

**PREPAREDNESS OF BRIDGING PROGRAMME GRADUATE NURSES TO ASSUME
THE ROLE OF A NEWLY QUALIFIED PROFESSIONAL NURSE**

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A dissertation submitted to the Department of Nursing at Durban University of
Technology in fulfillment of the requirement for the Degree of Master's in Nursing
Education

Date: May 2022

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly, acknowledged (including citation of published and unpublished sources). The work has not been previously submitted in any form to the Durban University of Technology or to another institution for assessment or for any other purpose.

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ABSTRACT

Introduction

Preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse has been an area of debate between nurse educators and employers in a rapidly changing healthcare environment. Factors such as heavy workloads, staffing shortages and increased patient turnover, can prove to be stressful for the graduate nurse, resulting in a lack of confidence in their ability to effectively carry out their new role in the clinical setting.

Purpose of the study

The purpose of this study was to explore the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse.

Methodology

A quantitative, descriptive survey research design was used for the study. The sample for the study was 95 bridging programme graduate nurses who had graduated from the Private Nursing Education Institution in the year 2020 and were working in the private hospital environment for not more than a year. Data was obtained through a questionnaire on KwikSurvey.

Findings

The study established that bridging programme graduate nurses that had more than five years of working experience as an enrolled nursing auxiliary and enrolled nurse, had significantly increased patient care and management competencies. While 52.50% (n=50), that had less than one year of experience as an enrolled nursing auxiliary and enrolled nurse significantly reduced their general nursing care activities and management competency. The study also noted that 61% of the respondents did not receive clinical support from the unit manager.

Conclusion

This study concluded that graduate nurses that had less than one year of work experience as an enrolled nursing auxiliary and an enrolled nurse significantly lowered their competencies in general and patient care activities. In this study, it was found that the bridging program graduate nurses needed more mentorship and activities that would enhance their general and patient competency because the more mentors they had, the more competent they were. The study further highlighted several challenges during their transition as a newly qualified professional nurse such as shift leading after a month after graduating and having no mentors to guide them in decision making; hence in this study it was noted that newly qualified graduate nurses must be provided with the necessary clinical and managerial assistance to better support them for their new role hence preventing new nurses from experiencing transition shock during their initial stages of transition from a graduate nurse to that of a professional nurse.

Dedication

I dedicate this dissertation to my late parents, Jaya and Rookmoney Naidu. I will always keep the beautiful memories that I have of you both, close to my heart. If wishes could be granted, I would want the both of you to be my parents in all of the lifetimes to come. I love you both more with each passing day. My dearest mum, thank you for always encouraging and supporting me throughout my academic journey. You have instilled the value of a good education in me and this is something that I have passed on to my children.

To my precious sisters: Sharon, Charmaine and Vanessa. Thank you for your enduring love, continuous support and most importantly, the encouragement to complete my study when I was ready to give up.

To my beautiful daughters Saiurie and Shivaria, thank you for your understanding and love and thank you for holding the fort during my academic journey. I love you to infinity and beyond.

To my nieces Yugeshnee, Davanya, Shriya and Saieshnee, and my nephews Davashin, Vidarshan and Nisaiyan, thank you for the laughter, joy and support.

Acknowledgements

I would sincerely like to express my gratitude to the people that assisted me in the completion of this study:

To the bridging programme graduate nurses, thank you for your time and valuable information which I have greatly appreciated.

To my supervisor Dr D. Sokhela, your encouragement, guidance and expert knowledge is greatly appreciated.

To my co-supervisor Mrs. P. Pillay, your supervision and guidance is highly appreciated.

To my co-supervisor Mrs. M. Coopasami, thank you for your supervision and guidance.

To my campus manager, Mariann Theron, thank you for your guidance and continuous support.

To Mrs. Loniese Manning, thank you for your continuous assistance. May you always be abundantly blessed.

To Ms. Tracy Bernhardt, thank you for your kindness and support. May God grant you the strength to complete your own dissertation

To Mrs. Devi Veerasami, your support and guidance is appreciated

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LIST OF ACRONYMS

Acronym	Full Term
SANC	South African Nursing Council
PNEI	Private Nursing Education Institution
KZN	Kwa-Zulu Natal
AHPRA	Australian Health Practitioner Regulatory Agency
STATS SA	Statistics South Africa
GEN	General Activities
PAT	Patient Care

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 Introduction and Background

In an ever-changing healthcare environment, one aspect that has remained unchanged is the demand for nurses. At the selected Private Nursing Education Institution (PNEI), the two-year diploma in general nursing is referred to as the bridging programme that leads to registration as a general or psychiatric nurse according to the South African Nursing Council (SANC) Regulation No. R683 of April 14, 1989, as amended. This bridging programme allows for the two-year trained enrolled nurse to become a professional nurse. Enrolled nurses must complete a two-year certificate programme (SANC Regulation R2175) and thereafter work under the direct and indirect supervision of a professional nurse. The breakdown of the bridging programme curriculum includes Ethos and Professional Practice, Ward Management, Applied Social Science, Integrated General or Psychiatric Nursing Science and Clinical Teaching (R683, 1989, Paragraph 7 (a), (b), (c)).

Upon completion of the bridging programme, the graduate nurse should be able to direct and control interaction with patients, be skilled in diagnosing an individual's health problems, plan and implement any therapeutic action. They are expected to provide nursing care for the individual and collaborate harmoniously with the nursing and multidisciplinary team (R683, 1989, Paragraph 7:1-b, c, and e). The graduates are employed by the private hospital group in the capacity of newly qualified professional nurses. Hence, employers expect them to be work-ready on completion of the bridging programme. Some of the expectations from employers include managing a shift and delivering safe patient-care in a complex healthcare environment with little or no clinical support. In the selected PNEI, the bridging programme nurses function in a dual role being that of a student nurse and part of the work force and may not always be allocated tasks that prepare them for roles as a newly qualified professional nurse. Christensen *et al.* (2016: 2784), insinuates that the various curricula may have some influence on the preparation of graduate nurses for practice. Despite not being a new topic of discussion,

the claim of work readiness continues to be a concern for clinical practices today as the shortage of senior professional nurses may often lead to a decrease in opportunities for mentoring newly qualified professional nurses in achieving their clinical competencies for their roles as professional nurses.

According to Duchscher (2009: 1111), clinical placements for student nurses should be dynamic, highly intensive and conflict-laden contexts of professional practice which offer an alternating balance between theoretical knowledge and clinical skill practice. Hence, the effective transition of a graduate nurse into the clinical environment is imperative as employers are of the opinion that the education and clinical experience provided to a student nurse prior to entering the work environment, is inadequate thus contributing to the lack of preparedness for the reality of the clinical environment (Muruvan 2018 : 1).

The healthcare environment needs to understand that autonomous skills and confidence of new graduates strengthens over a period of time, provided that they are adequately mentored. Duchscher (2009) cited in Ankers *et al.* (2017: 319) suggests that it takes one to four months for graduate nurses to adjust to the workplace and must be supported in the first three months of employment. Adjusting to employers' expectations and taking accountability in the healthcare setting is challenging in the initial months of employment for the graduate nurse. These challenges most often lead to the graduate nurse experiencing a transition shock in a fast-paced clinical setting. Similarly, Ankers *et al.* (2017: 319) highlighted that university teaching does not adequately prepare the new graduate for the realities of the clinical environment.

1.2 Research Problem

Newly qualified professional nurses face several obstacles that prevent them from transitioning successfully into practice. These include an increased number of patients with several co-morbidities and lack of clinical support from senior nursing staff. These factors negatively impact these newly qualified professional nurses' confidence and

competence. Often, they become overwhelmed in an unsupported nursing environment. Christensen *et al.* (2016: 2784) emphasise that in an unsupported healthcare setting, newly qualified professional nurses go through a transition shock which then leads to feelings of insecurity, especially with the increase in expectations and responsibilities that come with being a newly qualified professional nurse. As a nurse educator, the researcher has observed that these newly qualified bridging programme graduate nurses are often allocated to a shift leader's role in the nursing units and are expected to manage a shift in an unsupported environment. Edwards *et al.* (2017: 326) found that although newly graduated professional nurses meet all the qualification requirements, they have limited clinical experience, competence and confidence to manage nursing staff and to deliver safe patient care immediately.

The transition from a student nurse to a newly qualified professional nurse has been identified as a period of turbulence characterised by stress and anxiety (Walker *et al.* 2015: 2). In 1975, Kramer coined the term "reality shock" to highlight the difficulties, frustration and disillusionment that new nurses face as they transition to the new professional role (Kramer 1975: 891).

The consequences of these shortfalls have been highlighted in several studies for example (Mampunge and Seekoe 2014; Ortiz 2016 and Usher 2015). The researcher recognises that there may be a transition shock from a bridging programme graduate student nurse to a newly qualified professional nurse and therefore aims in this study, to explore the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse.

1.3 Purpose of the study

The purpose of this study was to explore the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse.

1.4 Research Objectives

- To ascertain how bridging programme graduate nurses view their preparedness to assume the role of a newly qualified professional nurse.
- To determine the factors that affect bridging programme graduate nurses' preparedness to assume the role of a newly qualified professional nurse.
- To determine if demographics have an effect on the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse

1.5 Research Questions

- How prepared are bridging programme graduate nurses to assume the role of a newly qualified professional nurse?
- What are the factors that affect the bridging programme graduate nurses' preparedness to assume the role of a newly qualified professional nurse?
- What is the relationship between demographic variables and the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse?

1.6 Significance of the study

The results of the study will be used to establish the presence and the level of preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse. The results obtained from this study will then inform nursing educators, preceptors, nurse managers and policy makers about the transition support needs and challenges experienced by newly qualified professional nurses.

1.7 Operational Definitions

1.7.1 Newly Qualified Professional Nurse

A newly qualified professional nurse is defined as a competent and independent practitioner in nursing who gives comprehensive nursing care, assuming responsibility and accountability for holistic care provided to a patient. (Nursing Act, No.33 of 2005).

1.7.2 Nursing

Describes a caring profession practiced by a person registered under section 31, which supports, cares for and treats a healthcare user enabling them to achieve or maintain good health and where this is not possible, cares for a healthcare user so that he or she lives in comfort and with dignity until death (Nursing Act 33 of 2005: 6).

1.7.3 Preparedness

Preparedness is defined as being ready to confidently deliver safe patient care (Usher *et al.* 2015: 3246 and Walker *et al.* 2017: 501).

1.7.4 Student Nurse

A student nurse refers to a person registered as such in terms of section 32 of Nursing Act, 33 of 2005 (South Africa 2005). For the purposes of this study, the researcher used the term “student nurse” to refer to a student who is registered for the two-year bridging course regulated by R. 683 of 14 April 1989 as amended (SANC 2005).

1.7.5 Bridging Programme

A bridging programme is specifically designed to assist a person who already has a qualification, to attend college and achieve a higher qualification in the same field of study, and in less time than an entry-level student would require. The bridging programme for enrolled nurses is a two-year programme that allows the enrolled nurse to proceed to the level of a professional nurse (Mellish and Paton 2009: 61).

1.8 Outline of the dissertation

Chapter 1: Introduction and background to the study

In this chapter, the background of the study, problem statement and scope of the study were discussed. The aim and objectives of the study were also described.

Chapter 2: Literature review

A discussion of the recent literature and the theoretical framework were provided in this chapter.

Chapter 3: Research Methodology

This chapter outlined the research methodology used to conduct this study. Techniques and methods of the research process were also discussed.

Chapter 4: Presentation of results

In this chapter, findings of the collected data were analysed with regards to the aim and objectives of the study.

Chapter 5: Discussion of results

This chapter highlighted the descriptive analysis of results obtained from the findings in order to answer the research questions.

Chapter 6: Conclusion, limitations of the study and recommendations

The conclusion, limitations of the study and recommendations were given in this chapter.

1.9 Summary

This chapter included the overview of the study, the purpose of the study as well as the background to the study, the population and the definitions of concepts that were used. The next chapter discusses the literature review conducted for the study.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature reviewed for the study. According to Grove, Gray and Burn (2015: 153), a literature review is an organised written presentation of what is already known about a topic or what has been published previously on an area of research that is of interest to a researcher. The literature review makes the researcher aware of the existing body of scientific knowledge on a subject of interest and assists the researcher in comparing and contrasting the findings of other researchers.

In this chapter, articles published from 2009 to date were perused for the literature review. Relevant documents published by the South African Nursing Council were also consulted and cited in this literature review. The chapter discusses the Nursing bridging programme in the South African Nursing context, the reality or transition shock, the preparedness of student nurses to assume the role of a newly qualified professional nurse, challenges confronting their level of preparedness and the intervention strategies to prepare newly graduated nurses for their roles as professional nurses. Literature was accessed and reviewed from various databases such as Ovid, Google Scholar, Science Direct, SCOPUS and PubMed. Keywords such as preparedness, readiness, student nurses/nurses and role-taking were used to source literature from the different databases. The literature reviewed included international, regional and local aspects of nurses' preparedness for practice and assuming the role a qualified professional nurse. The searches were restricted to articles published in the English language.

2.2 The Bridging Programme

A bridging programme is a degree pathway specifically designed to assist an individual who already has a qualification, to attend college and achieve a higher qualification in the same field in less time than an entry-level student would require (Boelen and Kenny, 2009: 533). In the Nursing profession, bridging programmes assist already qualified nurses to progress to the next level of their careers. These programmes may be pursued

while the student continues working or can be completed in a shorter time than it will take to return to the traditional nursing programmes. The various bridging programmes differ from country to country in terms of the admission criteria, duration of the programme, qualifications and the curriculum.

In Australia, the bridging programme is specially designed for qualified international registered nurses hoping to work in the country. The Australian Health Practitioner Regulatory Agency (AHPRA), through the Nursing and Midwives Board, has a bridging programme that helps international qualified nurses and midwives to gain knowledge and skills required to competently practice in the various healthcare settings. Upon completion of the bridging course, graduates apply to the AHPRA for registration as registered nurses (AHPRA, 2021).

In Ontario, Canada, college nursing bridging programmes also provide the education needed for registered practical nurses (RPNs) to get a Bachelor of Science in Nursing Science (BSCNS) degree and become Registered Nurses (RNs) thus enabling internationally trained nurses to get certified to work. The bridging courses are necessary to provide in-depth knowledge and learning experience for RPNs and RNs. Although the duration of the programmes vary, they comprise different categories of nursing courses that allow students to access BSCNS programmes if certain academic levels are achieved (Ontario College Application Service, 2021). Likewise, in South Africa, the bridging programme is also designed to assist enrolled nurses to be registered as general nurses or psychiatric nurses (SANC, R683).

2.2.1 The Bridging Programme in South Africa

In South Africa, the structure and design of the bridging programme differs from other countries. The South African Nursing Council (SANC) on April 14, 1989, published regulations relating to the minimum requirements for a bridging programme for enrolled nurses leading to registration as a general nurse or psychiatric nurse. The bridging programme, through SANC Regulation No. R683 was introduced to allow the two-year trained enrolled nurses to proceed to the level of a professional nurse.

- Admission to the bridging programme

Applicants for the programme must produce proof of enrolment as a nurse and have a Standard 10 (Grade 12) certificate. Applicants without a Standard 10 (Grade 12) certificate must apply to the SANC for recognition of prior learning. Recognition of prior learning assessment is matched with the learning outcomes of the final year of the programme for enrolled nurses. The applicant must meet the SANC requirements for enrolment as a registered nurse before he/she can access the bridging programme (SANC Guide for the implementation of recognition of prior learning by nursing education institutions 2009: 16).

- Duration of the programme

The programme is offered over a period of two academic years. During the programme, a student is granted not more than sixty (60) days leave of absence. Sick leave is calculated at twelve (12) days per academic year (R683, 1989, Paragraph 6). Any break during the programme has to be made up to complete the prescribed duration of the programme.

- Examinations

The nursing schools conduct formative theoretical examinations during both years of training. Entry requirements for the first-year examination are approximately 40 weeks of training and a pass with a mark of 40% in the Ethos and Professional Practice examination, which is conducted by the nursing school (R683, 1989, Paragraph 9(3) (c)). The practical examination is also conducted by the nursing school, which includes the integration of theory and practice. An average of 45% is required in both practical and theoretical assessments for entry into the examinations (R683, 1989, Paragraph 9(4) (b)). Some nursing schools have developed their own performance standards and have stipulated the pass mark to be 50%. The first-year examinations comprises two papers on the subjects of Integrated General Nursing Sciences 1 and Social Sciences 1. The nursing school conducts the practical examination and the marks are submitted to the

SANC. The SANC conducts the first-year theoretical examinations. In the second-year, the requirements include 44 weeks of training and an average mark of 45% both in theoretical and practical aspects using a system of continuous assessment which takes place during the month-end in which the examination is conducted (R683, 1989, Paragraph 9(4) (a). The final examination set by the SANC, consists of three parts: a written paper of three hours in the subjects Integrated General Nursing Sciences II; Ethos and Professional Practice (including Ward Administration and Clinical teaching) and Social Sciences II (R683, 1989, Paragraph 7(2) (a), (c). Management topics are tested in the second-year examinations to allow students sufficient exposure to management competencies and to integrate practice and theory.

The SANC Guidelines for the Bridging Programme for Enrolled Nurses leading to registration as a General Nurse or Psychiatric Nurse, (SANC 1989: Paragraph 7), provides guidelines for laboratory and clinical instruction which includes the following fields of practice: medical nursing; surgical nursing; operating theatre nursing; nursing in casualty and outpatients, and pediatric nursing. The students must complete a minimum of 1000 practical hours per academic year in the clinical practice areas. Students are placed in the different nursing units during their training and they have to work in that specific clinical area for a specified number of hours, which is approved by SANC. During this time, students are expected to achieve the management skills and competencies they would require on employment as registered nurses.

The SANC statistics for the outputs of the Bridging programme, from both public and private institutions for the period 2011-2020, is presented in table 2.1 below:

Table 2.1: Output by the bridging programme leading to the registration as a general nurse or a psychiatric nurse (2011-2020)

Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Private Institutions	1499	1881	1787	1617	2668	2107	2012	2629	3558	1541
Public Institutions	1465	2051	1504	1272	1614	1219	1003	1324	1611	757

(SANC 2021:<https://www.sanc.co.za/wp-content/uploads/2021/05/Output-2011-2020-BP.pdf>)

The table above presents the figures of the SANC on NEI Output 2011–2020 for the bridging programme across all nine provinces. The output of the bridging programme leading to the registration as general or psychiatric nurses has seen a steady increase in both private and public institutions over the years 2011-2020. The figures also indicate that the majority of nurses are pursuing courses that are vital to enhance their qualifications and practice as professional nurses namely general nursing and psychiatric nurse.

2.3 Reality/Transition Shock

The transition from a graduate nurse to a newly qualified professional nurse has been identified as a period of turbulence, characterised by stress and anxiety (Walker *et al.* 2015: 2). As early as 1975, Kramer coined the term “reality shock” to highlight the difficulties, frustration and disillusionment that new nurses face as they transition to their new professional roles (Kramer 1975: 891). Reality shock can be described as “a phenomenon with specific shock-like reactions of a person, who, after entering a profession, find themselves unprepared”. This term, in the nursing profession, theorises that those new to the nursing profession or entering the professional arena go through a learning and development period. In the beginning, nurses find themselves ill-prepared to assume their roles until they go through the learning and development stages or

transitions. These transitions are important to be able to function independently and maintain ongoing happiness and career success.

2.4 Graduate nurses' perceptions of preparedness to practice as professionals

Graduate nurses are expected to possess the required skills, attitude and knowledge to be work-ready. These characteristics are achieved through classroom teaching and clinical placement. Brooks and Morphet (2021: 4), in a Delphi study, found that a work-ready graduate needs to have basics skills, attributes and some knowledge to fit into practice. The skills mentioned include patient assessment, communication, essential nursing skills and time management. Adequate knowledge in Anatomy and Physiology, pathophysiology of disease, medication knowledge, knowledge of health systems and health policy are commonly identified areas by graduates, clinicians and academics in this study. The attributes of a work-ready graduate nurse also include professional behaviour, competence, patient-focus and emotional intelligence. These characteristics are essential in the preparation of graduate nurses to meet the different requirements of work-readiness (Brooks and Morphet, 2021: 7).

Graduate nurses form a large part of the nursing workforce in our current healthcare system. However, the transition from a graduate nurse into professional practice has been described as a challenging time for most graduate nurses (Bisholt, 2012b: 281). This transition often generates confusion and shock and can lead to a decision to leave the profession early (Bisholt, 2012a: 290; Wangenstein, Johansson and Nordstrom, 2008: 1881). Regardless of these challenging transitions, adequate preparation and readiness for practice is essential for graduate nurses to enable them to fit in the nursing workplace and competently execute their roles.

In Australia, Watt and Pascoe (2013: 23-30), explored the perceptions of ten new graduate nurses on their level of preparedness for practice. They found that familiarity with the training environment helped student nurses focus on the nursing care for a patient. The new graduate nurses were able to access clinical information and resources needed for the care of a patient. Therefore, they felt as if they were functioning members of the ward team. Both education and practice sectors play vital roles in ensuring that

graduate nurses are practice-ready (Wolff, Pesut and Regan 2010: 187-191). A focus group interview conducted by Wolff et al. (2010: 187-191) in Canada, explored the perspective of nurses about the readiness of new nurse graduates. They found that graduate nurses' readiness to practice is profoundly affected by the educational model used when preparing them. In addition, their regular access to clinical information and resources prepared them to fit in with the ward team.

Morrell and Ridgway (2014: 519), in the United Kingdom, also conducted a qualitative study using eight final-year nursing students. The aim was to assess their perceptions of preparedness for final practice placement and factors that supported or hindered their level of preparedness. The study revealed that nursing students felt that they were not well-prepared for placement. This was due to the inadequate knowledge and skills for practice, the absence of mentors, lack of support and the high expectations from hospital staff. The students also expressed trepidation that academic staff scared them due to poor outcomes of practice and common errors they made which significantly affected their level of preparedness. The study suggested that students needed more support from clinical mentors especially when placed in the clinical area.

Guner (2015: 847) conducted a mixed-method study to determine the level of preparedness of final-year Turkish nursing students starting their careers as professional nurses. A total of 1804 students from 38 randomly selected universities participated in the study. The study found that 57.6% of the students felt highly prepared to start their careers as professional nurses. The older male graduates who were already working as nurses or had high school vocational training, felt most prepared. Students who felt their education preparation and resources were adequate, were more prepared. Although more than half of the students felt prepared to start work, they had an insufficient clinical experience that contributed to their low level of confidence in their skills. The study also highlighted that a good clinical environment and a high-quality education programme is necessary to prepare students and give them more confidence in their skills when they join the professional nursing workforce.

Mampunge and Seekoe (2014: 1930) conducted a qualitative study exploring the experiences of final-year nursing students regarding their preparedness to fulfil the role of professional nurses. An unstructured focus group interview was conducted with 27 final-year nursing students in one nursing college in South Africa. The findings showed that students were inadequately prepared theoretically and clinically to take on the role of a registered nurse. Some students indicated that they were uncomfortable with certain aspects of their theoretical preparation because they felt there were discrepancies between what they were taught and the actual clinical practices. A small minority of the students indicated that they were prepared to practice as professional nurses. This was due to the lack of adequate resources and equipment, communication problems and inadequate education programmes to prepare them for professional roles. Hence, to prepare nurses, there is the need to have an environment that supports the improvement of student teaching and learning such as adequate teaching curricula, functional clinical supervision, accompaniment and access to adequate educational resources.

A similar study conducted by Roziars, Kyriacos and Ramugondo (2014: 95) in South Africa, explored the lived experiences of newly qualified nurses undertaking community services in the Western Cape. The newly qualified nurses expressed fear of the unknown and uncertainties in assuming their new roles. Some of the reasons for their fears and uncertainties was inability to manage conflict, meet the hospital's expectations regarding competencies and concerns about curriculum deficiencies.

A study conducted by Woods *et al.* (2015: 364) in Australia, also explored the perception of third-year nursing students on their level of preparedness for practice following a 240-hour clinical placement. A total of 113 students completed an online version of the Casey-Fink Readiness for Practice Survey tool. The results showed that the majority of students (88.8%) agreed or strongly agreed that they felt ready for the new graduate registered nurse role after completion of their final clinical placement. The students felt confident and comfortable communicating with doctors about patient care issues (mean=3.46, SD=0.52) and communicating with patients from diverse backgrounds (mean=2.97, SD=0.60). Documentation of patient care was also a skill most students were able to perform comfortably (mean=1.71, SD=0.59). The majority of student's (65%) were very

confident managing a two-patient care assignment, while only 31% of the students felt very confident managing four patients. In preparation for the final placement experience, students discussed their personal learning needs with their clinical preceptors (59%). A small percentage of students, 5%, did nothing to prepare for their clinical experience. The top two skills performance that student felt most uncomfortable performing independently were venipuncture (50%), followed by assisting with intubation (26%). The study highlighted that expanded placement and smaller clinical class sizes enhanced students' level of confidence and readiness for practice.

A similar study was conducted in New Zealand to understand senior nursing students' views on their readiness for practice (Jamieson, Sims, Basu and Pugh 2019: 28). The study used the Casey-Fink Readiness for Practice Survey tool. The study found that the vast majority of students agreed or strongly agreed that they were confident and comfortable in areas such as communicating with doctors, patients and other members of the health team (85%-98%); they were comfortable asking for help (97%-99%) and confident when solving problems (96% - 98%). However, areas such as caring for a dying patient and caring for more than four patients at a time posed challenges for the nurses.

2.5 Programme coordinators and hospital leadership perception of graduate nurses' preparedness to practice

Programme coordinators, hospital leadership and nurse educators play a major role in preparing nursing students for assuming professional roles in practice. The perceptions of these individuals on the level of preparedness of graduate nurses are important.

In Australia, Missen, McKenna and Beauchamp (2014: 136) investigated the perceptions of 16 graduate nurse programme coordinators of the professional practice readiness of graduate nurses. The study highlighted clinical skills deficits, communication issues and transitioning as an enrolled nurse to a registered nurse as areas of weakness and challenging for nursing graduates in their preparation for practice.

Dlamini *et al.* (2014: 151) also conducted a qualitative study of nursing education stakeholders in Swaziland. The study aimed at exploring their perceptions of employers and nurse educators regarding the proficiency of new graduate nurses from the university.

Participants expressed the view that new graduates were not ready for practice upon graduation. However, they were willing to learn and become autonomous in their practice. It was also established that graduate nurses lacked readiness for practice due to inadequate preparation and the lack of support on assuming employment. It is expected that on graduating, nurses attain specific clinical skills, professional attitudes and scientific knowledge that will enable them to be proficient and autonomous in practice. Nurse educators indicated that graduates' clinical competencies were of great concern after graduating. However, they needed constant supervision and could not be left in charge of a unit.

A recent study conducted in Namibia by Ashipala and Shatimwene (2021: 5) aimed at describing the perceptions of employers regarding the employability skill of newly qualified graduate nurses assuming the role of professional nurses. A total of 114 nursing service managers completed a self-administered questionnaire. Results showed that the skills of newly qualified nursing graduates were rated as poor and there was no association between poor skills and invasive procedures and the number of years of practice. More than 70% of the employers also ranked graduate nurses' demonstration of managerial skills to be average and above average. Again, the provision of basic nursing care such as comfort and hygiene care, taking vital signs, patient assessment and obtaining blood samples were rated as above average by 43.8% to 61.4% of the employers. However, employers rated graduate nurses' professional skills very highly indicating that they meet employer's demands when they graduate.

Similarly, Motsa and Malesela (2018: 610) also noted that newly qualified nursing graduates in Swaziland had limited knowledge in the provision of quality patient care. It was also revealed that they lacked confidence, were incompetent in certain clinical procedures and were unable to perform independently despite their extensive theoretical and practical training.

Ballem and Macintosh (2014: 378) conducted a narrative inquiry exploring the perspectives of eight experienced nurses working with new graduate nurses. These experienced nurses were working in two hospitals in Eastern Canada. The study found

that some experienced nurses were pleased to have graduate nurses working in their units due to staff shortages and excessive overtime. Others described working with new graduate nurses as frustrating as they were unprepared for practice, needed a lot of guidance and were unable to prioritise patients. While nurses in the study perceived graduate nurses as enthusiastic, they also found that they lacked confidence and nursing skills when working in the various wards. It was also highlighted that the presence of new graduate nurses in the workplace motivated the experienced nurses to stay up-to-date and knowledgeable in anticipation of numerous questions. Similarly, their workload also increased due to constant orientation programmes and responding to numerous requests for information.

2.6 Challenges and factors affecting nurses' level of preparedness and readiness for practice.

The literature has described the transition from a graduate nurse into a professional nurse as being difficult. There are numerous challenges that graduate nurses' face during the transition period. The section below discusses the challenges nurses face during the transition into practice

2.6.1 Challenges that nurses face during the transition into practice

Wong *et al.* (2018: 30) conducted a qualitative study exploring the challenges graduate nurses encounter after the first year of graduation. Eight graduate nurses between the ages of 23 to 25 participated in the study. The common challenges identified included heavy workloads, communication, lack of support, lack of knowledge, working environment, personal attitude, expectations and a change of role. Graduate nurses expressed that the nurse-patient ratio of 1:21 burdened them with a heavy workload. The paperwork with the accompanying management of multiple tasks such as ward rounds, drug administration and attending to patients and families were also mentioned.

A study done by Suresh, Matthews and Coyne (2013: 773) investigated the perceived stress level of newly qualified nurses and fourth-year student nurses. High stress levels

were reported and this was associated with a heavy workload. Having to do too many non-nursing tasks within a short space of time was perceived to have a negative impact on holistic patient care. The study also highlighted that the lack of knowledge, particularly advanced skills such as advanced cardiovascular life support, performing venipuncture and blood extraction were some of the challenges that affected graduate nurses.

Self-expectation and expectations of others was one of the uppermost challenges found in a study done by Wong *et al.* (2018: 33). Graduate nurses indicated that the high expectation placed on them by others to know everything as registered nurses was a problem. As a result, some nurses wanted to work independently and competently in order to not disappoint colleagues. A similar study conducted by Parker, Giles, Lantry and McMillan (2014: 152) in Australia, explored the experiences of new graduates in their first-year of entering the nursing workforce. A total of 282 new nurses responded to an online survey. The findings highlighted that the expectations from students and others were high to be work-ready yet the support that they received was inadequate. Over 45% of the respondents rated the level of stress associated with role expectations from high to extreme.

In the nursing profession, communication with the healthcare team, patients and their relatives is very important. However, difficulty in communicating effectively often becomes a challenge for new graduates in their early years of practice (Parker *et al.* 2014: 155; Wong *et al.* 2018: 32).

Roziers, Kyriacos and Ramugondo (2014: 96) postulated that the shortage of staff and the nature of the hospital environment made it difficult to enhance patient care in the first month of the qualified nurses' placement as they did not receive any proper orientation due to the shortage of staff. This meant that they were not familiarised with the environment in which they were placed and that made the transition very difficult.

2.6.2 Factors that affect graduate nurses' preparation for practice

Factors that affect the graduate nurses' preparation for practice include insufficient access to satisfactory clinical placements and a predicted nursing shortage which then

places significant emphasis on the preparedness of student nurses to practice competently as new graduates (El Haddad *et al.* 2017: 391).

Graduate nurses are expected to be work-ready from the moment they are placed in the workplace. Inadequate orientation and being allocated to patients with complex acuity beyond the new practitioner's scope (Phillips, Esterman and Kenny 2015: 118) affect graduate nurses' confidence and engagement.

It is a reality that graduate nurses encounter many factors that affect their performance in the clinical setting. Factors such as the increasing number of patients with complex conditions and numerous comorbidities are challenges, which they are faced with in an ever-changing healthcare environment (Muruvan 2018: 1). Different levels of care and high-patient acuity have intensified the demands and expectations of healthcare employers that new nurses are skilled and ready to enter the workplace.

The shortage of skilled nursing staff to mentor these newly qualified professional nurses is an area of concern, as noted from the study by Jameison *et al.* (2019: 31). Hence, student nurses are not confident in caring for a dying patient and caring for four or more patients at a time. With no clinical support, graduate nurses are often overburdened when taking care of patients with complex health issues. The healthcare environment is seeing experienced nurses leave the profession because of increased workload and a lack of resources. This leads to a disparity that exists between nursing as taught and nursing as practiced, resulting in a gap between theory and practice.

Hofler and Thomas (2016: 134) stated that workplace bullying has also prevented new graduate nurses from socialising into their new roles. Ideally, the transitional process should enable nurses to build their clinical confidence and consolidate their clinical skills as well as develop positive professional qualities and work attitudes. It is also during this transition period that they should begin to fully understand their responsibilities as professionals (Nash *et al.* 2009: 48).

Newly qualified professional nurses work preparedness may be further hindered by inadequate interpersonal skills to seek assistance and guidance in the challenging

healthcare setting. This may lead to potential errors in patient care. In a study done by Baumann *et al.* (2018: 825), it was noted that hospital nurses were once thought to have a “wealth of practice and a dearth of theory,” but new graduate nurses are now thought to have a “wealth of theory and a dearth of practice”. Unfortunately, student nurses do not get the exposure needed to efficiently run a ward, yet these graduates are expected to manage a ward upon completing their training. This was further highlighted in a study by Rizany *et al.* (2018: 154).

Factors such as lack of managerial guidance affect the new graduate nurses' competency skills in meeting their role expectations. Studies have also shown that limited exposure to managerial skills such as delegation of staff often leads to conflict in the workplace.

A study conducted by Mampunge and Seekoe (2014) in the Eastern Cape, South Africa, to determine the preparedness of final year nursing students for role-taking, highlighted that student nurses were allocated in large numbers to the clinical setting. This deprived them of learning opportunities to develop skills such as problem-solving, despite having the theoretical knowledge. An unsupportive clinical environment affects the graduate nurse's ability to work autonomously therefore drastically impacting their confidence (Missen *et al.* 2016: 2134). Staff shortages and extra responsibilities delegated from senior nursing staff often leaves very little or no time for mentoring (Mampunge and Seekoe 2014: 62), thus compromising the transition of the graduate nurse to a newly qualified professional nurse. A study by Ingvarsson *et al.* (2017: 5), found that staff shortages contributed to a delay in personal growth as a newly qualified professional nurse.

2.7 Intervention and programmes to assist the graduate nurses' transition to practice

The transition from student to a newly qualified professional nurses entering the practice can be stressful, especially for many who feel inadequately prepared. A variety of support strategies and programmes have been cited by international literature to assist this cadre of nurses' transition into practice. These support strategies and programmes are crucial

in increasing the confidence, competence and knowledge level and also promote a sense of belonging for these new graduates (Edwards, Hawker, Carrier and Rees, 2015: 1255). Graduate nurse retention and job satisfaction are also enhanced. Some of the support strategies and programmes are discussed in detail below.

- Mentorship and preceptorship

Mentorship and preceptorship are often used interchangeably. The common element is that qualified nursing staff are specifically trained and allocated to support and work alongside newly qualified nurses within the clinical area (Edwards *et al.* 2015: 1263). The experienced nurses provide guidance to the newly qualified nurses through daily discussions on patient care and information sharing on the skills or procedures needed. A well-planned mentorship and preceptorship programme has a positive effect on students' confidence, competencies, stress levels and retention. A recent review conducted by Rogers, Redly and Rawson (2021) explored the strategies used to support graduate transition-to-practice such as work readiness, work competence, personal work characteristics, organisational acumen and social intelligence. Preceptorship was reported as the second most common strategy used to support graduate transition-to-practice. Having a preceptor positively influenced graduate nurses' work readiness, competence and personal work characteristics.

- Orientation

A well-designed orientation programme has a positive effect on newly graduated nurses and patient care in the hospital (Pertiwi and Hariyati, 2019: 613). Wong *et al.* (2018: 32) found that pre-RN training and orientation programmes, mentorships and peer support were highly effective and useful for work adaptations. Participants in the study expressed that these programmes provided basic nursing skills revision and imparted advanced skills such as resuscitation. Roziars, Kyriacos and Ramugondo (2014: 98) also suggested that proper orientation for newly qualified nurses acts as an intervention to assist them to familiarise themselves with the hospital environment. Unfortunately, once again, shortage of staff leads to the premature termination of orientation programmes.

- Internship / residency programmes

Internship or residency programmes are necessary to bridge the gap between academic preparation and the demands of clinical practice (Edwards *et al.* 2015: 1255). It affects nurses' confidence, competencies and knowledge level as well as promotes job satisfaction and retention. A study conducted by Ulrich *et al.* (2010: 363) observed an accelerated increase in clinical competency and self-confidence among more than 6000 new graduate nurses who completed the RN residency over a 10-year period. The longitudinal study also found a significant decrease in turnover intent and actual turnover. These findings highlight the benefits of a structured clinical RN residency programme for new graduate nurses. Findings from Kowalski and Cross's (2010) study also indicated improved clinical competency and communication among new graduate RNs after a year-round residency programme. There was a decreased sense of threat as leadership skills improved after the residency programme.

- Simulation

Simulation-based graduate programmes also expose newly qualified graduate nurses to patient scenarios that they are likely to encounter in the clinical settings. It offers nurses the opportunity to gain knowledge and skills in a safe area (Edwards *et al.* 2015: 1263). Beyea, Slattery and von Reyn (2010: e169-e175) investigated the outcomes of a simulation-based nurse residency programme and the study found a significant improvement in competence, confidence and readiness for practice at the end of the programme.

2.8 Theoretical Framework

The theoretical framework that guided this study was the transition shock theory developed by Duchscher (2009). Duchscher's transition shock theory (2009) was built on Kramer's theory of reality shock. According to Duchscher (2008: 443), transition shock begins within the first month of a new graduate nurse entering the nursing profession. The transition shock theory is presented in stages namely: doing, being and knowing.

Characteristics associated with the first stage (doing) includes learning, performing, concealing, adjusting, and accommodating (Duchscher 2008: 443). Stage 2 (being) characteristics include searching, examining, doubting, questioning, and revealing (Duchscher 2008: 443). Stage 3 (knowing) characteristics include separating, recovering, exploring, critiquing and accepting (Duchscher 2008: 443). Contained within the framework are descriptions of experiences, meanings, expectations of newly qualified professional nurses' intellectual role related to changes associated with transitioning into nursing practice (Duchscher 2009: 1105).

According to Duchscher (2009), the path from novice to expert nurse is a winding road rather than a straight line to successful expert practice. Duchscher (2009: 1105) defined transition shock as “the experience of moving from the known role of a student nurse to the relatively less familiar one of a professionally practising nurse”. Individuals experiencing transition expressed emotions such as relentless anxiety, isolation, self-doubt and loss of control (Duchscher 2009: 1106). Emotional fears associated with transition shock is the fear of being exposed as incompetent, not providing safe care, and not coping with his or her new role (Duchscher 2009: 1107). Transition shock encompasses several key components: emotional, physical, developmental and intellectual changes (Duchscher 2009: 1103). Figure 2.1 below illustrates Duchscher's stages of transition shock theory model.

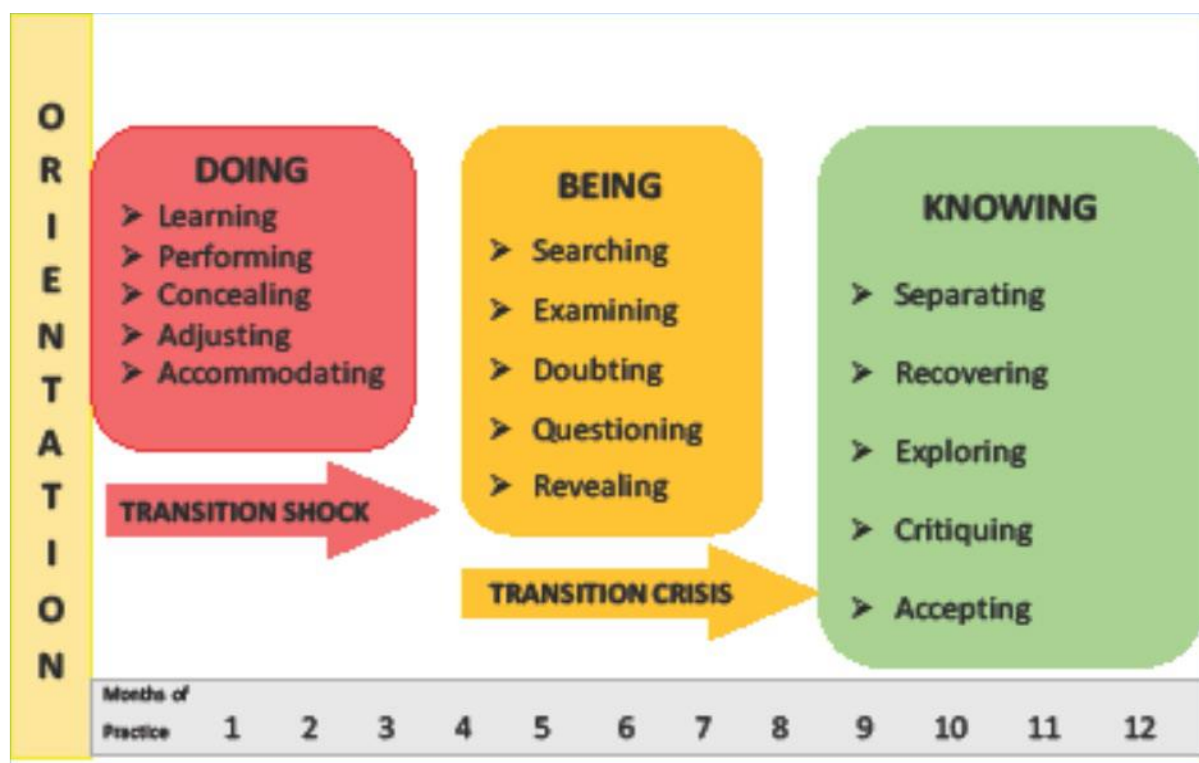


Figure 2.3: Duchscher's Stages of Transition Shock Theory Model (Duchscher 2009: 1103).

Duchscher (2008) established very early in the **doing phase** that newly qualified professional nurses entered their profession with idealistic expectations that were far from the real situations that they were faced with within the clinical setting. These newly qualified professional nurses' attributed this disparity to not being adequately prepared in clinical skills for role expectation. It was not until these nurses were a few months into their practice that they accepted their limitations and could ask their colleagues questions (Duchscher 2008: 444).

Regarding this study, bridging student nurses' were rotated monthly in the different disciplines to gain experiential learning. These student nurses' were allocated routine tasks and were given limited opportunities to practice new clinical skills for role-taking. The doing phase of the model has supported this study by recognising that clinical support for bridging programme student nurses during their rotation process is required. This

would provide them with solid knowledge of clinical practices, which will ensure that the preparedness for the transition as a newly qualified professional nurse will be successful. The **being phase** of the transition theory recognises that a newly qualified professional can now see beyond the horizons of their competencies. Again, the new graduate nurses are torn between remaining under the protection of the title of new graduate nurse or being thrown into the deep end of the role expectation of the professional nurse with the new graduate nurses questioning their professional identity by challenging the pre-graduate notion of nursing (Duchscher 2008: 446). Regarding this study, the bridging programme graduate nurses are expected by employers to be work-ready from the day they graduate. Support from managers and senior nursing staff will enable these newly graduated professional nurses make the successful transition from a student nurse to a graduate nurse and not feel as if they were thrown into the deep end of assuming the role of a professional nurse.

The **knowing phase** of the transition shock theory is where professional socialisation takes place. New graduate nurses move away from their insecurities during this phase. They continue to recover from the initial transition shock (Duchscher 2008: 447). Regarding this study, once the bridging graduate nurse progressed to a newly qualified professional nurse and found their confidence to cope with role changes, clinical skills were developed for role-taking.

2.8.1 Application of Duchschers' Stages of Transition Shock model

As Duchscher (2008) explained in her model, transition shock can occur from the first week to months after the newly qualified professional nurse enters the nursing profession. Similarly, bridging programme graduate nurses often have to make the adjustment from a known role of a student nurse to a less familiar role of a professional nurse. These graduate nurses enter the clinical environment with little or no supervision which can prove to be stressful for the graduate nurse, resulting in a lack of confidence in their ability to effectively transition into their new roles.

Exploring the preparedness of these graduate nurses during the initial stages of role-assumptions as a newly qualified professional nurse will assist clinical facilitators, senior professional nurses, nurse educators and hospital managers better support these new graduate nurses. Healthcare institutions, nursing institutions and the policymakers of these institutions need to explore and to act on factors that may be hindering the preparedness of bridging programme graduate nurses to make a successful transition to professional nurse. The transition shock theory underpins the need for sound clinical preparedness for role responsibilities from a graduate nurse to a professional nurse, meeting the demanding workplace expectations. The implications of the new graduate nurses working in an unsupported clinical environment may lead to patient dissatisfaction and burnout. In the capacity of a nurse educator, the researcher used this transition shock theory model to explore the clinical preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse at a PNEI, which is the purpose of this study. The stages of the transition shock model are presented in the discussion of the research findings.

2.9 Summary

This chapter provided an 'expose' of bridging programmes in Nursing, the bridging programme in South Africa and the perception of graduate nurses on their level of preparedness for practice. The chapter concludes with a discussion of the interventions and strategies that are necessary to prepare graduate nurses to be work-ready. A review of studies conducted globally, nationally and locally constituted a major part of this chapter. However, there is no specific study on the preparedness of bridging programmes graduate nurses to assume the role of a newly qualified professional nurse. Chapter 3 covers the research design and methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

According to Polit and Beck (2012: 273), research methodology are steps, procedures and strategies to investigate the problem being studied and to analyse the collected data. In this chapter, the research methodology included the population: sample and sampling; data collection; data analysis; validity and reliability for this study.

3.2 Research Design

Descriptive research is conducted in a natural setting to answer a research question related to incidence, prevalence or frequency of occurrence of a phenomenon of interest (Gray *et al.* 2017: 200).

A quantitative, non-experimental, descriptive survey research design was used in this study. Quantitative research is best defined as a formal, objective and systematic process that is implemented to obtain numerical data in order to understand the world's aspects (Grove, Burns and Gray 2016: 56). The quantitative, descriptive design was appropriate for this study as the researcher aimed to determine the preparedness of all bridging programme graduate nurses from a selected PNEI to assume the role of a newly qualified professional nurse. According to Brink, van der Walt and van Rensburg (2018: 95), “non-experimental designs have no manipulation of the independent variable and therefore no intervention – nor is the setting controlled. The study is carried out in a natural setting and phenomena are observed as they occur.” Brink, van der Walt and van Rensburg (2018: 96) further explain descriptive designs as those concerned with gathering information from a representative sample in the population. The importance of data collection in descriptive studies is structured observations, questionnaires, interviews or survey studies.

This research design has assisted the researcher to ascertain specific data related to how prepared the bridging programme graduate nurses are, to assume the role of a newly qualified professional nurse and the factors that affect bridging programme graduate

nurses' preparation to assume the role of a newly qualified professional nurse without influencing the variables. Descriptive designs may identify problems, describe variables and determine cause and effect interactions between variables (Gray *et al.* 2017: 28). The researcher used an online survey to collect quantifiable evidence in support of the research problem and aims. Descriptive and inferential statistics was used to analyse the data as precisely as possible. The recommendations to improve the transition support for newly qualified professional nurses was based on the findings of the study.

3.2.1 Research Paradigm

A research paradigm represents a worldview that includes a set of philosophical assumptions that guide the research process. Positivism uses scientific methods to generate knowledge and follows strict rules of logic, predictions, law and truth. It is assumed that the positivist approach in research focuses on factual and objective knowledge, with the researcher having very limited contact with the respondents (Gray *et al.* 2017: 25). A positivist approach underpinned this study. Logical sequence was utilised to gain an in-depth understanding of the research problem. The researcher focused on deductive reasoning which moves from general to specific (Gray *et al.* 2017: 7). Specific challenges were identified from the perspectives of the respondents at the selected PNEI. The positivist approach was applied throughout the research as the researcher maintained limited contact with the respondents during data collection to avoid bias. Data was collected using an online KwikSurvey from the accessible population. Numerical data was objectively analysed, using statistical analysis to answer the research questions.

3.2.2 Research Setting

The study setting is the location where the research was conducted and may be naturally occurring, partially controlled or highly controlled (Gray *et al.* 2017: 353). The research setting was a PNEI in KwaZulu-Natal (KZN). KZN is one of the nine provinces in South Africa, with the second largest population of approximately 11.5 million people (Stats SA 2020). In KZN, nursing education is offered at public and private nursing colleges. The KwaZulu-Natal College of Nursing (KZNCN) is administered by the Department of Health in KZN and their nursing programmes address the needs of the KZN province , with a

focus on professional, legal and ethical foundations of nursing (KZN Department of Health 2021). Private nursing colleges either belong to private hospital groups or are businesses operated by individuals. The selected PNEI belongs to a private hospital group, which was not identified in order to maintain the confidentiality of the organisation. The private hospital group in this study owns five PNEIs in the following provinces in South Africa namely: one in Western Cape, one in Eastern Cape, two in Gauteng and one in KZN. There are seven lecture venues at the campus in KZN, with two of these venues allocated to students in the bridging programmes. Diploma studies and short course programmes for ICU and Trauma are also offered at this PNEI. Students attend lectures at this campus and work their clinical hours in the allocated private hospital setting which belongs to the private hospital group.

3.2.3 Sampling

Sampling is the selecting of groups of people, events, behaviours and other elements to conduct a study (Gray *et al.* 2017: 329).

3.2.3.1 Population

The population for this study was a selected group of bridging programme graduate nurses. The target population is the entire set of individuals or elements meeting the sample criteria (Gray *et al.* 2017: 330). The target population was one hundred and forty-five (145) bridging programme nurses who had completed their training at the selected PNEI in the years 2019 to 2020 and 45 of these graduate nurses were no longer employed in the private hospital setting. For the purposes of this study, there were 100 bridging programme graduate nurses who made up the accessible population. These newly qualified professional nurses were currently working in the private hospital setting that belongs to the selected hospital group and are of mixed gender and age groups.

3.2.3.2 Recruitment of respondents

On receiving the Institutional Research Ethics Committee approval and approval from the PNEI, the researcher sought permission to use the email addresses of the bridging programme graduate nurses via a KwikSurvey. A Letter of Information was emailed to all respondents (Appendix D) outlining that the purpose of the study was to determine the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse and that the findings will assist all stakeholders to provide better support to the graduate nurse for roles as professional nurses. Voluntary consent (Appendix E) was also emailed to all potential respondents and the researcher did not coerce any graduate nurse to participate in the study. The respondents in the study completed the KwikSurvey voluntarily. The researcher did not promise any monetary benefits to the graduate nurses for participating in the study. The respondents were informed that participation was voluntary and that they could withdraw from the study at any time. Respondents were reassured that all data collected from the study will be kept confidential and will only be used for the purposes of the study. A KwikSurvey link with the data collection tool was emailed to all graduate nurses who consented to participate in the study.

3.2.3.3 Sampling technique

A sample refers to a subset of a population, individuals, elements, objects or a group of people selected to represent a population as a whole (Polit and Beck 2012: 275). A register of all the bridging programme graduate nurses from the year 2020 was obtained from the selected PNEI. The population size was 145. The researcher applied the census sampling method for this study. This sampling technique was suitable for this study as all bridging programme nurses who graduated from the PNEI within one year from the accessible population in the sample, were included. Even though the total sample of 100 respondents was a desired sample, not all bridging programme graduate nurses were available for data collection. It was anticipated that some professional nurses would not agree to participate in the research study.

3.2.3.4 Inclusion Criteria

All bridging programme graduate nurses who graduated in the year 2020 from the selected PNEI and are working as newly qualified Professional Nurses in the selected private hospital setting for not more than a year.

3.2.3.5 Exclusion Criteria

- Bridging programme students that have not yet graduated from the selected PNEI.
- All bridging programme graduate nurses who graduated before the year 2020.
- All bridging programme graduate nurses who graduated in the year 2020 but are unemployed.

3.2.3.6 Sample Size

The minimum required sample from a population of 100, using $\alpha = .05$ and a margin of error of .05 (the usual levels), was $n=80$. The researcher added 10% as a contingency measure should some respondents not have agreed to participate in the study or if the questionnaires were not returned or spoiled. This meant that $n=88$ respondents was an acceptable sample out of the $n=100$ to represent the population. The sample size for this study was $n=88$ bridging programme nurses who have graduated from the PNEI in the year 2020 and are working in the private hospital setting.

3.3 Data Collection

Data collection is the precise, systematic way of gathering data relevant to research specific objectives and questions of a study (Holloway and Galvin 2017: 142) A KwikSurvey link with the data collection tool was emailed to all graduate nurses who consented to participate in the study. The respondents had to click on the link created for the data collection process. Anonymity was maintained by ensuring that names or surnames of respondents were not recorded on the data collection tool. There was no face-to-face contact with the respondents thus giving them a greater sense of anonymity.

Respondents had a week to complete the online survey. After a week, raw data was downloaded by the researcher and was analysed with the assistance of a statistician.

Due to the COVID protocol, it was not possible to administer the questionnaire and collect data face to face. Hence, data was collected from respondents using an electronic KwikSurvey instrument. This was a much more convenient way to collect data as no paperwork was involved. The researcher was able to target all the bridging programme graduates who had just completed the bridging programme and were now working in the private hospital setting.

3.3.1 Data Collection Instrument

An adapted Casey-Fink Readiness for Practice Survey instrument (Appendix H) was used to collect data in this study. Regina Fink and Kathy Casey granted permission to use this tool on the 2nd of July 2019 (Appendix F). The instrument was developed in the United States and comprised three sections. Section One included questions related to the respondents' demographic data and information about placement experience. The second section focused on the students' comfort and confidence level with clinical and relational skill performance. The last section was a 19-item section on information about the level of agreement with certain statements relating to management scales. A 6-point Likert-scale (strongly disagree, slightly disagree, disagree, agree, slightly agree, and strongly agree) was used. The instrument was validated and as it was used in most peer reviewed studies for example (Woods *et al.* 2015: 360). Respondents were given a week to complete the online data collection tool.

3.3.2 Pre-testing the data collection instrument

In order to establish the reliability and the validity of the research instrument, it was pre-tested within the South African setting using a smaller sample. Pretesting assisted the researcher to establish whether the respondents understood the questions and if there was any ambiguity in the questions. This was also important for content validity and ensures that the questionnaire addresses the study objectives. The respondents for this

study were selected using a simple random sampling technique. All bridging programme graduate nurses' names were written on paper, folded and put into a hat. The researcher picked five (5) names from the hat. Once the name was selected, it was put back into the hat to ensure that all bridging programme graduate nurses had an equal opportunity to be selected to participate in the pretest of the data collection tool. Information letters detailing the purpose of the study was emailed to the graduate nurses that had been chosen for the pretest of the data collection tool. For the purposes of data collection, the researcher set up a KwikSurvey link, which was emailed to all respondents. A voluntary consent and data collection tool were uploaded on the website. The respondent could choose to participate in the study or not by clicking 'yes' or 'no' in the tick box. A week was allocated to the respondents to complete the online survey. After a week, the researcher emailed the respondents to comment on specific aspects of the data collection tool, namely ambiguity of the questions, understanding of wording and the layout of the data collection tool. The researcher received feedback from the respondents clarifying that there was no ambiguity in the questions, wording was understandable and easy to read, and no language barriers were experienced when answering the KwikSurvey. Therefore, no changes were made to the KwikSurvey data collection tool. These bridging programme graduate nurses who participated in the pre-test did not form part of the main study.

3.4 Validity and Reliability

3.4.1 Validity

Validity refers to the soundness of the study's evidence, that is, whether the findings are unbiased and well-grounded (Polit and Beck 2018: 175). The content validity of the survey is addressed using an expert consensus development process (Casey *et al.* 2011: 646). Validity was ensured by findings from the literature and evaluated input from the biostatistician appointed by the Academic Institution, an expert in the field. A content validity table assisted in matching the objectives with the research questions against the items of the tool. Face validity was supported by entering the pilot data on an Excel programme and collected data was tested to see if it met the target variables using the

Statistical Package for Social Sciences (version 27 of SPSS). The construct validity was addressed using the Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO). This computation was based on the exploratory factor analysis (EFA). The EFA is a statistical technique used for determining the dimensionality of a set of variable factors (Kayisoglu 2015: 60). The EFA helped to generate two factors for the regression analysis. Thus, GEN and PAT activities.

3.4.2 Reliability

Reliability is concerned with the consistency, accuracy of information obtained in a study, as well as the researcher's ability to collect and record information accurately (Polit and Beck 2018: 175). After adapting the questionnaire to the South African context, the tool was sent to the statistician for validity and reliability of the questionnaire to ensure that it measured the variables that it was intended to measure. A pretest of the data collection tool was conducted to establish the bridging programme graduate nurses understanding of the questions in the instrument and to identify any ambiguity in understanding the questions. To ensure the reliability of the results, several reliability tests were performed. The Cronbach alpha reliability statistics was used to assess how several items explained a particular factor/construct. The higher the alpha value, the higher the reliability of the responses (Tavakol and Dennick, 2011: 181). The alpha value for the various constructs was highly reliable since they met the reliability threshold value of 0.70 (Hair *et al.* 2011: 139). The one-sample t-test was also adopted to determine whether the mean score was significantly different from the mean or scalar values. These results were highly significant at a 5% significance level. The Binomial test also tested whether a significant proportion of the respondents selected one of two possible responses. An independent sample t-test was employed to compare two independent groups of cases. This was used to determine the significant differences for gender and the results showed no significant differences. These tests helped in evaluating the strength of the results. The results of these tests are reported in Chapter Four.

3.5 Data Analysis

Data analysis in quantitative research is the reduction, organisation and statistical testing of information obtained in the data collection phase (Gray *et al.* 2017: 46). Data was analysed using version 27 of SPSS. Descriptive statistics, in the form of tables and graphs was used to describe data graphically. To test for significant trends in the data, inferential statistics was applied. These included Pearson's correlation, t-tests, ANOVA and chi-square tests. Where the conditions were not met for the application of these tests, non-parametric equivalent tests or exact tests, where applicable, was used. A p-value that was greater than 0.05 indicated that the results were significant for the sample.

3.6 Data storage

Informed consent, which was obtained from potential respondents to participate in the study, was stored in an encrypted online file. The questionnaire was administered as an anonymous online KwikSurvey where no names or surnames were recorded and codes were used instead so that students did not feel intimidated or forced to participate in the study as the researcher is a bridging programme lecturer. Raw data was downloaded after a week and sent to the statistician via an encrypted folder. All data will be kept in a password-protected folder for a period of five years and will be deleted by the researcher thereafter. All electronic copies will be permanently deleted by the researcher to ensure confidentiality of all respondents.

3.7 Ethical Considerations

Ethics in research refers to a set of standards, measures and systems that regulate research activities. Ethics also considers the responsibilities that individuals have towards each other with careful attention being paid to right and wrong conduct, including good and bad character traits. The manner in which research respondents are treated is crucial in ethics because ethics in research provides a strengthened framework regarding the quality of research output. In research, ethical approval must be granted before the commencement of a research study (Sibinga 2018: 2). During this study, the researcher

adhered to the principles of ethics by protecting the rights of the respondents and the college where the study took place, hence, the nursing college was referred to as a private nursing education institution (PNEI). Institutional approval was sought before commencing this study. An information letter (Appendix D) was given to all respondents detailing the purpose of this research which they thereafter ticked 'yes' on an electronic consent form (Appendix E) if they agreed to participate. Respondents were also informed that participating in this study was voluntary and that they could withdraw from the study if they needed to do so without any consequences.

3.7.1 Institutional Approval

The research proposal was reviewed and approved by the IREC (Appendix A) and approval was also sought from the Research Review Committee of the PNEI (Appendix B 1) and approval was granted (Appendix B 2). Permission to conduct research was sought from the campus manager of the PNEI (Appendix C1) and permission was received (Appendix C 2).

3.7.2 Non-Maleficence

Respondents were not forced to participate in this research study hence voluntary electronic consent was obtained from the respondents before the respondents received the web link for the data collection instrument. Respondents were informed in writing that they could withdraw at any time from the research study without any negative consequences to them. The researcher did not foresee any discomfort and harm to the respondents in this study.

3.7.3 Beneficence

All information from respondents was kept confidential and was only used for this study. Respondents were informed that there was no financial benefits for being a respondent in this study. All findings from this study were used to identify factors that affect bridging programme graduate nurses to assume the role of a newly qualified professional nurse.

3.7.4 Anonymity

Anonymity was maintained in the online survey as no names or surnames were recorded. There was no face- to- face contact so that the graduate nurses did not feel intimidated or forced to participate for fear of consequences if they refused to participate in the study. Hence, all respondents were informed in writing about the nature of the study and that the potential respondents had a right to refuse to participate in the research study. The researcher set up a KwikSurvey link for the data collection and this link was emailed to all respondents. Voluntary consent and the data collection tool was uploaded on KwikSurvey. The respondents could choose to participate in the study or not by clicking 'yes' or 'no' in the tick box.

3.7.5 Informed Consent

All 88 respondents were provided with written information regarding the purpose of the research study and voluntary electronic consent was obtained after respondents read the information letter regarding the purpose of the study.

3.7.6 Rights to privacy and confidentiality

Names of respondents were not recorded on the data collection instrument. Only the researcher, supervisor and statistician had access to the data. There was no face-to-face contact with the respondents hence they had a greater sense of anonymity. Confidentiality was maintained by ensuring that all collected data was kept in a password-protected computer.

3.7.7 Justice

The principle of justice holds that human subjects should be treated fairly (Gray *et al.* 2017: 161). The researcher used the census sampling technique to collect data from respondents. All bridging programme graduate nurses of mixed race and gender who graduated from the PNEI during the year 2020 and are presently working in the private hospital setting for not more than a year, were allowed to complete the online data

collection instrument. Respondents were assured in writing that anonymity will be maintained by using codes on all data collection instruments and that all data collected will be stored in a password-protected computer in a safe location and will only be used for this study. All respondents were treated with the utmost respect and dignity regarding their cultural beliefs and background.

3.7.8 Benefit-Risk ratio

A Benefit-risk ratio is determined based on the maximised benefits and the minimised risks (Gray *et al.* 2017: 176). The researcher did not anticipate any risk to the respondents during the research study and all findings were used for future training of bridging programme graduate nurses in their preparedness to assume the role of a newly qualified professional nurse.

3.8 Summary

This chapter outlined the rationale for the study and also delineated the research objectives, questions and the research design and methodology used for the purposes of this study. It also defined the ethical principles that were considered for this study. The following chapter gives an overview of the literature reviewed in support of the rationale for conducting the study and the theoretical framework that guided this study. Chapter Four presents the findings of the study.

Chapter 4: Presentation of Findings

4. 1 Introduction

This chapter presents the results and interpretation of the survey data, which was collected during October 2021, by means of a KwikSurvey. It presents and describes the demographic characteristics of the respondents. This chapter further provides the results on the adequacy of bridging programme graduate nurses as newly qualified professional nurses in performing nursing tasks. In addition, the competency to carry out the role as a newly qualified nurse and factors affecting the preparedness of bridging programme graduate nurses are explained.

The purpose of this study was to explore the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse. The research objectives were to:

- To ascertain how bridging programme graduate nurses view their preparedness to assume the role of a newly qualified professional nurse.
- To determine the factors that affect bridging programme graduate nurses' preparedness to assume the role of a newly qualified professional nurse.
- To determine if demographics have an effect on the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse.

4.2 Sample realisation

The acceptable sample size of 100 respondents was 88, however for this study 95 respondents completed the questionnaire representing a 95% response rate. Mugenda and Mugenda (2003) explained that a response rate of 50% was adequate while a response rate of 60% was good. They further stated that a response rate of 70% and

above, is excellent for analysis and reporting. Hence, the response rate of 95% from the data administered is sufficient for analysis.

4.3 Tests used for data analysis

Descriptive statistics, in the form of tables and graphs were used to describe the data graphically. To test for significant trends in the data, inferential statistics were applied.

- Pearson's correlation: This is a test statistic that examines the statistical relationship, or association between two variables (Benesty *et al.* 2009: 1-4). This was used to assess the linear associations between the demographic factors and bridging programme graduate nurses' preparedness to assume the role of a newly qualified professional nurse
- T-tests: This is a statistical test which is used to examine whether a mean score is significantly different from a scalar value (Kim 2015: 540).
- ANOVA: The analysis of variance (ANOVA) is a statistical analysis technique that divides observed aggregate variability within a data collection into two pieces. This was used to test for several independent samples that compares two or more groups of cases in one variable (Kim 2014: 74).
- Chi-square tests: This is a univariate test which is used on a categorical variable to test whether any of the response options are selected significantly more/less often than the others (McHugh 2013: 143). Under the null hypothesis, it is assumed that all responses are equally selected.

Where the conditions were not met for the application of these tests, non-parametric equivalent tests or exact tests, where applicable, were used. Throughout, a p-value of 0.05 was used to indicate significance.

4.4 Analysis of Demographic Characteristics of the Respondents

The demographic characteristics of the respondents are presented in Table 4.1. The characteristics include gender, race, and age. Other factors regarding their profession

were considered and explained in this section. These include the experience of an enrolled nursing auxiliary, an enrolled nurse experience and management clinical experience.

Table 4.1: Demographic characteristics

Variables	Response	Frequency (N=95)	Percentage
Gender	Male	13	13.70%
	Female	82	86.30%
Race	Black	41	43.20%
	Coloured	11	11.50%
	Indian	40	42.10%
	White	3	3.20%
Age	<30	62	65.30%
	30-39	29	30.50%
	40-49	2	2.10%
	50-59	2	2.10%
Enrolled Nursing Auxiliary Experience (ENA)	<1 years	66	69.40%
	1-5 years	22	23.20%
	>5 years	7	7.40%
Enrolled Nurse (EN)	<1 years	50	52.70%
	1-5 years	37	38.90%
	>5 years	8	8.40%
Management Clinical Experience	<1 month	2	2.10%
	A month	93	97.90%

4.4.1 Gender

The majority (86.30%; n=82) of the respondents were females and males were represented by (13.70%; n=13) respondents.

4.4.2 Race

The results showed that the majority of the respondents were Black (43.20%; n=41), followed by Indians at (42.10%; n=40). About (11.50%; n=11) and (3.20%; n=3) of the respondents indicated that they belonged to the Coloured and White races respectively. Most of the respondents were Blacks and Indians because the setting of the study was a PNEI in Kwazulu-Natal, a province in South Africa where the Black and Indian race groups make up most of the population. The study further revealed that females dominated in each of the race distribution. The majority of the females were Indian (39%; n=37) and the whites were in the minority with (0.02%; n=2).

4.4.3 Age

With regards to the age category, most of the respondents were below the age of 30 years, representing (65.30%; n=62) of the total sample. About (30.5%; n=29) were within the age bracket of 30-39 years, while the lowest number were between the age brackets of 40-49 and 50-59 (with both age brackets equaling 2.10%; n=2). The survey results indicated that most of the professional nurses were in the very youthful stage.

4.5 Clinical experience

4.5.1 Enrolled Nursing Auxiliary Experience

The analysis revealed that the respondents had varying work experiences before graduating from the bridging programme. The results from the sample indicated that a significant number (69.50%; n=66) of the respondents had less than one-year of experience as an enrolled nursing auxiliary before graduating from the bridging programme, ($p < .001$). 7.40% (n=7) of the respondents had more than five years of work experience as an enrolled nursing auxiliary. In summary, the results showed that each of the enrolled nursing auxiliary had a minimum of one-year working experience.

4.5.2 Enrolled Nurse Experience

Regarding the enrolled nurses' work experience, most of the respondents (52.50%; n=50), recorded less than one-year of experience before graduating from the bridging programme. In addition, (38.90%; n=37) and (8.40%; n=8) had work experience between one to five years and more than five-years respectively.

4.5.3 Management Clinical Experience

The majority of the respondents (97.90%, n=93) had a month of management clinical experience during their bridging programme. While only 2.10% had less than a month experience. Figure 4.1 below illustrates the areas of clinical experience

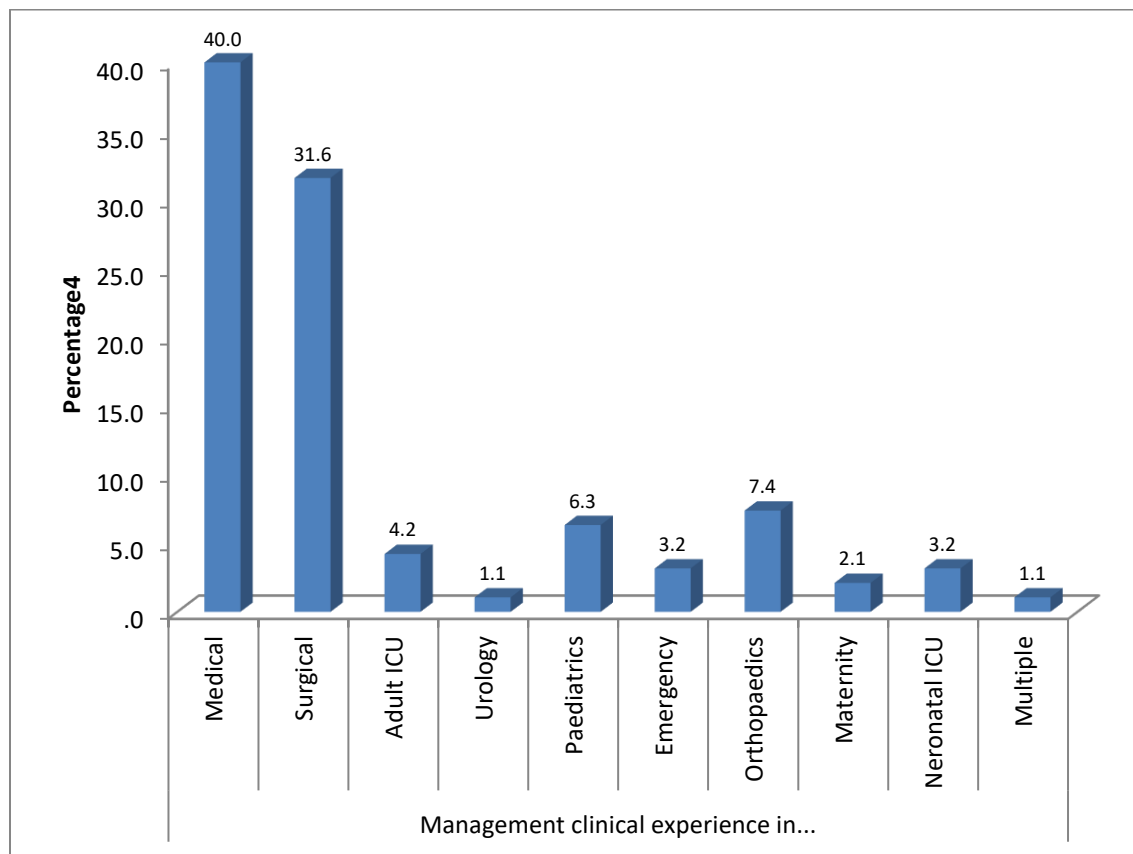


Figure 4.1 Areas of clinical experience

Figure 4.1 illustrates the areas from where the respondents received their management clinical experience. The majority of respondents (40%; n=38) received their management

clinical experience in the medical area, followed by the surgical area (31.6%; n=30). Urology and the multiple areas were the least represented, with both having (1.1%; n=1) of the respondents who received clinical experience from them. This shows that the medical and surgical areas play an important role in enriching professional nurses with the basic management clinical experience before graduating from the bridging programme.

4.6 Enrolment in an employer supported programme

Employer support programmes addresses individual performance and wellbeing in the work place. A significant number (73.7%: n=75) of the respondents were not yet enrolled in an employer supported programme as a bridging programme graduate nurse. Only (26.3%: n=25) of the respondents reported that they were enrolled in an employer support programme. The binomial test, which shows the significant differences, was statistically significant at 95%. This shows that 74% of the respondents were not enrolled in an employer supported programme. This is an indication that just a few of the respondents are engaged in a support programme that prepares them for their roles in clinical areas. Figure 4.2 below depicts the percentage of employer supported programmes.

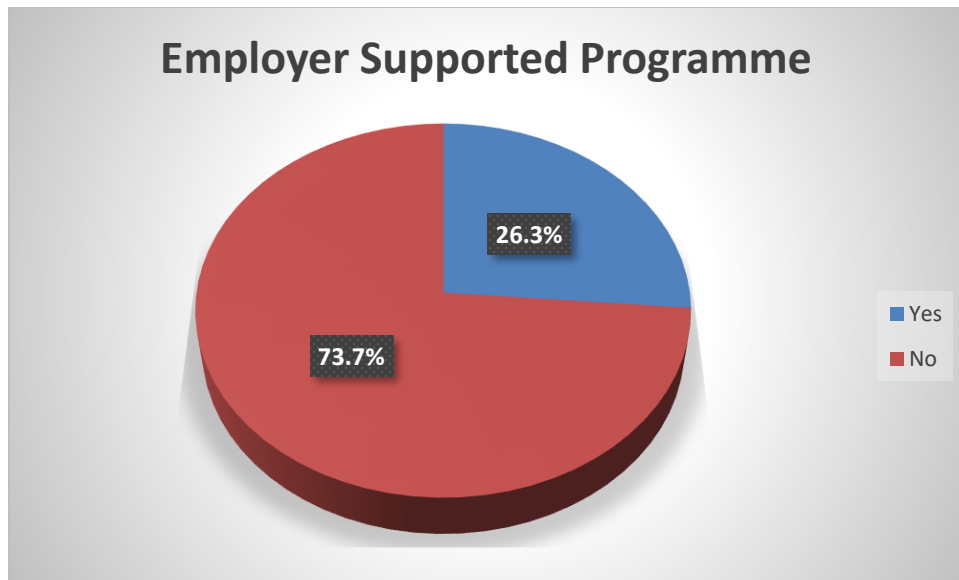


Figure 4.2 Employer Supported Programme

4.7. Clinical areas currently employed

According to the results, (33%; n=31) of the respondents were currently employed in the surgical area. The second area was the medical field which is represented by (31%; n=29) of the respondents. Neo-natal was the least represented (0%; n=0) (Figure 3). Figure 4.3 shows the Clinical Areas in which respondents are employed.

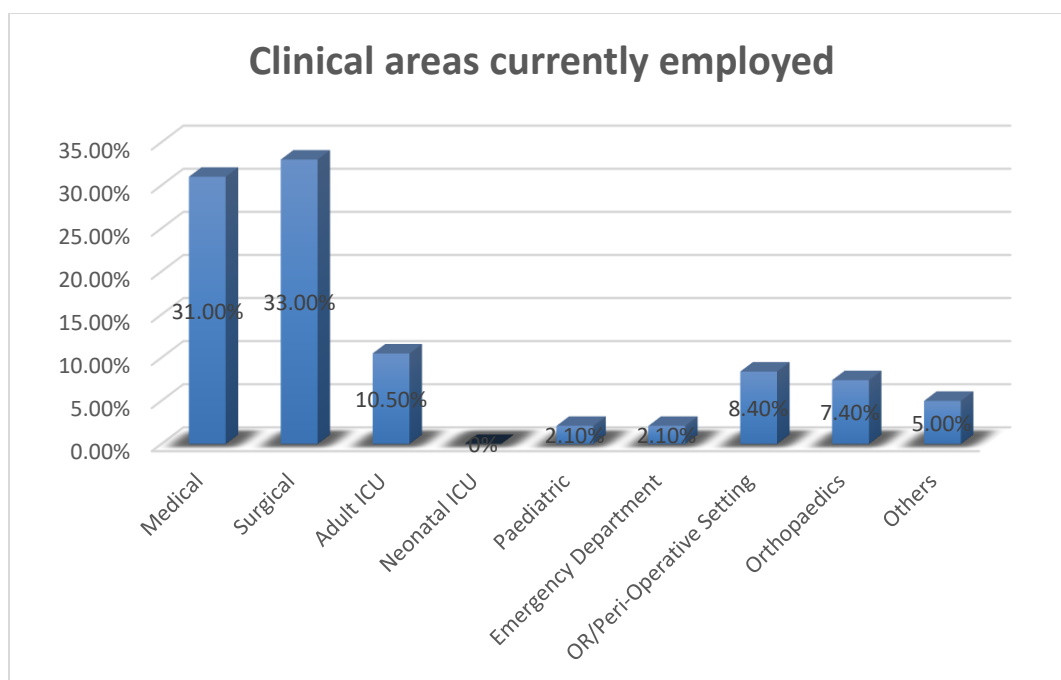


Figure 4.3 Clinical Areas in which respondents are employed

Table 4.2.1 below highlights the hours of Orientation received in the units where respondents are currently employed

Table 4.2.1 Hours of Orientation received in the units where respondents are currently employed

Variable	Response	Frequency (N=95)	Percentage (100%)
Orientation	None	56	59%
	<5 hours	10	10.50%
	5-10 Hours	1	1.00%
	>10 hours	28	29.50%

4.8 Number of Orientation Hours

4.8.1 Hours of Orientation

Respondents' hours of orientation in the unit where they are currently employed were also reported and (59%; n=56) of the respondents indicated that they had not received any form of orientation. This can be detrimental to their effectiveness as professional nurses because they may have limited knowledge on how things operate in their current area of employment. Some of the respondents (10.50%; n=10) stated that they had received less than five hours of orientation, while (29.50%; n=28) had more than 10 hours of orientation and (1%; n=1) indicated that they received orientation of 5-10 hours. Generally, just a few, have received some level of orientation teaching them about the practices and procedures in their employment area. Table 4.3 below indicates the number of months before respondents were left in charge of a shift.

Table 4.2.2 Months before left in charge of shift

Variable	Response	Frequency (N=95)	Percentage (100%)
Months before left in charge of shift	Up to Six Months	79	83.20%
	> 6 Months	0	0%
	Never been in charge	16	16.80%

4.8.2 Months Before left in charge of shift

From the information that was provided, the majority of the respondents (83.20%; n=79) mentioned that it took about six months before they were left in charge of a shift, while (16.80%; n=16) indicated that they have never been in charge of a shift as yet. Table 4.2.3

below provides the hours of clinical support from the unit manager.

Table 4.2.3 Hours of Clinical Support from the Unit Manager

Variable	Response	Frequency (N=95)	Percentage (100%)
Hours of clinical Support Received from Unit Manager	None	58	61.10%
	<5 hours	13	13.70%
	5-10 hours`	11	11.60%
	>10 hours	0	0%
	I have not led a shift yet	13	13.70%

4.9 Hours of Clinical Support from the Unit Manager per month

Regarding the hours of clinical support received from the unit manager per month, (61%; n=58) of the respondents mentioned that there was no clinical support from the unit manager and (13.70%; n=13) indicated that they received less than 5 hours of support from the unit manager. In comparison, (11.60%; n=11) of the respondents received between 5-10 hours of support from the unit manager. None of the respondents received support from the unit manager beyond 10 hours (0%; n=0). A lack of clinical support makes transition difficult as these newly qualified nurses no longer have the clinical support that they had as bridging students.

4.10 Mentorship

Figure 4.4 shows information about the number of mentors received since graduating from the bridging programme. The results from the survey showed that most of the respondents (63.2%; n=60) have not yet received any mentors since they graduated from the bridging programme while (13.7%; n=13) and (10.5%; n=10) of the respondents had received at least one or two mentors, respectively. About (12.6%; n=12) had received more than two mentors after graduating from the bridging programme.

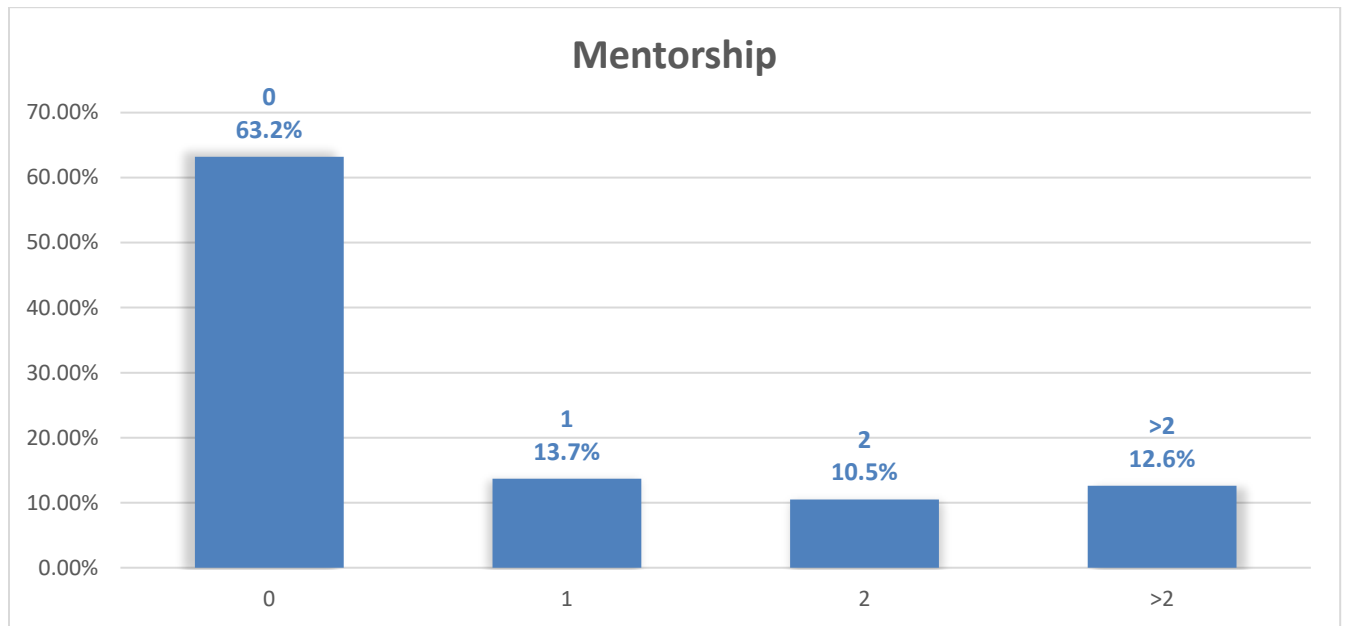


Figure 4.4 Mentorship received after graduating

4.11 Buddy System

Table 4.5 below shows the buddy system.

Table 4.3 Buddy System

Buddy System	Never	<1 month	1-2 months	3+ months
Buddied with a registered Nurse	36(37.9%)	54(56.8%)	3(3.2%)	2(2.1%)
Buddied with an enrolled Nurse	77(81.1%)	16(16.8%)	2(2.1%)	0(0%)
Buddied with someone else	87(91.6%)	7(7.4%)	1(1.1%)	0(0%)

Table 4.3 presents information on the number of times a bridging programme graduate nurse experienced the buddy systems or was never buddied at all. The results indicated that (56.8%; n=54) of the respondents were buddied with a registered nurse for less than a month, while (37.9%; n=36) had never buddied with a registered nurse. About (3.2%; n=3) had been buddied with a registered nurse for about 1-2 months while (2.1%; n=2) were buddied with a registered nurse for more than three months. The results further

indicated that (81.1%; n=77) had never buddied with an enrolled nurse and (91.6%; n=87) had never buddied with someone else. No respondents (0%; n=0) had buddied with an enrolled nurse or with someone else for more than 3 months.

The results imply that 10.5% (n=10) of the respondents had never experienced any of the above-mentioned buddy systems.

4.12 The adequacy of a bridging programme graduate nurse as a newly qualified professional nurse in performing the following tasks

Table 4.4 below presents the respondents' opinions on their adequacy to perform GEN and PAT tasks.

Table 4.4 Respondents' Opinion on the Adequacy to perform the following tasks

Item	Responses as Frequency (%)					n	Mean (SD)	T	Df	p-value
	Not at all adequate				Extremely adequate					
	1	2	3	4	5					
Assessment of a patient	1 (1.1%)	3 (3.2%)	7 (7.4%)	41(43.2%)	43(45.3%)	95	4.28 (0.821)	15.25	94	<.001*
Obtaining telephonic orders for medication	1(1.1%)	1(1.1%)	4(4.2%)	13(13.7%)	76(80%)	95	4.71 (0.698)	23.82	94	<.001*
Handing over of patients	0(0%)	3(3.2%)	3(3.2%)	20(21.1%)	69(72.6%)	95	4.63 (0.700)	22.70	94	<.001*
Bladder catheter insertion/irrigation	3(3.2%)	2(2.1%)	7(7.4%)	30(31.6%)	53(55.8%)	95	4.35 (0.943)	13.93	94	<.001*
Central line care (dressing change)	0(0%)	1(1.1%)	7(7.4%)	30(31.6%)	57(60%)	95	4.51 (0.682)	21.50	94	<.001*
Charting/documentation	0(0%)	2(2.1%)	4(4.2%)	22(23.2%)	67(70.5%)	95	4.62 (0.671)	23.53	94	<.001*
Chest tube care	13(13.7%)	6(6.3%)	17(17.9%)	28(29.5%)	31(32.6%)	95	3.61 (1.363)	4.36	94	<.001*
Intravenous (IV) medication administration	1(1.1%)	1 (1.1)	3(3.2%)	25(26.3%)	65(68.4%)	95	4.60 (0.706)	22.10	94	<.001*
IV starts–feeds given via a central line	4(4.2%)	1(1.1%)	8(8.4%)	25(26.3%)	57(60%)	95	4.37 (0.990)	13.47	94	<.001*
Operating IV pump/PCA pump	4(4.2%)	1(1.1%)	7(7.4%)	25(26.3%)	58(61.1%)	95	4.39 (0.982)	13.79	94	<.001*
NG tube insertion/ care/ removal	4(4.2%)	3(3.2%)	8(8.4%)	19(20%)	61(64.2%)	95	4.37 (1.052)	12.67	94	<.001*
Administration of scheduled medication	0(0%)	1(1.1%)	2(2.1%)	24(25.3%)	68(71.6%)	95	4.67 (0.573)	28.46	94	<.001*
Responding to an emergency/CODE/changing patient condition	3(3.2%)	1(1.1%)	14(14.7%)	51(53.7%)	26(27.4%)	95	4.01 (0.869)	11.33	94	<.001*
Advanced Wound care/dressing change	1(1.1%)	3(3.2%)	8(8.4%)	26(27.4%)	57(60%)	95	4.42 (0.858)	16.14	94	<.001*
Patient teaching	0(0%)	2(2.1%)	8(8.4%)	30(31.6%)	55(57.9%)	95	4.45 (0.740)	19.12	94	<.001*

The tasks were assessed using a 5-point Likert scale between the range of [1] = not at all and [5] = extremely adequate. The one-sample t-test was used to determine whether the adequacy differs significantly from the average adequacy score of 3. The task of obtaining 'a telephonic order' for medication had the highest mean value of 4.71 while the 'chest tube care' task recorded the lowest mean value of 3.61.

The results from the Table 4.6 showed that the adequacy of newly qualified graduate professional nurses recorded an average value above the central rating of 3 for all of the tasks listed in the table above, indicating that the bridging programme graduate nurse as a newly qualified professional nurse can perform these tasks effectively. The p-values were statistically significant at 95%, affirming that these graduate nurses were able to adequately perform nursing tasks.

In addition, the study assessed the reliability of the 15 tasks combined and the average value was 4.399 and was statistically significant ($p < .001$) indicating significant adequacy in performing general nursing tasks. The Cronbach alpha was used to test if a combination of these tasks will give a reliable measure for this construct, termed general task adequacy (ADEQ), where an alpha score of >0.7 indicates reliability. The average of the individual scores for the 15 tasks listed in the table above gives a reliability measure of $\alpha = .932$. This is a high value and shows good reliability.

4.13 Management competency to carry out the role of a professional nurse

Respondents' opinions on the management competency to carry out their role as a newly qualified professional nurse is presented in Table 4.5 below. Respondents were asked to rate their level of agreement, using the 6-point Likert scale, concerning the roles outlined in the table.

Table 4.5 Management competency

Item	Responses as Frequency (%)						n	Mean (SD)	t	Df	p-value
	Strongly Disagree	Disagree	Slightly Disagree	Slightly agree	Agree	Strongly Agree					
	1	2	3	4	5	6					
I feel confident communicating with physicians	5(5.3%)	13(13.7%)	19(20.0%)	15(15.8%)	24(25.3%)	19(20.0%)	95	4.02(1.516)	25.857	94	<.001*
I am comfortable communicating with patients from diverse populations	0(0.0%)	1(1.1%)	3(3.2%)	18(18.9%)	45(47.4%)	28(29.5%)	95	5.01(0.844)	57.85	94	<.001*
I am comfortable delegating tasks to lower categories of nursing staff	3(3.2%)	12(12.6%)	10(10.5%)	32(33.7%)	25(26.3%)	13(13.7%)	95	4.08(1.310)	30.387	94	<.001*
I have difficulty prioritising patient-care needs	10(10.5%)	31(32.6%)	10(10.5%)	36(37.9%)	6(6.3%)	2(2.1%)	95	3.03(1.259)	23.477	94	<.001*
I am confident in teaching nursing-care to lower categories of staff	0(0.0%)	3(3.2%)	15(15.8%)	31(32.6%)	29(30.5%)	17(17.9%)	95	4.44(1.059)	40.882	94	<.001*
I am confident in my ability to problem solve	5(5.3%)	13(13.7%)	12(12.6%)	24(25.3%)	29(30.5%)	12(12.6%)	95	4.00(1.407)	27.716	94	<.001*
I feel overwhelmed by ethical issues in my patient-care responsibilities	6(6.3%)	24(25.3%)	6(6.3%)	32(33.7%)	23(24.2%)	4(4.2%)	95	3.57(1.373)	25.325	94	<.001*
I have difficulty recognising a significant change in my patient's condition	14(14.7%)	39(41.1%)	12(12.6%)	24(25.3%)	4(4.2%)	2(2.1%)	95	2.69(1.236)	21.21	94	<.001*
I am confident in guiding nursing staff towards aligning nursing - care according to the philosophy of the unit.	0(0.0%)	6(6.3%)	15(15.8%)	35(36.8%)	31(32.6%)	8(8.4%)	95	4.21(1.020)	40.236	94	<.001*
I am comfortable asking for help	1(1.1%)	7(7.4%)	11(11.6%)	30(31.6%)	20(21.2%)	26(27.4%)	95	4.46(1.270)	34.252	94	<.001*
I use current evidence to make clinical decisions	1(1.1%)	2(2.1%)	4(4.2%)	37(38.9%)	38(40.0%)	13(13.7%)	95	4.56(0.931)	47.73	94	<.001*

Item	Responses as Frequency (%)						n	Mean (SD)	t	Df	p-value
	Strongly Disagree	Disagree	Slightly Disagree	Slightly agree	Agree	Strongly Agree					
	1	2	3	4	5	6					
I am comfortable communicating and coordinating care with multidisciplinary team members.	0(0.0%)	6(6.3%)	6(6.3%)	35(36.8%)	26(27.4%)	22(23.2%)	95	4.55(1.109)	39.978	94	<.001*
I am comfortable acting as a patient advocate	0(0.0%)	0(0.0%)	1(1.1%)	14(14.7%)	52(54.7%)	28(29.5%)	95	5.13(0.688)	72.632	94	<.001*
I am comfortable in planning the routine nursing tasks in the unit	1(1.1%)	8(8.4%)	12(12.6%)	28(29.5%)	30(31.6%)	16(16.8%)	95	4.33(1.207)	34.944	94	<.001*
I feel comfortable with scheduling of duties for all staff	3(3.2%)	10(10.5%)	12(12.6%)	31(32.6%)	26(27.4%)	13(13.7%)	95	4.12(1.287)	31.167	94	<.001*
I am comfortable taking action to solve problems independently	6(6.3%)	11(11.6%)	9(9.5%)	28(29.5%)	28(29.5%)	13(13.7%)	95	4.05(1.409)	28.025	95	<.001*
I feel confident identifying actual or potential safety risks to my patients	0(0.0%)	0(0.0%)	4(4.2%)	44(46.3%)	32(33.7%)	15(15.8%)	95	4.61(0.803)	55.973	96	<.001*
I am comfortable drawing up a nursing care plan according to the specific needs of the patient	0(0.0%)	0(0.0%)	4(4.2%)	40(42.1%)	34(35.8%)	17(17.9%)	95	4.67(0.818)	55.695	97	<.001*
As a bridging programme graduate nurse I am prepared for the management role of a newly qualified professional nurse	17(17.9%)	9(9.5%)	14(14.7%)	18(18.9%)	24(25.3%)	13(13.7%)	95	3.65(1.687)	21.103	98	<.001*

The one-sample t-test was used to determine whether management competency differs significantly from the average score of 3.5. The results showed that the management competency level of respondents was above the average value for all the items, except for “I have difficulty prioritising patient care needs,” and “I have difficulty recognising a significant change in my patient’s condition,” which showed average values of 3.03 and 2.09, respectively.

The results indicated a strong agreement of the competency of nursing professionals in relation to the aforementioned roles. Hence, the bridging programme graduate nurse as a newly qualified professional nurse had the competency to perform these roles. The p-values were statistically significant at 95% thus affirming the management competency of respondents. Table 4.8 below illustrates the factor loadings of management competency.

Table 4.6 Factor Loadings of Management Competency

	Factor	
	1	2
Management Competencies		
Q17.11 I use current evidence to make clinical decisions.	1.107	
Q17.15 I feel comfortable with scheduling of duties for all staff.	1.012	
Q17.14 I am comfortable in planning the routine nursing tasks in the unit.	.802	
Q17.6 I am confident in my ability to problem solve.	.782	
Q17.16 I am comfortable taking action to solve problems independently.	.699	
Q17.10 I am comfortable asking for help.	.661	
Q17.12 I am comfortable communicating and coordinating care with multidisciplinary team members.	.659	
Q17.19 As a bridging programme graduate nurse I am prepared for the management role of a newly qualified professional nurse.	.608	
Q17.18 I am comfortable drawing up a nursing care plan according to the specific needs of the patient	.575	
Q17.5 I am confident in teaching nursing care to lower categories of staff.	.575	
Q17.9 I am confident in guiding nursing staff towards aligning nursing care according to the philosophy of the unit.	.572	
Q17.1 I feel confident communicating with physicians.	.547	
Q17.8R I do NOT have difficulty recognizing a significant change in my patient's condition.		.840
Q17.4R I do NOT have difficulty prioritizing patient care needs		.670
Q17.17 I feel confident identifying actual or potential safety risks to my patients.		.607
Q17.7R I do NOT feel overwhelmed by ethical issues in my patient care responsibilities.		.545
Q17.13 I am comfortable acting as a patient advocate.		.537
Q17.2 I am comfortable communicating with patients from diverse populations.		.471

Factor analysis with Promax rotation was applied to the 19 items measuring the management competency of the respondents. A Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO) value of 0.933 and a significant Bartlett's test indicated that reliable factor extraction has taken place. Two factors were extracted that account

for 61.27% of the variance in the data. Rotation converged in 3 iterations. Item 3 (I am comfortable delegating tasks to lower categories of nursing staff) was removed because it loaded onto both factors with a similar loading (Table 4.6).

The factor loading analysis was done to determine if there was significant agreement or disagreement on whether graduate nurses feel that they can competently perform the management competencies listed in Table 4.6 The highest factor loading was 1.107, which represents the statement, “I use current evidence to make clinical decisions” and the lowest factor loading was 0.471, which was “I am comfortable communicating with patients from diverse populations.”

The various statements in Table 4.6 are further summarised in Table 4.7 below. Two factors were extracted from this data. That is factor one which represents GEN competency and factor two, which represents PAT competency. The Cronbach alpha result indicated the reliability of the two factors extracted as both factors had an alpha value >0.7.

Table 4.7 Factors extracted

Factor	Label	Items included	Percentage variance extracted	Cronbach's alpha
1	GEN	1, 5-6, 9-12, 14-16, 18-19	56.65	.957
2	PAT	2, 4, 7, 8, 13, 17	4.62	.790

Table 4.8 Summary of the extracted factors

Factors/Constructs	N	Mean	Std. Dev.	Std. Error Mean	Df	T	Sig. (2-tailed)
GEN	95	4.2553	1.030	.10572	94	7.144	.000
PAT	95	4.4088	0.745	.07650	94	11.879	.000

The two factors extracted were calculated by averaging the scores of the items included in the factor. Analysis to determine significant agreement or disagreement that they feel competent in these roles was carried out by applying the one-sample t-test. The average value for GEN and PAT were 4.255 and 4.408, respectively. These factors were statistically significant ($p < .001$) using the one-sample t-test. The study concluded that there was significant agreement that graduate nurses felt competent to care for patients and do general management activities.

4.14 Factors that affect bridging programme graduate nurses' preparedness

This section addresses the second research objective, which sought to identify the factors that affect bridging programme nurses' preparedness to assume the role of a newly qualified professional nurse. To address this objective, two dependent variables/factors were considered. That is GEN and PAT. The first set of regression analyses examined how the experience as an enrolled nursing auxiliary (ENA) and enrolled nurse (EN) prior to enrolling for the bridging course affected graduate nurses' preparedness to assume the role of a newly qualified professional nurse. The results are indicated in the Table 4.10 below.

Table 4.9 The impact of Enrolled Nursing Auxiliary (ENA) and Enrolled Nurse (EN) on GEN and PAT

GEN				PAT		
Variables	Stand.			Stan.		
	Coefficients	Error	Sig	Coefficients	Error	Sig
Intercept	5.43	0.283	0.000	4.718	0.231	0.000
ENA = <1 year	-0.927	0.324	0.005	-0.509	0.265	0.058
ENA = 1-5 years	-0.085	0.322	0.792	0.138	0.263	0.601
ENA = >5 years	0.000	0.000	1.000	0.000	0.000	1.000
EN = <1 year	-0.969	0.313	0.003	-0.258	0.255	0.314
EN = 1-5 years	-0.004	0.292	0.99	0.381	0.238	0.113
EN = >5 years	0.000	0.000	1.000	0.000	0.000	1.000
R-Squared	0.594			0.484		
Adj R Squared	0.576			0.461		
Prob>F	32.889(0.000)			21.098(0.000)		
Obs	95			95		
DF	(4, 90)			(4, 90)		

The experience as an enrolled nurse or an enrolled nursing auxiliary accounted for 59.4% of the variance in GEN R-Squared value 0.594. The Prob>F (4; 90) = 32.889, $p < .001$, indicated that the variables (years of experience for an Enrolled Nursing Auxiliary and an Enrolled Nurse ranging from <1 year to >5 years) were jointly significant and were significant predictors of general activities.

The results from the regression analysis showed a significant coefficient value for enrolled nursing auxiliary (ENA) with less than one year (<1 year) of experience. Compared to having more than five years (>5 years) experience as an ENA, having <1 years' experience significantly reduced GEN management competency ($\beta = -.927$, $p = .005$). In the same way, compared to having more than five years (>5 years) experience as an enrolled nurse (EN), having less than one year (<1 year) experience significantly reduced general nursing management competency ($\beta = -.969$, $p = .003$).

The impact of the experience as ENA and EN before enrolling for the bridging programme on PAT competency, accounted for 48.4% of the variance in PAT. The Prob>F (4; 90) = 21.098, $p < .001$ further shows the joint significance. The experience was a marginal predictor of PAT competency. Compared to having >5 years of experience as an ENA, having <1 years' experience marginally reduced patient care competency, $\beta = -.509$, $p = .058$. Table 4.11 below, illustrates the effect of a graduate nurse enrolled in an employer supported programme on GEN and PAT.

Table 4.10 The effect of a graduate nurse enrolled in an employer supported programme on GEN and PAT

Variables	GEN			PAT		
	Coefficients	Stand Error	Sig	Coefficients	Stand Error	Sig
Intercept	3.906	0.102	0.000	4.248	0.083	0.000
Enrolled=Yes	1.327	0.198	0.000	0.612	0.163	0.000
Enrolled=No	0.000	0.000	1.000	0.000	0.000	1.000
R-Square	0.325			0.132		
Adj R Squared	0.318			0.123		
Prob>F	44.811(0.000)			14.164(0.000)		
Obs	95			95		
Degrees of Freedom	(1, 93)			(1, 93)		

The results in Table 4.11 showed that the variables included were jointly significant. This is validated by the probability value (Prob>F), which was significant at 95% level ($p < .001$) for the GEN competency model and PAT model. The results indicated that graduate nurses enrolled in an employer-supported programme had a positive coefficient for the general activity and patient care models and this relationship was statistically significant.

The findings indicated that being in a supported programme was a significant predictor of GEN and PAT competency. Therefore, these factors significantly impacted bridging programme graduate nurses' preparedness to assume the role of a newly qualified professional nurse. Table 4.11 shows the number of mentors.

Table 4.11 Number of Mentors**4.11: Number of Mentors**

Variables	GEN			PAT		
	Coefficients	Stand. Error	Sig	Coefficients	Stand. Error	Sig
Intercept	5.486	0.215	0.000	5.083	0.182	0.000
Mentors=0	-1.771	0.236	0.000	-0.983	0.199	0.000
Mentors=1	-0.493	0.299	0.102	-0.109	0.252	0.666
Mentors=2	-0.428	0.319	0.184	-0.367	0.269	0.177
Mentors=3	0.000	0.000	1.000	0.000	0.000	1.000
R-Square	0.493			0.312		
Adj R Squared	0.476			0.289		
Prob>F	29.497(0.000)			13.732(0.000)		
Obs	95			95		

The study further examined how the number of mentors in a bridging graduate programme affected the newly qualified professional nurses' preparedness to assume the role of a newly qualified professional nurse (Table 4.11).

It was found that professional nurses who have had mentors were statistically insignificant as the significance probability (p-value) is greater than 0.05 ($p > 0.05$). The insignificant values for those with mentors may be because most respondents indicated that they received no mentors (63.2%; $n=60$), which accounted for several missing values for these variables. Interestingly, nurses who had received no mentors since graduating from the bridging programme, had a statistically significant negative relationship with GEN and PAT. The results implied that, compared to having mentors, not having a mentor significantly reduces competencies in GEN and PAT practices. Table 4.12 below provides the correlation analysis between competencies (GEN and PAT) and the number of mentors.

Table 4.12 Correlation Analysis between Competencies (GEN and PAT) and the number of mentors

Correlations				
			GEN	PAT
Spearman's rho	Q14 How many mentors have you had since graduating from your bridging programme?	Correlation Coefficient	.696**	.535**
		Sig. (2-tailed)	.000	.000
		N	95	95
**. Correlation is significant at the 0.01 level (2-tailed).				

Significant strong positive correlations existed between the number of mentors and these competencies. In GEN, the more mentors they had, the more competent they were in the year 2020 during data collection, $\rho=.696$, $p<.001$; while in patient care (PAT), having more mentors was associated with higher competencies, $\rho=.535$, $p<.001$. (Table 4.12). Table 4.13 below demonstrates Spearman correlation for “Buddy System”.

Table 4:13 Spearman correlation for “Buddy System”

			Q15.1 Buddied with a RN	Q15.2 Buddied with an EN	Q15.3 Buddied with someone else
Spearman's rho	GEN	Correlation Coefficient	.265**	.320**	.321**
		Sig. (2-tailed)	.009	.002	.002
		N	95	95	95
	PAT	Correlation Coefficient	.173	.200	.244*
		Sig. (2-tailed)	.093	.052	.017
		N	95	95	95
	ADEQ	Correlation Coefficient	.194	-.183	-.075
		Sig. (2-tailed)	.060	.075	.468
		N	95	95	95

The correlation between having a buddy and the three dependent variables: (Adequacy, GEN and PAT) was examined. The results indicated that there were weak to moderate positive correlations between being buddied with someone and GEN. There was a weak positive correlation between being buddied with someone else and PAT.

According to the findings, there were no significant correlations between being buddied and general adequacy, even though these are not significant, there are weak negative correlations with ADEQ and being buddied either with an EN or with someone else (Table 4.13). Table 4.14 shows the adequacy (ADEQ) of Gen and Pat.

Table 4.14 Adequacy (ADEQ) of GEN and PAT

GEN			PAT			
Variables	Coefficients	Stand. Error	Sig	Coefficients	Stand. Error	
Intercept	2.787	0.751	0.000		0.526	0.000
ADEQ	0.334	0.169	0.051	2.73	0.118	0.002
R-Square	0.040			0.101		
Adj R Squared	0.030			0.091		
Prob>F	3.899(0.051)			10.398(0.002)		
Obs	95			95		
Degrees of Freedom	(1,94)			(1,94)		

Test – linear regression.

Table 4.14 presents results which determined whether the level of adequacy (ADEQ) of a bridging programme graduate nurse as a newly qualified professional nurse significantly predicts GEN and PAT competencies.

The results indicate that the ADEQ in performing nursing tasks accounts for 10.1% of the variance in PAT. The Prob>F (1, 93) = 10.398 and was jointly significant ($p=0.002$). The coefficient for adequacy was positive and statistically significant ($\beta = .382$, $p=.002$). The results explain that adequacy is a significant predictor of the PAT competency.

A positive relationship was found ($\beta = .332$, $p=.051$) for the adequacy of GEN. The result shows that adequacy is a marginal predictor of GEN as it is not significant, but marginally significant.

4.15 The effect of demographics on the preparedness of bridging programme graduate nurses as a newly qualified professional nurse

The third objective of this study was to determine whether demographics significantly influence the adequacy and competencies of professional nurses. To achieve this, three dependent variables (adequacy, GEN and PAT) were considered. The analysis

was done to determine if the dependent variables differed significantly across the demographic characteristics (gender, age or race).

An independent sample t-test was used to determine the significant differences for gender and the results showed no significant differences and an ANOVA test (Table 4.15 and 4.15.1) was done to determine if there are significant differences for race.

Table 4.15 ANOVA Analysis showing the impact of ADEQ, GEN and PAT on Race

DV	Race	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimu m	Maximu m
						Lower Bound	Upper Bound		
ADE Q	Black	41	4.3593	.59327	.09265	4.1721	4.5466	2.13	5.00
	Coloured	11	4.4364	.69497	.20954	3.9695	4.9033	2.60	5.00
	Indian	40	4.4117	.65683	.10385	4.2016	4.6217	1.47	5.00
	White	3	4.6444	.20367	.11759	4.1385	5.1504	4.47	4.87
	Total	95	4.3993	.61958	.06357	4.2731	4.5255	1.47	5.00
GEN	Black	41	3.9106	.97154	.15173	3.6039	4.2172	2.42	5.92
	Coloured	11	3.9167	1.10050	.33181	3.1773	4.6560	2.08	5.50
	Indian	40	4.6354	.93934	.14852	4.3350	4.9358	2.67	6.00
	White	3	5.1389	.80075	.46231	3.1497	7.1281	4.42	6.00
	Total	95	4.2553	1.03048	.10572	4.0453	4.4652	2.08	6.00
PAT	Black	41	4.2520	.76478	.11944	4.0106	4.4934	2.67	6.00
	Coloured	11	4.2424	.48513	.14627	3.9165	4.5683	3.67	4.83
	Indian	40	4.5917	.74244	.11739	4.3542	4.8291	3.00	6.00
	White	3	4.7222	1.01835	.58794	2.1925	7.2519	3.83	5.83
	Total	95	4.4088	.74566	.07650	4.2569	4.5607	2.67	6.00

Table 4.15.1 ANOVA Analysis – Further Analysis of results in Table 4.14.

		Sum of Squares	Df	Mean Square	F	Sig.
ADEQ	Between Groups	.267	3	.089	.226	.878
	Within Groups	35.817	91	.394		
	Total	36.084	94			
GEN	Between Groups	14.256	3	4.752	5.054	.003
	Within Groups	85.561	91	.940		
	Total	99.817	94			
PAT	Between Groups	2.944	3	.981	1.811	.151
	Within Groups	49.320	91	.542		
	Total	52.265	94			

The ANOVA test was used to examine the impact of race on ADEQ, GEN and PAT. The findings from the data (as presented in Table 4.15 and Table 4.15.1) show that GEN differs significantly across 'race', with a significant F value ($F(3, 91) = 5.054$, $p=.003$). A Post-hoc analysis using Tukey's test shows that Indians perceive their competency in GEN higher than Blacks, $p=.006$.

Table 4.16: Pearson's correlation

		Age
GEN	Pearson Correlation	.237*
	Sig. (2-tailed)	.020
	N	95
PAT	Pearson Correlation	.223*
	Sig. (2-tailed)	.030
	N	95
ADEQ	Pearson Correlation	.054
	Sig. (2-tailed)	.605
	N	95

The Pearson correlation (Table 4.16) for age showed weak positive correlations between age and GEN and PAT. Older nurses are shown to be associated with higher nursing competencies.

4.16 Challenges during the transition as a newly qualified nurse

Respondents' opinions were solicited from an open – ended question regarding what they found to be most stressful during their transition to a newly qualified professional nurse.

What was found most stressful by respondents in the transition from graduate nurse to a newly qualified professional nurse is evident in the following responses:

Taking responsibility for staff and patients

No mentors to guide you in decision making

Time management to complete all tasks

Dealing with different doctors and their preferences

Delegating to lower category of staff that had more work experience

High expectations from management to be able to manage a unit in the absence of a unit manager

Working with staff shortages made managing the unit and patients difficult

No support from management to socialize in to the new role

Shift leading a month after graduating as a newly qualified professional nurse

Being accountable for all staff and their activities in the unit

Conflict management amongst staff

Staff do not want to take instructions from a new graduate nurse

Making the role adjustment from being supervised as a student to being left on your own as a newly qualified professional nurse

Being undermined by senior staff for the lack of management clinical experience for the new role

Being respected and accepted in the unit by staff who still see you as a student nurse

4.17 Summary

The results showed that the adequacy and management competency of bridging programme graduate nurses as newly qualified professional nurses recorded an average value above the threshold values for all items, indicating high acceptance of these factors. Also, when compared to having more than five years of experience as an enrolled nursing auxiliary and enrolled nurse, having less than one year of experience significantly reduces the GEN and PAT competency. Nurses enrolled in an employer-supported programme positively affected bridging programme graduate nurses' preparedness confidence assuming the clinical skill and role of a newly

qualified professional nurse. The results further indicated that there was a negative relationship between no mentors and performing general nursing duties, based on their significant value, however the results also indicated the more mentors the graduate had, the more confident they were in performing GEN and PAT. The findings further indicated that the demographic characteristics influenced the preparedness of bridging programme graduate nurses.

Chapter 5: Discussion of findings

5.1 Introduction

This chapter presents the discussion of the research findings and conclusion.

5.2 Demographic Characteristics of the Respondents

5.2.1 Gender

A total of 86.30% of the respondents were females and 13.70% were male. This is in line with the study by Langtree *et al.* (2018: 132), who found that the nursing profession is dominated by females.

5.2.2 Race

The results from the analysis further showed that among the respondents, the majority were black (43.20%) and Indians (42.10%). This was because the setting of the study was the PNEI in KwaZulu-Natal, a province in South Africa where the black and Indian community are in the majority. This is confirmed by the findings of eThekweni Health District (2015: 13) who stated that the majority of nursing professionals in KwaZulu-Natal belonged to the black and Indian race groups.

5.2.3 Age

Regarding the age category, the current study found that 65.30 % of the nurses were below the age of 30 years thus supporting a report by the South African Nursing Council which stated that most of the student nurses were in their twenties (SANC, 2015). This supports the age category, which revealed that most of the respondents are in their youthful age and may require several years of work experience as enrolled nurses to better prepare them to function in their roles as newly qualified professional nurses. Solvik and Struksnes (2018: 7) contended that age may compensate for lack of experience.

5.3 Clinical experience

5.3.1 Enrolled Nursing Auxiliary Experience

Respondents were required to indicate years of work experience as an enrolled nurse auxiliary prior to graduating as a professional nurse. Sixty-nine (69%) of these nurses had less than a year of work experience whereas 7.40% of the respondents had more than five years of work experience. It may be that many of these nurses, on completion of the one-year enrolled nurse auxiliary programme (R 2176: 1993) progressed to the enrolled nurse programme prior to commencement of the bridging programme.

5.3.2 Enrolled Nurse Experience

Prior to the commencement of the bridging programme, 52.50% of the respondents indicated that they had less than one year of work experience whereas 8.40% had more five years of work experience. The assumption that enrolled nurses with more years of clinical experience are better prepared for the role transition as professional nurses, as they can use their past clinical experience to support their transition journey. As stated by Muruvan (2018: 4), lack of clinical experience is found to undermine the newly qualified professional nurses' confidence in their knowledge and skills, resulting in workplace transition shock.

5.3.3 Management Clinical Experience

The results also indicated that 97.90% of the graduate nurses had a month of management clinical experience whereas 2.10% had less than a month of management clinical experience before graduating from the bridging program. Although the graduate nurses, during their training, were allocated to a supernumerary month for the practice of management skills, this may have been too short for the development of management competencies. This is further supported by the doing stage of the transition shock theory whereby the graduate nurse enters the clinical setting with an idealist expectation that is far from the real situation. Newly qualified professional nurses attributed this disparity to not being adequately prepared with clinical skills for role-taking (Duchscher 2008: 444). The

expectation from employers is that the graduate nurses must be work-ready from the moment they graduate but this expectation may be unrealistic.

5.4 Enrolment in an Employer Supported Programme

The study findings show that 74% of the respondents are not enrolled in an employer supported programme and only 26.3% of the newly qualified professional nurses have been through an employer supported programme. In a fast-paced clinical environment, graduate nurses need strong theoretical knowledge and excellent clinical skills to provide fundamental nursing care to patients with complex medical conditions. According to (Edward *et al.* 2015: 1254), employer supported programmes improves the confidence and competence of a new graduate nurse. Employer support programmes bridges the gap between theory and practice in nursing, hence preventing the doing phase (Duchscher 2009) of the transition shock theory whereby newly qualified professional nurses felt as if they were thrown into the deep end of role expectation while often questioning their professional identity.

5.5 Clinical Areas currently employed

To fully comprehend the transitional challenges of new graduate nurses, it is imperative to understand their clinical environment and workplace conditions (Hussein *et al.* 2017: 2). Findings revealed that 33% of the respondents were employed in the surgical units and 10.40% in intensive care units. The bridging programme curriculum focused more on general nursing care and not on specialised nursing care. Newly qualified professional nurses would not have had their specialised training as yet in these disciplines. Hence, these nurses may not have the confidence and skills in these areas and often experienced the being phase of the transition shock theory where they felt safer remaining under the protection of the title of 'new nurse'.

5.6 Number of orientation hours

5.6.1 Hours of orientation

A formal unit orientation programme addresses the transition from a bridging programme student nurse to that of a newly qualified professional nurse in the unit.

The study revealed that 59% of the respondents did not receive any form of orientation in their new role whereas 10.50% had less than five hours of orientation. As stated by Lalithabai (2021: 181), an orientation process is an introduction of new employees to new technologies, procedures and policies in the workplace, therefore inspiring the new graduate to demonstrate competence in patient care. These graduate nurses may go through the knowing phase of the transition shock theory where new graduate nurses identify their insecurities in the workplace and have to move away from this, in order to socialise into their new role.

5.6.2 Months before left in charge of a shift

All graduate nurses need time for role adjustment from a student to that of a newly qualified professional nurse. Duchscher (2009) contended that the transition period is twelve months from graduation, when graduate nurses transition to a qualified professional nurse. The majority of the respondents 83.20%, mentioned that it took about six months after graduation when they were left in charge of a shift and 16.80% of the respondents were not leading a shift at the time of data collection. According to Wong (2018: 30), nurses need time to adjust to new roles and responsibilities when transitioning from a supervised environment to the real working world, where they need to take care of the afflicted. This was further highlighted in the knowing phase of the transition shock theory where new graduates needed to recover from the initial shock of the work environment and question their pre-graduate notion of nursing (Duchscher 2008: 446).

5.6.3 Hours of clinical support from unit managers per month

According to Wong (2018: 32), factors such as an increased workload, staffing shortages and lack of clinical support leads to increased stress levels of new graduates. Sixty-one (61%) of the respondents did not receive clinical support from

the unit manager and 13.70% received less than five (5) hours of clinical support from the unit manager. Unit manager support may not always be provided for new graduates as staffing shortages of senior nurses continues to be a problem in current times. This was further argued in a study by Mohammadnezhad *et al.* (2021: 1) that one of the main challenges that the healthcare setting is facing globally, is the shortage of a skilled workforce.

5.7 Mentorship

As stated by Kreedi *et al.* (2021: 94), graduate nurses' experience reality shock in an unsupported clinical environment, due to their limited clinical experience of how to take responsibility without help. Study findings revealed that 63.20% of the respondents had no mentors and 12.60% had more than 2 mentors. Mentorship might assist in the smooth transition from a graduate nurse to that of a newly qualified professional nurse and may be the solution to the reality shock that is experienced in the clinical environment.

5.8 Buddy System

The buddy system may support new graduates in socialising into the nursing profession. In this study, 56.8% of the respondents had less than a month of the buddy system with a Registered Nurse while 37.9% had never been buddied with a Registered Nurse at the time of data collection. According to Ashurt (2020: 21), the experienced buddy supports the new nurse by giving them a sense of value and importance, hence the buddy system might prevent a transition crisis for the new graduate nurse. Duchscher (2009) suggested that it takes one to four months for the graduate nurse to adapt to the new surroundings, hence these nurses need to be adequately supported in a fast-paced health care setting.

5.9 Adequacy of a bridging programme graduate nurse as a newly qualified professional nurse in performing tasks

Brooks and Morphet (2021: 4) explained that a graduate nurse needs to have basic skills, attributes and some knowledge to fit into practice in order to be work-ready. Respondents in this study revealed that they were adequately prepared to perform

GEN tasks as a newly qualified professional nurses because all tasks recorded an average value above the central rating of three, which indicated that these nurses had been adequately prepared to perform these tasks. The respondents were most adequate with receiving telephonic orders, as this task had the highest mean average of 4.71. Chest tube care had the lowest mean average of 3.61, however, the respondents indicated that despite this task having the lowest average, they still felt adequately prepared to perform this task. This result is in line with the study by Woods *et al.* (2015: 364), who showed that most students agreed that they felt ready to perform tasks for the new graduate registered nurse role.

5.10 Management Competency to carry out the role of a professional nurse

In a study conducted by Willman *et al.* (2020: 720), it was found that the student nurses viewed their management clinical competencies as being high and newly qualified graduate nurses viewed their management clinical competencies as being good. This could be that these graduates experienced a transition shock with them questioning their management competencies once they start to practice. Out of the nineteen management competencies, only two scored below the average value of 3.5. The results indicated that graduates had difficulty in recognising significant changes in the patient's condition and difficulty prioritising patientcare needs as these competencies recorded an average of 2.69 and 3.03 respectively.

All the other management competencies scored above the average of 3.5, thus indicating that graduate nurses have the ability to competently perform these management skills. The highest rated management competency was the ability to act as an advocate for the patient and the second highest management competency was the ability to communicate with patients from diverse populations. These two management competencies recorded an average of 5.13 and 5.01 respectively.

From the theoretical framework and the literature used in this study, it is evident that it takes six to twelve months before a new graduate nurse can assume a leadership role. Despite these graduates indicating that they had difficulties in recognising significant changes in the patient's condition and prioritising patientcare, they were still allocated as shift leaders in the units. These findings support the need for more

time for management skills to be integrated into the bridging programme in order for these nurses to function in a leadership role.

5.11 Factors that affect bridging programme graduate nurses' preparedness

5.11.1 Years of experience

Having less than one year experience as an enrolled nurse auxiliary and an enrolled nurse, significantly reduced the GEN and PAT competencies of a newly qualified nurse. These graduates had very limited clinical experience before commencing with the bridging programme, hence they may have found it difficult to transition from a student nurse in a supported environment to that of a graduate nurse in a less supported environment. This was further supported by Rizany *et al.* (2018: 154), who argued that demographic characteristics such as work experience and education have a higher propensity to influence the development competencies of nurses in the clinical setting.

5.11.2 Employer-supported programmes

The results showed that there is a significant, positive relationship between being enrolled in an employer-supported programme and adequacy to perform general activity and patient-care activities. This means that graduates who were enrolled in an employer support programme were more adequate in performing GEN and PAT activities. Phillips, Esterman and Kenny (2015: 118) stated that a lack of employer support affects graduate confidence and engagement in the clinical setting.

5.11.3 Mentors

The results implied that there is a significant, negative relationship between not having a mentor and the adequacy to perform GEN and PAT activities. This means that not having a mentor resulted in graduate nurses GEN and PAT competencies being significantly lower than that of graduate nurses that had mentors. This indicates that an unsupportive clinical environment affects the graduate nurse's ability to work autonomously, hence drastically impacting their confidence (Missen

et al. 2016: 2134). A lack of confidence could result in graduate nurses not having the ability to seek assistance or guidance in the healthcare setting and this could lead to errors in patientcare (Baumann *et al.* 2018: 825).

The results from this study showed that there was a significant positive relationship between having a mentor and adequacy in performing PAT activities. This means that having a mentor significantly increased the confidence and competencies of the graduate nurse, thus allowing them to efficiently carry out PAT activities. A study by Edwards *et al.* (2015: 1263) explained that well-planned mentorship and preceptorship programmes have a positive effect on students' confidence, competencies, stress levels and retention as experienced nurses guide the newly qualified ones through daily discussions on patientcare and information sharing on the needed skill or procedure.

Newly qualified professional nurses' work preparedness may be further hindered if they do not have adequate interpersonal skills to seek assistance and guidance in the challenging healthcare setting, hence this may lead to potential errors in patient care activities. Silvestre *et al.* (2017: 110) emphasise that providing safe nursing care is one of the most important goals of healthcare settings globally and this can only be accomplished if the newly qualified graduate nurse is effectively supported during the transition journey.

5.11.4 Buddy System

The results indicated that there is a weak to moderate positive relationship between being buddied with someone other than a registered nurse or an enrolled nurse, in relation to GEN and PAT. This means that being buddied with someone else improved GEN and PAT competencies. Ashurst (2020: 20) recognises that the role of the buddy is not the same as being the graduate nurses' line manager but instead being a supportive colleague. Supporting the new nurse with routine in the unit will assist them to better acclimatise, reducing the transition shock theory.

5.12 The effect of demographics on the preparedness of bridging programme graduate nurses as newly qualified professional nurses

The study findings revealed that GEN differed significantly across race groups where Indian graduate nurses perceived their competency in GEN higher than black graduate nurses. There is a positive relationship between ages, GEN and PAT, however this relationship is weak. It may be assumed that older nurses had more clinical experience prior to commencement of the bridging programme. Keykha *et al.* (2016: 18368) documented those factors such as age and race significantly affected nursing competency, hence younger nurses with limited clinical experience should be supported through mentorship programmes to enhance clinical skills.

5.13 Challenges during transition as a newly qualified nurse

The respondents in this study are still in the learning process for role-taking as a newly qualified professional nurse, which is different from that of a student nurse. Graduate nurses found the transition journey very stressful and this was intensified by the lack of support in the clinical environment. Respondents' comments were that the responsibility in their new role overwhelmed them and that as bridging programme student nurses, they did not experience this as they had the clinical support from the senior professional nurses, clinical facilitators and unit managers. This changed for the respondents as employers are expecting graduate nurses to be work-ready from the moment they graduate. These findings are supported by Al Mekkawi and El Khalil (2020: 305) where the healthcare environment expected new nursing graduates to "hit the ground running". This assertion is not different from the experiences of the bridging program graduate nurses as the respondents had these challenges during their transition to a newly qualified professional nurse.

Taking responsibility for staff and patients

No mentors to guide you in decision making

Time management to complete all tasks

Dealing with different doctors and their preferences

Delegating to lower category of staff that had more work experience

High expectations from management to be able to manage a unit in the absence of a unit manager

Working with staff shortages made managing the unit and patients difficult

No support from management to socialize into the new role

Shift leading a month after graduating as a newly qualified professional nurse

Being accountable for all staff and their activities in the unit

Conflict management amongst staff

Staff do not want to take instructions from a new graduate nurse

Making the role adjustment from being supervised as a student to being left on your own as a newly qualified professional nurse

Being undermined by senior staff for the lack of management clinical experience for the new role

Being respected and accepted in the unit by staff who still see you as a student nurse

5.14 Summary

Based on the information provided in this chapter, it can be concluded that the respondents were in the youthful period of their lives and had very limited work experience before commencement of the bridging programme. This chapter also concluded that these new graduates experienced challenges during their transition to a newly qualified professional nurse. Chapter 6 discusses the summary of the findings, limitations, recommendations and further research.

CHAPTER 6: SUMMARY OF THE FINDINGS, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY

6.1 Introduction

This chapter presents a summary of the research findings, limitations, conclusions, and recommendations of this study. Bridging programme graduate nurses' preparedness to assume the role of a newly qualified professional nurse were explored from the responses as a newly qualified professional nurse working in the private hospital setting for not more than a year.

6.2 Summary of the findings

The study findings revealed that most of the respondents were in the youthful age and were dominated by graduate nurses belonging to the black and Indian race groups, which is representative of the demographics of the province of KZN in which this study was conducted. Females had the highest representation because it is believed that they dominate the nursing profession. It was also discovered that the racial distribution of graduate nurses had an impact on their competency. This study further revealed that Indian graduate nurses perceive their competency in general practice higher than black graduate nurses. The results also indicated that the respondents who had less than one year of an enrolled nurse experience had a significantly reduced GEN and PAT competency than those respondents who had more than five years of work experience prior to commencement of the bridging programme. The study further found that graduate nurses who had no mentors, had significantly lower competencies in GEN and PAT activities. It can then be concluded that bridging program graduate nurses need more mentorship and activities that would enhance their GEN and PAT competency because the more mentors they had, the more competent they were. Respondents further highlighted several challenges during their transition to a newly qualified professional nurse. This implies that the transition process is very difficult, hence, newly qualified graduate nurses must be provided with the necessary clinical and managerial assistance to better prepare them for their new role thereby preventing new nurses from experiencing the different stages of the transition shock theory.

6.3 Limitations of the study

This study was limited to the bridging programme graduate nurses, who graduated from the selected PNEI in the year 2020 and are employed in the private hospital setting for not more than a year.

This study may not be a reflection of all other bridging programme graduate nurses' preparedness to assume the role of a newly qualified professional nurses, from PNEIs in other provinces. The KwikSurvey was sent out to bridging programme graduate nurses that are working in the private hospital setting owned by the private hospital group. The study did not include graduate nurses that were trained and are working in the public hospital settings.

6.4 Recommendations

These recommendations are suggested by the researcher, as they are vital to nursing education, clinical practice and for future research.

Bridging programme graduate nurses need more exposure to the management role of a newly qualified professional nurse during their training. These graduate nurses should be supernumerary during their training, so that they are given the best exposure to management under the guidance of senior professional nurses, thus allowing for the closure of the theory-practice gap. Increased management clinical hours would enhance their clinical skills to effectively assume the role of a newly qualified professional nurse.

Allocated mentors must provide continuous support and guidance for the bridging programme graduate nurses, by allocating them to work in shifts where there are senior professional nurses. In the work environment, senior professional nurses are an integral part of the grooming of newly qualified professional nurses.

Bridging programme graduate nurses need support from managers during the transition from a graduate nurse to that of a newly qualified professional nurse to acquire the skills of a newly qualified professional nurse. An unsupportive clinical environment affects the graduate nurse's ability to work autonomously drastically, thereby negatively affecting their confidence levels (Missen *et al.* 2016: 2134).

A specific needs analysis must be done prior to the implementation of a structured micro-orientation programme. The orientation programme should include conflict management and staffing shortages as these are problems that newly qualified professional nurses may be faced with on a regular basis in the clinical environment. Unit managers should implement this micro-orientation programme from the very first day that the newly qualified professional nurse is allocated to the unit as this will better support the bridging programme graduate nurse to make the transition from a graduate nurse to that of a newly qualified professional nurse.

6.5 Further research

Although, the research findings from the study presented many important concerns regarding the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse, this research study was conducted in only one PNEI but further research should be done in other PNEIs and public nursing colleges in different provinces, to ascertain the preparedness of bridging programme graduate nurses to assume the role of a newly qualified profession nurse. This may provide richer and more in-depth findings that can assist in improving the bridging nursing programmes. Future research should also be conducted to determine if the clinical skills for role-taking as newly qualified professional nurses has improved after the implementation of a structured employer-assisted programme over a period of more than a year.

6.6 Conclusion

Academic staff, unit managers, preceptors and policy makers have been challenged to develop strategies or find solutions to better support the transition needs of the bridging programme graduate nurses to a newly qualified professional nurse in the nursing profession. The findings of this study have provided in-depth knowledge about the challenges of the bridging programme graduate nurse for role-taking. The results of this research study support the need for transformation in the clinical and academic settings that will offer the bridging programme graduate nurse with specific learning opportunities to enhance their clinical skills for role-taking, ensuring a smooth transition to a newly qualified professional nurse.

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Appendices

Appendix A: Full Approval Letter from IREC



16 September 2021

Mrs S Karapan
2 Libra Road
Woodhurst
Chatsworth
4092

Dear Mrs Karapan

Preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse.
Ethical Clearance number IREC 134/21

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letter.

Please note that **FULL APPROVAL** is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

Prof J K Adam
Chairperson: IREC

Appendix B 1: Letter of permission to conduct research from Intuitional Ethics Committee.

Selvum Karapan

To: Research
Subject: Permisiion to conduct non clinical focus research

Good Morning Research Operations Committee

I am a M.Cur student at the Durban Institute of Technology studying towards a Master's degree in Nursing Education.

I am employed as a campus based academic staff in KZN Campus. I hereby would like to request your Permission to conduct my Non _Clinical Focus Research, the title of my study is preparedness of bridging programme graduate nurses to assume the role

Of a newly qualified professional nurse. Please see attached documents as per research application checklist Non-Clinical Focus Research.

Selvum Karapan
Nursing Tutor

APPENDIX B 2: Letter of approval Institutional Ethics Committee

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Ms Selvum Karapan

Approval number: UNIV-2021-0037

E mail: selvum.karapan@netcare.co.za

Dear Ms Karapan

RE: PREPAREDNESS OF BRIDGING PROGRAMME GRADUATE NURSES TO ASSUME THE ROLE OF A NEWLY QUALIFIED PROFESSIONAL NURSE

The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at Private Nursing Education Institutions, has been approved, subject to the following:

- i) Research may now commence with this FINAL APPROVAL from the Committee.
- ii) All information regarding the Company will be treated as legally privileged and confidential.
- iii) The Company's name will not be mentioned without written consent from the Committee.
- iv) All legal requirements with regards to participants' rights and confidentiality will be complied with.
- v) All data extracted may only be used in an anonymised, aggregated format and for the purposes of this specific study as specified in the proposal. The data may under no circumstances be used for any other purpose whatsoever.
- vi) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.
- vii) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date..
- viii) The Company has the right to implement any recommendations from the research.

- ix) The Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/ Company or should the researcher not comply with the conditions of approval.
- x) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE STUDY, WHICHEVER IS THE FIRST.

We wish you success in your research.

Yours faithfully

Prof Dion du Plessis

Full member: Research Operations Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Dr Shannon Nell

Chairperson: Research Operations Committee

Date: 22/9/2021

This letter has been anonymised to ensure confidentiality in the research report. The original letter is available with author of research

Appendix C 1: Letter requesting permission to conduct research at the PNEI

2 Libra Road
Woodhurst
Chatsworth
4092

Campus Manager /Programme Manager
Netcare Limited
95 Umhlanga Rocks Drive
Durban North
4016

Dear Madam

I am presently registered for a Master's Degree at the Durban University of Technology in the Department of Nursing. The proposed title of my study is 'The preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse'. I hereby request permission to conduct the study at this Private Nursing Education Institution.

The purpose of this study will be to explore the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse and to make recommendations to better support the clinical preparedness in assuming the role of a newly qualified professional nurse. This study will use a census sampling method in the collection of data. The respondents required for this study will be all second year bridging programme graduate nurses at this PNEI. Principles of Ethics will be adhered to by maintaining confidentiality of the respondents at all times. Participating in this study will be voluntary. All data received will be password protected and only the researcher, biostatistician and the supervisor will have access to the data collection. Data will be managed and analysed ensuring anonymity of all respondents. There is no predicted risk to any of the respondents in this study.

Your kind assistance in granting permission for my study will be highly appreciated.

Yours Sincerely

Mrs S. Karapan
Telephone: 0622750371
Email: Selvumkarapn@gmail.com

Mrs P Pillay (Supervisor)
Telephone: 08265330179
Email: padminip@dut.ac.za

Dr DG Sokhela (Co-Supervisor)
Telephone: 031 3732039
Email: dudus@dut.ac.za

Appendix C 2: Letter of approval to conduct research at the PNEI

Netcare Education KZN Campus
Durban
Faculty of Nursing and Allied Healthcare

Date: 3rd September 2021

To: Durban University of Technology: Ethics Committee

RESEARCH TO BE CONDUCTED IN NETCARE FACILITY

The Management of Netcare Education KZN Campus (S177) has taken note of the application for ethical approval by the Durban University of Technology Ethics Committee for the following research study to be conducted

Preparedness of Bridging Programme graduate nurses to assume the role of a newly qualified professional nurse

In principle the Netcare Hospital Management does not have any reservations for the abovementioned research to be conducted on its premises subject to unconditional ethics approval being granted.

We furthermore confirm that application will then be made to the Netcare Research Operations Committee and that the research may not commence prior to receipt of FINAL APPROVAL from the Netcare Research Operations Committee.

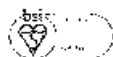
Yours faithfully

Signed by Hospital Management

Date

8/9/2021

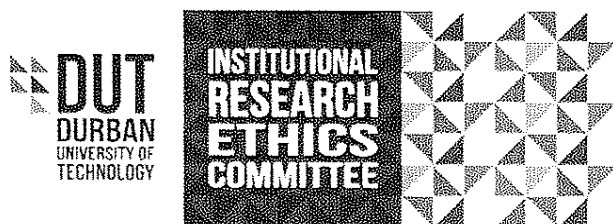
Netcare Education KZN Campus Manager:
(Specify designation)



Netcare Education KZN Campus
Durban
Faculty of Nursing and Allied Healthcare



Appendix D: Letter of information to respondents



LETTER OF INFORMATION

Thank you so much for agreeing to participate in this study.

Title of the Research Study: Bridging programme graduate nurses preparedness to assume the role of a newly qualified professional nurse.

Principal Investigator/s/researcher: Mrs. Selvam Karapan, Ba Cur Nursing Science

Co-Investigator/s/supervisor/s: Mrs P. Pillay; Masters in Nursing (Supervisor)

Dr D. Sokhela, D Nursing (Co- Supervisor), Ms Marilynne Coopasami; Master's in Public Health (Co-Supervisors)

Brief Introduction and Purpose of the Study: Many student nurses perceive that there is not much support and mentorship for them to make the adjustment from a bridging programme graduate nurse to that of a newly qualified professional nurse; hence there are feelings of uncertainty and not being adequately prepared to meet role expectations. The purpose of this study is to explore the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse.

Outline of the Procedures: Campus Manager will send out a KwikSurvey link to the bridging programme graduate nurses requesting permission for the researcher to use personal information for the purpose of the study. After receiving consent from potential respondents via KwikSurvey, to use their personal information for the purpose of this study, all bridging programme graduate nurses that make up the accessible population will be invited via email by the researcher to participate in this research study. Information letters pertaining to the study will be emailed to the respondents. A web link will be set up by the researcher for the data collection and this web link for the survey will be emailed to all respondents. Voluntary consent and data collection tool will be uploaded to the web site. The respondent will then click on the link created for the data collection process. Respondent will have a choice to participate in the study or not to participate in the study by clicking yes or no in the tick box. Anonymity will be maintained by ensuring that names or surnames of respondents will not be recorded on the voluntary consent and the data collection tool. There will no face to face contact with the respondent hence they will have a greater sense of anonymity. Respondents will have a week to

complete the online survey. Confidentiality will be maintained by ensuring that all collected data will be kept in a password protected computer in the department for 5 years after which , electronic copies will be deleted by the researcher after 5 years..

Risks or Discomforts to the Participant: There are no foreseeable risks or discomforts posed to you.

Benefits: The findings are hoped to create a better understanding for all stakeholders on the factors that affect the preparedness of bridging programme graduate nurses to assume the role of a newly qualified professional nurse and to better support the bridging programme graduate nurse in making the transition to a newly qualified professional nurse

Reason/s why the Participant May Be Withdrawn from the Study: Participation in this study is voluntary and therefore you are under no obligation to participate and can withdraw from the current study at any time.

Remuneration: You will not receive any monetary or any other remuneration for your participation in this study.

Costs of the Study: You will not expected to cover any cost towards this study

Confidentiality: Data collected from this study will be kept confidential and will only be used for the purpose of this study. The researcher, the research supervisor and the statistician will have access to the data. Data will be stored on a password protected computer.

Research-related Injury: The study does not pose any risk of injury to the participant.

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher Selvam Karapan on 0622750371 my supervisor Mrs P Pillay 0313732606 or the Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the DVC: Research, Innovation and Engagement Dr L Langaniso on 031 373 2577 or linganisol@dut.ac

Appendix E: Letter of consent for respondents



CONSENT

Statement of Agreement to Participate in the Research Study:

I hereby confirm that I have been informed by the researcher, Selvam Karapan about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____.

I have also received, read and understood the above written information (Participant Letter of

Information) regarding the study. I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.

- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.

I may, at any stage, without prejudice, withdraw my consent and participation in the study.

- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant

Date
Right

Time

Signature /

Thumbprint

I, Selvam Karapan herewith confirm that the above participant has been fully Informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	Date	Signature

_____	_____	_____
Full Name of Witness (If applicable)	Date	Signature

_____	_____	_____
Full Name of Legal Guardian (If applicable)	Date	Signature

Appendix F: Permission to use data collection survey

Selvum Karapan

From: Fink, Regina <Regina.Fink@ucdenver.edu>
Sent: Tuesday, July 2, 2019 10:36 PM
To: Selvum Karapan
Cc: 'Casey, Kathryn RN'
Subject: Re: Permission to use the Casey-Fink Readiness for practice survey for masters dissertation

This message originated from outside your organization

Dear Selvum Karapan--

Here is the link to the website where you will be asked to complete a brief survey providing us with your contact information; we like to keep a database of users of any of the Casey-Fink instruments. After completion of the survey, you will be provided with the documents related to the tool - The Casey-Fink Readiness for Practice survey (including the actual survey, psychometric information including reliability and validity, and original journal articles which discuss the tool).

<https://www.uchealth.org/professionals/professional-development/casey-fink-surveys/>

Please use our work emails, if you have any questions. You have our permission to use our survey and we wish you the best of luck with your studies and dissertation.

Take care--

--Regina Fink and Kathy Casey

Regina M. Fink, PhD, APRN, AOCN, CHPN, FAAN
Professor | School of Medicine
University of Colorado Anschutz Medical Campus
12631 E. 17th Avenue
Academic Office 1, Room 8410
Box B-180
Aurora, CO 80045
regina.fink@ucdenver.edu
303.724.9192 work
303.886.8655 cell

From: Selvum Karapan <Selvum.Karapan@netcare.co.za>
Sent: Tuesday, July 2, 2019 8:21 AM
To: Fink, Regina
Subject: Permission to use the Casey-Fink Readiness for practice survey for masters dissertation

Good Afternoon

I am an academic staff member at Netcare Education in Durban South Africa, I am currently studying towards a master's degree

In education in Nursing Science at the Durban Institute of Technology my topic for the Masters dissertation is Readiness of final year Nursing Students to assume the role Of a newly qualified professional nurse. The Casey-Fink Readiness for practice survey

Is similar to what I am looking for in terms of answering my research question. Please may I request permission to use this survey for my masters dissertation

I look forward to a favorable response from you.

Thanks

Appendix G: Letter from Statistician

Gill Hendry B.Sc. (Hons), M.Sc. (Wits), PhD (UKZN)
Mathematical and Statistical Services

Cell: 083 300 9896
Email: gillhendrystats@gmail.com

2 December 2021

Re: Assistance with statistical aspects of the study

Please be advised that I have assisted Selvam Karapan (Student number 21950285), who is currently studying for a Masters in Health Sciences (Nursing) at DUT, with the alignment/development of the questionnaire, the sampling process and the statistical analysis of her data.

Yours sincerely

Dr Gill Hendry
Private Consulting Statistician

Appendix H: Data Collection Tool (Adapted from Casey-Fink Readiness for Practice Survey)

Instructions to Respondent

Thank you for being a respondent in this study. Kindly read the questions carefully and answer

All questions truthfully. Please do not leave any of the questions blank.

Please fill in the blank or select the response that represents your individual profile.

1 Age _____ years

2 Gender

Male	Female

3 Race

Black	Coloured	Indian	White

3.1 If you selected 'OTHER", please indicate your Race _____

4 How many years of work experience did you have as an Enrolled Nursing Auxiliary before you graduated from the bridging programme?

<1 year	1 – 5 years	>5 years

5 How many years of work experience did you have as an Enrolled Nurse before you graduated from the Bridging program?

<1 year	1 – 5 years	>5 years

6 How many months of management clinical experience did you receive during your bridging programme that assisted you to perform management skills of a newly qualified professional nurse?

Up to 1 month	>1 month

7 In which of the following clinical areas did you receive management clinical experience?

7.1 Medical	7.2 Surgical	7.3 Adult ICU	7.4 Neonatal ICU	7.5 Paediatric
7.6 Emergency department	7.7 OR / Peri-operative setting	7.8 Orthopaedics	7.9 Other: Please specify	

8 Are you, as a bridging programme graduate nurse, enrolled in an employer supported program?

Yes	No

9 In which of the following Clinical Areas are you currently employed?

Medical	Surgical	Adult ICU	Neonatal ICU	Paediatric
Emergency department	OR / Peri-operative setting	Orthopaedics	Other: Please specify	

10 How many hours of orientation did you receive as a newly qualified professional nurse in the unit that you are currently employed in?

_____ Hours

11 Since graduating from the bridging programme, how many months was it before you were left in charge of a shift?

Up to 6 months	>6 months	I have not been in charge of a shift yet

12 On average, how many hours of clinical support did you get from your unit manager per month while you were shift leading?

none	<5 hours	5 – 10 hrs	>10 hrs	I have not lead a shift yet

13 How many mentors have you had since graduating from your bridging programme?

0	1	2	>2

14 Indicate for how many months in total you experienced the following 'buddy systems' since graduating from the bridging programme:

Buddy system	never	<1 month	1 - <2 months	2 - <3 months	3 or more months
14.1 I was 'buddied' with a Registered nurse					
14.2 I was 'buddied' with an Enrolled nurse					
14.3 I was 'buddied' with someone else					

15 Indicate how adequate you think you are, as a bridging programme graduate nurse and a newly qualified professional nurse, to perform the following nursing tasks

	Not at adequate				Extremely adequate
	1	2	3	4	5
15.1 Assessment of a patient					
15.2 Obtaining telephonic order for medication					
15.3 Handing over of patients					
15.4 Bladder catheter insertion/irrigation					
15.5 Central line care (dressing change)					
15.6 Charting/documentation					
15.7 Chest tube care					
15.8 Intravenous (IV) medication administration					
15.9 IV starts –feeds given via a central line					

15.10 Operating IV pump/PCA pump					
15.11 NG tube insertion/ care/ removal					
15.12 Administration of schedule medication					
15.13 Responding to an emergency/CODE/changing patient condition					
15.14 Advanced Wound care/dressing change/					
15.15 Patient teaching (e.g. how to care for their wound on discharge; possible side effects of medications; necessary precautions to be taken post-operatively; etc)					

17 Indicate your level of agreement with the following statements relating to your management competency to carry out your role as a newly qualified professional nurse.

	Strongly disagree	Disagree	Slightly disagree	Slightly agree	Agree	Strongly agree
17.1. I feel confident communicating with physicians.						
17.2. I am comfortable communicating with patients from diverse populations.						
17.3. I am comfortable delegating tasks to lower categories of nursing staff.						
17.4. I have difficulty prioritizing patient care needs.						
17.5. I am confident in teaching nursing care to lower categories of staff.						
17.6. I am confident in my ability to problem solve.						
17.7. I feel overwhelmed by ethical issues in my patient care responsibilities.						
17.8. I have difficulty recognizing a significant change in my patient's condition.						
17.9. I am confident in guiding nursing staff towards aligning nursing care according to the philosophy of the unit.						
17.10. I am comfortable asking for help.						
17.11. I use current evidence to make clinical decisions.						
17.12. I am comfortable communicating and coordinating care with multidisciplinary team members.						
17.13. I am comfortable acting as a patient advocate.						
17.14. I am comfortable in planning the routine nursing tasks in the unit.						

17.15. I feel comfortable with scheduling of duties for all staff.						
17.16. I am comfortable taking action to solve problems independently.						
17.17. I feel confident identifying actual or potential safety risks to my patients.						
17.18. I am comfortable drawing up a nursing care plan according to the specific needs of the patient						
17.19. As a bridging programme graduate nurse I am prepared for the management role of a newly qualified professional nurse.						

18 What did you as a bridging programme graduate nurse found to be most stressful when you had to make the transition to that of a newly qualified professional nurse?

Thank you for your time