactly how, but just to, to have a mentor to tell "I am struggling with this. This is something you can help me with to learn to delegate better and not to step on anybody's toes when I delegate."

9

Comment [A35]: P1 NEED
Need RN show me the ropes- orientation P9

Comment [A36]: P1 NEED
Needs RN show me how to use equipment – orientation equipment P9

Comment [A37]: P1 CHALLENGE/NEED struggle with assertive, delegate P9

Comment [A38]: Good quote

Comment [A39]: Good quote

Researcher	You talk about a mentor. You talk about a mentor being with you. Would you have liked to have the mentor during your course or when you were finished as a RN?
Participant 1	I don't think (sigh). That is a difficult one. Uhm (interjection) sometimes when I was still busy with the course I thought it would be nice to have somebody with me, not somebody working with me, somebody I can go to. *"I know you are my mentor. I am struggling with this. Can you quickly help me"* Uhm (interjection) if I think back on it now I think more the end of my course when you were in the last steps, when there were no turning back from where you have been, you can't go back to being a staff nurse, not anymore. You have gone too far from that point on. Just to say the first two three months when I have just became a sister I would have liked to have somebody either working with me in the unit. Or ja, preferably somebody working in my unit that has been there before, that understands the unit and works, that works differently from any other ward. That can give you just a little bit of advice. You can go to and if you want to cry or shout if you want to shout at. Cause even though my husband tries to understand there is some things in nursing that he doesn't understand. He has never experience it before so he can't fully understand what you are going through. You want somebody that has been through the steps to know what you are going through and just to give a little bit of help and support if you need it.
Researcher	How can transition support be facilitated in future?
Participant 1	Uhm(interjection)
Researcher	If you can develop the ideal plan.
Participant 1	If I can develop the ideal plan.... Uhm (interjection) a mentorship program is a good thing for me. Uhm (interjection) if you have someone, I know in the wards it might be easier or it might be difficult. I don't know I haven't worked in the medical or surgical wards for a long time now. If I could develop the ideal plan uhm (interjection) it be once you have been identified as coming to work in that unit. Once you are done uhm (interjection) that somebody already start working with you even though you might be rotating still in other wards. Start talking to you what is expected of you when you are coming to the unit with your maroon epaulettes. So that you can mentally prepare yourself for what you are going to be doing once you get in the ward. Then if you have questions or something you can go to the person and ask them without being funny about it that would be my plan.

Comment [A40]: P1 NEED Needs mentor P9

Comment [A41]: P1 Mentoring p10

Comment [A42]: P1 NEED Support mentor end of course P10

Comment [A43]: P1 NEED Support first 2-3 months FROM SISTER FROM UNIT P10

Comment [A44]: Good quote

Comment [A45]: P1 NEED MENTOR Facilitation- start working with before results. Prepare you P10

10

Researcher	I would just like to clarify because you talk about a mentor before?
Participant 1	Ja, before and.
Researcher	Am I understanding you correct?
Participant 1	And after. Uhm (interjection) just the guys that finish. Uhm (interjection) even before you finish it is a month or two. I cannot actually remember how long before you finish your course already know to which ward are you allocated to. You are given a choice of two and hopefully if there is a space hopefully you get your choice. Otherwise they are all allocated to where you are needed. Uhm (interjection) I think it will be a good thing that already at that point know I am going to work in this unit; somebody can start working with you and then two to three months afterwards just as you have been qualified as well. Until you feel I'm now fully in the transition. I made the transition and I'm ready to be on my own and then the mentorship can end.
Researcher	You said a mentor before you go to the unit starts working already with you. Did you mean that you already before starting to work as a newly-qualified professional nurse you are already working there a little bit?
Participant 1	You do work there a little bit, yes. Uhm (interjection) it all depends how the rotation works. Usually you start working in the unit that you are allocated to before you write your exams. You already go to that unit and you start working in that unit. Then it would be nice if somebody can tell you *"Get ready this is what is coming for you when you are finished."*
Researcher	Anything that you would like to add for future nurses? That we can facilitate them more?
Participant 1	Uhm (interjection) they must just be strong. It is not easy thing to become a RN. Some of them think it is moonlight and roses and it is gonna be nice. It is not as nice as everybody tells them. It's very hard work. Your responsibility is immense but if you are ready for it, then go for it and then hopefully you`ve got the support of all your educators. Because educators are also important in supporting you and if they support you, you are good to go.
Researcher	How does your educator support you?

Comment [A46]: P1 NEED Mentoring before starting p 11

Comment [A47]: P1 Had Support-Educator

11

Participant 1	They motivate you while they are especially in class. They motivate you to ask questions and to think outside the box, to think a little bit wider than you are suppose to study. I know our educator did that for us. That's why I am in this unit. She lets you think outside of the box and if you think out of the box Then you are a little, I don't know how to say, you are better sister than others because you can think of a situation and around a situation.
Researcher	You referred earlier to management and your family being supportive but you also refer now to your educators. Are you adding them to your support?
Participant 1	Yes, I am definitely adding to my support. I didn't think of them before. But I am definitely adding them. Uhm (interjection) if they see something in you uhm (interjection) that they can identify as a good quality, something that will make a good sister, they some of them tend to push you a little bit harder because they want the best in you to come out. You can always go to them and tell them. Uhm (interjection) my educator worked in my unit before. Uhm (interjection) you can go to her tell her what I am having difficulty with and she understands. And then she can also give you advice on whatever you need. But she is also strict on you because she wants to push you to be the best that you can be.
Researcher	Was this support only when you were a student?
Participant 1	It is ongoing. I am a student again, so for now I can still go to her. *"This is what I am struggling with in the practice or when you were still a student how did this work"* then she can just give you guidelines. But now it's more of it's not a bridging student uhm (interjection) the relationship that we have its more of we are both specialised trained although she has years of training above me. But your relationship changes once you become a sister. I still look up to her and respect her an awful amount but the relationship changes once you become a sister because then they see you as a peer and not a bridging student.
Researcher	Was that your experience when you finished?
Participant 1	That's how I feel at this moment.
Researcher	And when you finished as a student and you were a newly-qualified professional nurse?

Comment [A48]: Support think outside the box

12

Participant 1	The relationship did change a lot, not as much as the last past how many years have I been qualified. Then you still the student that you have been but you still get the support that you got all the years you have been studying.
Researcher	Thank you for participating. Were there any questions from your side that I need to clarify?
Participant 1	Don't think so. No. If there is anything you are welcome to contact me again.
Researcher	Thank you.

	Field notes
Participant	1
Interview date:	27/06/2016
Age	29
Gender	F
Years EN experience	6 months
EN ward	Specialised unit
NQPN year qualified	2012
NQPN years experience	4 years
NQPN ward	Specialised unit
Behaviour in interview	**The participant** The participant was slightly anxious, talked and giggled a lot before starting the interview. The participant spoke non stops and had occasionally more than one idea in a sentence which could indicate anxiety. Participant 1 loosened up and relaxed as the interview progressed and spoke with more ease. The researcher had to keep on re- directing the participant back to the topic. The participant had difficulty sticking to topic possibly due to having students in her ward with her current focus on students. The participant tends to get lost in own thoughts when recalling events.

13

The participant struggled speaking in English and sometimes reverted to some Afrikaans words. Even though English is not her first language it could also be an indication of stress due to interview.

The participant has recently completed her specialised trauma training and is very opinionated about how things should be done.

The participant used "Uhm" a lot which could be a sign of anxiety or difficulty with the English language.

In the interview the participant was hesitant in remarks about management possibly due to lack of management support.

The participant displayed a slouch posture and tends to lean forward, makes eye contact and is facially expressive which can indicate open body language and willingness to partake in the interview.

The Researcher

The researcher did not know the participant prior to the interview and was not a clinical training specialist to the participant previously. There for the researcher could not have been biased towards the participant.

The researcher experienced a positive attitude from the participant.

The researcher was slightly nervous since it was the first full interview to be done.

The researcher had to constantly change and re-direct the questions to keep the participant's focus on the topic.

Environment

The office where the interview was conducted was private and not in the participant's ward to eliminate disturbance and anxiety.

The office was private and quiet with no disturbances to prevent distractions.

The unit manager gave permission to the participant to go for the interview while on duty since there was enough staff on duty to cover her absence.

Prior to commencement of the interview the researcher turned her cell phone off and asked the participant to do the same to prevent disturbance.

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Theme	Category	Subcategory
1. Transition support challenges (Section 4.3)	• Role adjustment difficulties (Section 4.3.1)	• Lack of professional confidence (Section 4.3.1.1)
		• Theory-practice gap (Section 4.3.1.2)
	• High organisational expectations (Section 4.3.2)	• Role competence (Section 4.3.2.1)
		• Organisational socialisation (Section 4.3.2.2)
	• Resistance to accept NQPN (Section 4.3.3)	• Nursing hostility (Section 4.3.3.1)
	• Lack of support (Section 4.3.4)	• Availability of support (Section 4.3.4.1)
		• Being the shift leader and the registered nurse (Section 4.3.4.2)
2. Transition support Needs (Section 4.4)	• Guidance (Section 4.4.1)	• Availability and accessibility (Section 4.4.1.1
		• Emotional support (Section 4.4.1.2)
	• Support from an experienced registered nurse (Section 4.4.2)	• Orientation (Section 4.4.2.1)
	• Understanding (Section 4.4.3)	• Regular feedback (Section 4.4.3.1)
		• Opportunity of trust (Section 4.4.3.2)

Annexure D

DECLARATION BY THE EDITOR

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28 November 2016

TO WHOM IT MAY CONCERN

I hereby certify that I have edited Annelie du Toit's master's dissertation, **Transition support needs of newly-qualified professional nurses who upgraded from enrolled nurses**, for language and content.

IM Cooper

Iauma M Cooper
192-290-4