RESEARCH

CRITICAL EVALUATION OF THE NEWLY QUALIFIED NURSE'S COMPETENCY TO PRACTISE - PART 1

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Opsomming

Die bevoegdheid van die nuutgekwalifiseerde verpleegkundige om as geregistreerde verpleegkundige te praktiseer, word bevraagteken.

'n Kritiese evaluering van die bevoegdheid van die nuutgekwalifiseerde verpleegkundige is uitgevoer deur gebruik te maak van selfevaluering en evaluering deur die nuutgekwalifiseerde verpleegkundige se toesighouer. Die studie het ook die verband tussen die bevoegdheid van die nuutgekwalifiseerde verpleegkundige en haar plasing, ori-ntering en begeleiding nagevors.

Data analise het aangetoon dat plasing en ori-ntering van die nuutgekwalifiseerde verpleegkundige in 'n geringe mate haar bevoegdheid be5nvloed. Die noodsaaklikheid van voldoende begeleiding aan die nuutgekwalifiseerde verpleegkundige het egter, duidelik na vore gekom.

Summary

The competence of the newly qualified nurse practitioner is questioned. Critical evaluation of the competency of the newly qualified nurse is performed by means of self evaluation as well as evaluation by the newly qualified nurse's supervisor. This study shows the relationship between competency of the newly qualified nurse and placement, orientation and guidance.

Data analysis indicated that there is no significant relationship between the competency of the newly qualified nurse and placement and orientation. The importance of adequate guidance to the newly qualified nurse was quite clear.

PROBLEM

A critical evaluation of the newly qualified nurse's competency to practise, in which she participates is essential to ensure the delivery of high quality care. Thorough orientation and guidance is necessary to help her accept the reality of her responsibilities. Allen (1982:1) maintained

"A society undergoing rapid change needs professionals who have developed skills and who are able to evaluate the way their knowledge, experience and energy can best be utilized".

In the Republic of South Africa a variety of factors influence the nurse's competency, such as:

- **The changing pattern of health care delivery, necessitated by the shift from a curative orientated to a comprehensive health service.** The Health Act, 63 of 1977 as well as the National Health Plan of 1986 formulated policy to meet the demands of this change. The South African Nursing Council, in response to the above policy, introduced the course for the education and training of a nurse (general, psychiatric and community) and midwife, leading to registration with the South African Nursing Council (Regulation no. 425 of 22 February 1985). The competency of the professional nurse having completed this course is being queried by senior members of the profession.

- **The population profile in the Republic of South Africa.** It has been estimated that there will be a population of between 27 million and 36 million in the Republic of South Africa by the year 2000 (Gerber, Nel & Van Dyk 1987:3). The Republic of South Africa is confronted by both a first and third world situation. This requires a diverse approach to health care in which primary health care, population development and family planning should receive priority (President Council Report 1983:76). Advancements in medical technology should however not be overlooked. *"Increased acuity levels of patients, decreased length of hospitalization and the proliferation of health care technology and specialization have increased the need for highly experienced nurses"* (Benner 1982:402).

- **Utilisation of available resources.** The available nursing personnel should be used effectively, and they should use the opportunity to develop themselves. Orientation and guidance of the newly qualified nurse will largely determine whether she will be competent to perform her duties in the changing health care scenario.

The problem investigated in this study is concerned with determining whether the newly qualified nurse is competent to practise within her scope of practice.

THE OBJECTIVES

The objectives of the study were to

- identify the influence placement has on the competency of the newly qualified nurse;
- determine whether orientation contributed towards the competency of newly qualified nurses;
- identify the type of guidance given by the supervisor/preceptor;

- compare the supervisor's evaluation of the newly qualified nurse with that of the nurse's self-evaluation;
- evaluate the competency of the newly qualified nurse related to:-
  * communication skills
  * management skills
  * the application of the scientific foundations of her practice and her participation in research;
- determine other factors that could contribute towards the competency of the newly qualified nurse;
- identify the knowledge base that could contribute towards the subject Nursing Administration by developing a model for competency development.

HYPOTHESES

The following null hypotheses were formulated to test the relationship between the variables:

- There is no relationship between correct placement and the competency of the newly qualified nurse in her first post.
- Newly qualified nurses who are adequately orientated will not be evaluated at a higher level of competency than those who are not adequately orientated.
- Effective guidance does not contribute towards the competency of newly qualified nurses to practice.
- There will not be a considerable difference between the self-evaluation of the newly qualified nurse, and evaluation by her supervisor.

DEFINITION OF TERMS

The concepts in terms of this study were defined as follows:

Competency.
The nurse acquires an official mandate to practise as a registered nurse after successfully completing her training. This mandate recognises the nurse's abilities, skills, knowledge, understanding and experience. She therefore should be able to perform nursing activities safely, according to predetermined standards, within her scope of practice, in coordination with other members of the health care team.

Evaluation.
In this study evaluation refers to determining the degree of competency of the registered nurse to practise. The norms of measurement are based on the scope of practice of the registered nurse as stipulated in the South African Nursing Council Regulation no. 2598 of 30 November 1984 and Regulation no. 425 of February 1985.

Newly qualified nurse.
Refers to a registered nurse within the first nine months after having completed the course in accordance with the Regulation no. 425 of 22 February 1985 of the South African Nursing Council.

THEORETICAL FRAMEWORK

The study was based on Bandura's social learning theory in which it was concluded that behaviour is learned through the processing of key concepts observed during the demonstration of desirable conduct. The observer arranges and combines the events to produce new behaviour after thorough practice. Retention of the observed conduct can only occur if the newly qualified nurse is given the opportunity to practise. Feedback should be given by the supervisor about those aspects which are only partly mastered. The newly qualified nurse must be motivated to acquire the behaviour and should therefore work in the area of her interest (Marriner-Tomey 1990: 304-305).

LITERATURE STUDY

The literature studied revealed the following:

Evaluation instrument

The Slater nursing competency rating scale was studied as it was originally developed to measure the competency of newly qualified nurses *"Quality performance expected of a first level staff nurse was the standard of measurement"* (Wandelt & Stewart 1975). Other instruments used in the construction of the evaluation tool were:

- competency evaluation by Benner and Benner (1979:128 - 135) based on practical procedures, was the measuring scale adapted for use in this study;
- Ohio "Commission on nursing" instrument to measure the competency of two categories of nurses (State of Ohio Department of Health 1980: 10 - 17) mentioned specific responsibilities of registered nurses similar to those in the South African situation;
- point evaluation by Bernhard and Schulte (1975: 18 - 21);
- evaluation instrument by Forbes Regional Health Center (Scrima 1987: 41-45).

These served as guidelines for factors requiring evaluation. With this background information, and the scope of practice and training regulations of the South African Nursing Council as a basis, the instrument for this study was constructed.

Competency of the newly qualified nurse

It was assumed that the newly qualified nurse is uncertain of her competency to practise as a registered nurse. Runciman (1983: 69) stated that support by experienced nurses helped the newly qualified nurse to accept her role and to practise competently.

Phillips (1987: 5) is of the opinion that *"If every organization would examine the needs of new graduates at every stage of the transition period and address these concerns individually, adjustment difficulties and resulting problems would be minimized"*.

The newly qualified nurse should be placed in the area in which she is interested. The responsibilities delegated to her should be scrutinised to determine whether she is able to cope as too much responsibility too soon may cause unnecessary stress preventing the nurse from optimum function. (Benner & Benner 1979: 105-107).

The influence of orientation on the competency of the newly qualified nurse

The goal of orientation is not to educate but to help the nurse to adjust to her working environment and to apply her knowledge. O'Connor (1986: 401) describes problems experienced by the newly qualified nurses as:

- having theoretical knowledge but not being able to solve problems effectively;
- a lack of technical skills as a result of lack of experience;
- not being able to organise their work according to objectives;
- insufficient leadership skills;
- insufficient support from the group with which they work .

The need for guidance and a preceptor in developing as a competent practitioner

Most nurses experience the period immediately after registration as the most stressful of their career. According to Benner (1982: 402) the newly qualified nurse could be classified as an advanced beginner. This implies that she needs help in determining priorities as she is only ". . . *beginning to perceive recurrent meaningful patterns*" in her clinical practice. Support by an experienced nurse is necessary to identify the most important patient care needs.

Quinn's (1982: 298) role theory, based on Bandura's social learning approach, indicates that a person displays a particular role when engaging in social interaction. The supervisor/preceptor should be aware that she may be regarded as a role model whose behaviour likely to be copied.

The competency of the newly qualified nurse in communication

The complexity of the interpersonal network of relationships within a health service has increased and a variety of people are making demands on the attention of the nurse (Ogier: 1982:96). The nurse must be able to communicate with such variety at different levels of service.

A need for management skills

Each nurse practises within the policy of the organisation and simultaneously the South African Nursing Council regulates her practice and professional conduct. Management development and training is an ongoing process to prepare the nurse to set objectives to achieve the goal of the institution (Gerber et al. 1987: 208).

The management skills of the newly qualified nurse need attention because such skills are not practised during her training. This has been verified by Kihlgren & Rydholm (1988: 95) and summarised thus: " . . . *nurses are inadequately prepared both formally and informally to assume management and leadership roles* . . .".

The research function of the newly qualified nurse

The literature study clearly indicated that the research skills of nurses need attention. Brownlee (1983: 97) reported that, even where instruments were available to evaluate the rendering of care (for example nursing audit, problem orientated nursing records and nursing care plans) nurses did not use them.

Using the scientific base of the practice of nursing

Research identified a major degree of incompetence among newly qualified nurses in performing certain basic procedures, which caused them to feel insecure (Speedling et al. 1981: 225). The scope of practice of the nurse is not described in specific procedures but is given in broad guidelines such as:-

- sufficient knowledge of preventive and promotive care;
- knowing principles, concepts and scientifically based facts;
- keeping up to date with advancements in the medical science;
- using research findings to improve the service.

Practising in a first and third world situation

To ensure value for money within a first and third world situation the following factors should be considered:

- increase in the potential manpower hours, through an increase in productivity;
- improving the quality of the service;
- developing new areas of service;
- change in attitudes of both the provider and user of the health service.

Essentially a literature study revealed that critical evaluation of the the newly qualified nurse's competency to practice has become a necessity. Such evaluation will help to determine whether the newly qualified nurse is meeting the requirements set by changes in health policy. The areas requiring more practice could be identified, as well as the role of orientation and guidance, in preparing her for her responsibilities as an effective fully functioning professional nurse.

METHODOLOGY

Target population

The target population included all newly qualified nurses within nine months of completion of training, from June 1989 to April 1990, in the Republic of South Africa, as well as their supervisors. Statistics from the register of the South African Nursing Council indicated a total of:

- 336 Newly qualified nurses until June 1989;
- 1097 Newly qualified nurses from July 1989 to April 1990.

These nurses were working in a variety of services in the Republic of South Africa which included areas such as:-

- general, midwifery, psychiatric, community health services;
- private institutions, military hospitals;
- rehabilitation centers, hospices;
- local authorities, divisional councils;
- occupational health services.

A longitudinal survey with a cohort study was done. The sub-population, registered nurses within nine months of completion of training, was used. Although the two samples used were made up of different nurses they remained members of the originally defined population. This quantitative descriptive study was carried out over a period of three years. The longitudinal survey selected as the target population when the study was commenced in June 1989, was only 336 of whom only 142 could be traced.

At that time there were no training schools in Natal and only one in Transvaal where the target population had completed their four year integrated training. To generalise from such a non-representative sample could have jeopardised the validity of the study.

A second sample taken from nurses who had completed their training in the ensuing semester, December 1989, contributed towards the validity of the study. The data from the two groups were compared. As the data obtained from these two samples did not differ significantly, the data were finally analysed in entirety.

To prevent bias and subjectivity of evaluation the supervisors of the newly qualified nurses were included in the survey. Therefore the study includes self-evaluation by the newly qualified nurse as well as the evaluation of the newly qualified nurse by her supervisor.

Sampling

Random sampling was not feasible as the target population worked in a variety of

services and not all the services which were contacted in order to grant permission to undertake this study, responded to the request. Thus it was decided to use as a sample all members of the target population who could be traced.

Sample No.1
Letters requesting the first 336 possible respondents to participate were dispatched in July 1989. Despite two reminders to return the short questionnaire, only 142 could be contacted. From this total of 142, 19 were selected for the pilot study, resulting in the final sample size being 123 or 33,6% of the target population.

Sample No. 2
The second round of sampling was done in April 1990. Letters were once more sent to all the possible respondents from a list received from the South African Nursing Council. A total of 280 possible respondents were contacted representing 25,5% of the target population.

Permission

Permission was obtained from the four provinces (Transvaal, Orange Free State, Natal and Cape Province) as well as the institutions where respondents were working. The respondents had the option of free participation and return of the short questionnaire was proof of informed consent.

Instruments

The instruments were based on studies discussed above in the literature review. Discussions also were held with nurse managers, tutors, professional nurses and members of the target population to determine the expectations of for the newly qualified nurse.

A questionnaire to the newly qualified nurse as well as one to her supervisor were constructed asking for information about:-

- biographical details;
- orientation and guidance received by the newly qualified nurse;
- evaluation of the newly qualified nurse's communication skills, management skills and her clinical skills.

The competency was measured on a scale from 1 to 4 that could be interpreted as follows:

- **Level 1** = Supervision and instruction is needed. Was not introduced to the theory and principles.
- **Level 2** = Supervision is needed. Understands theory and principles, but has had limited practice.
- Level 3 = Safe but practice is needed. Able to perform without supervision, but needs practice to perform efficiently.
- **Level 4** = Completely competent. Can perform efficiently without supervision.

Internal validity, the degree to which the instrument revealed an accurate picture of the newly qualified nurse in her work situation and the **external validity** referring to the degree to which generalisations could be made from the findings were tested. **Construct validity** was ensured by using the South African Nursing Council Regulation 425 and Regulation 2598 as a basis for evaluation. Experts and specialists in the field of study were asked to evaluate the tool for construct validity. Concepts used in the instrument were clearly defined. A factor analysis was done to further prove the construct validity and a high correlation among items grouped under a specific heading was found.

Criterion validity was tested by determining whether the questions and evaluation were directed at competency in the practical situation. Testing was done by comparing the instrument with the regulations for training and practice as well as the responsibilities of a registered nurse. **Concept validity** was tested against the theoretical framework.

Reliability was tested by using the same instrument at three different times within one year. The findings did not differ significantly. Identical instruments were used by the newly qualified nurse and her supervisor.

An annexure is given with some examples from the instrument measuring the management competency of the newly qualified nurse. This instrument, which also gathers data related to orientation and guidance received by the newly qualified nurse, takes 45 minutes to complete and is available from the researcher on request. It is too lengthy to publish in full.

Pilot study

From the possible respondents 19 newly qualified nurses and their supervisors were selected for the pilot study. Analysis of the data revealed that the self-evaluation by the newly qualified nurse and the evaluation by her supervisor did not differ with more than 1 point on the scale from 1 to 4. Questions requiring adjustments were changed accordingly and the instrument translated into English.

Data gathering

During August 1989 the instruments were posted or handed to the first sample. Anonymity and confidentiality were ensured as respondents did not mention their names or the name of the institution on the questionnaire. Pairs of questionnaires were given the same code number to enable comparison of the self-evaluation and the evaluation by the supervisor.

The return date for the questionnaires was the 15 October 1989. Because of the poor return by the closing date, letters reminding the respondents to return the questionnaire were sent to all respondents. Despite all efforts only 62 out of the 123 pairs had been received plus 22 of the newly qualified nurses and 16 supervisors which could not be matched.

The second round was conducted during March 1990 and April 1990. The 280 pairs of questionnaires were posted and where possible handed out personally. A total of 151 pairs were received by the closing date 31 May 1990 as well as 18 questionnaires from the newly qualified nurses and 9 from the supervisors that were not paired.

Limitations

The numbers of questionnaires returned by the two samples were:

- 213 pairs (52,9% feedback) - 253 newly qualified nurses (62,8% feedback) - 238 supervisors (59,1% feedback)

Only those nurses who could be contacted could be included in the study, and random sampling was therefore impossible. Letters, however, were sent to all possible respondents but their response was poor.

Data analysis

The computer programme Statistical Analysis System was used to analyse the data. A t-Test to determine the difference in evaluation between the newly qualified nurse and her supervisor was done. Factor analysis using the

programme Proc Factor, was done on all the items in the questionnaires, the objective being to group the variables into more manageable sets of measures. The Scree test where the selection of factors is based on the point where the cumulative variable decreases sharply and apparently reaches a straight line, was completed. All factors with an Eigenvalue of more than 1 were extracted.

The rotated solutions grouped the variables to the factor with which it was primarily associated. A more meaningful interpretation of data was achieved through the Varimax rotation of factors. In the interpretation of these solutions factor loadings of more than 0,40 were used; in a few cases only factor loadings of less than 0,40 but not less than 0,30 were used. The common factor variance (commonality) of the items were generally more than 0,5, thus a total of more than 200 responses per question was sufficient to justify factor analysis.

From the questionnaires ten factors were rotated from the management section and sixteen from the scope of practice competency section. Biographical information rotated into nine factors and orientation and guidance into eleven factors.

Table 1 indicates the names of the five factors rotated, items and factor loadings of the communication evaluation section of the questionnaire.

In part two of this report, the results of the data analysis are discussed.

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Table 1
Factor analysis results: communication- competency

Factor	Loadings	Item
1. Communication with patients and family	0,800	Guidance to patients
	0,753	Include patient planning
	0,748	Guidance to family
	0,748	Include family planning
	0,710	Support to family
	0,622	Support to patient
	0,544	Orientating patient
2. Cummunication with team members	0,784	Discuss with colleage
	0,769	Discuss other members
	0.724	Discuss with doctors
3. Correct use of communication	0,838	Writing report channels
	0,790	Keeping statistics
	0,690	Handing over report
4. Interpersonal relationships	0,796	Relationship patient
	0,761	Relationship team
5. Explaining admission procedures	0,823	Explaining to family
	0,795	Explaining to patient

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BOOK REVIEWS / BOEK RESENSIES

DIE ONDERSOEK VAN DIE PASGEBORE BABA - Ist uitgawe
P.A. van Schaik
Pretoria, 1993.
142 bladsye, R39.00 BTW ingesluit.

Hierdie ondersoek-handleiding gee 'n besonder volledige, sistematiese en duidelike uiteensetting van die ondersoek van die pasgebore baba. Die klem val hoofsaaklik op die ondersoektegniek en normale bevindinge, alhoewel dit ook die mees algemene abnormale bevindings en die oorsake uitwys.

Die boek bestaan uit 11 Hoofstukke. Die eerste hoofstuk behels die neem van 'n geskiedenis, ouerbetrokkenheid, ondersoekgeleenthede en spesiale kategorie babas. Hoofstuk 2 handel oor algemene beginsels en die algemene ondersoek. Hoofstukke 3 tot 10 spreek die belangrikste aspekte aan waarna daar opgelet moet word tydens die ondersoek van die pasgeborene. Dit sluit die skedel, gesig en nek, borskas en respiratoriese sisteem, kardiovaskulêre stelsel, buik, luierarea, ledemate en rug asook neurologiese stelsel in. Hoofstuk 11 beskryf die gestasiebepaling asook die nuwe Ballard-gestasiebepaling. Aanvullend tot die boek kan 'n elfdelige video-opleidingsprogram, wat die ondersoek van die pasgebore baba visueel uitbeeld, bestel word.

Die teks is keurig versorg, maklik leesbaar en maak baie gebruik van lyn-illustrasies. Hierdie handleiding kan nuttig aangewend word deur dosente en studentverpleegkundiges, asook verpleegkundiges wat betrokke is by die hantering en versorging van pasgebore babas.

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RESEARCH

CRITICAL EVALUATION OF THE NEWLY QUALIFIED NURSE'S COMPETENCY TO PRACTISE - PART 2

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INTRODUCTION

In part one of this report a review was given on the problem, theoretical framework, literature study and methodology. The factor analysis was discussed briefly.

Analysis of variance tested the significance of differences between the four areas in which the newly qualified nurse was trained and working at the time of the research.

From the analysis of the data as discussed in part 1 of the report on the research done, the following information was extracted:

FINDINGS

Age

The ages of the newly qualified nurses varied between 21 and 36 years, with only 18,3% older than 25 years. The newly qualified nurse clearly has to assume responsibilities of a registered nurse at a relatively early age and the services requiring that she function on her own, could cause feelings of insecurity. It is interesting to note that, on average, nurses working in the community (26,80) were three years older than those working in the general hospital (23,40).

Course completed only 36 (14,2%) of the 253 respondents had completed a degree course. The rest did the diploma course in association with a university. According to Pearson correlations indicated that the only positive significant relationships with the course followed by the respondent included setting nursing care standards and doing a nursing audit. The graduate nurse was more competent in performing these procedures than the diplomate nurse. Graduate nurses seemed to be more assertive as found by DeBack & Mentkowski (1986:282) who state that graduates ". . . *tended to exhibit more positively coded Ego Strength and independence* . . . ".

Influence of placement on the competency of the newly qualified nurse

It has been assumed that correct placement influenced the ability of the newly qualified nurse to practice effieciently. A null Hypothesis postulated that the placement of the newly qualified nurse had no influence on her ability to practice in her first post. Of the newly qualified nurses 201 (80,4%) worked in their area of interest. This agrees with the opinion of most supervisors (213 or 89,5%) mentioned that it is essential to consult the newly qualified nurse about her placement.

To determine the influence on her competency of the four main areas (general, psychiatric, community and midwifery) where the newly qualified nurse could be working, analysis of variance (ANOVA) was carried out. Results indicated that the nurse working in a psychiatric hospital received a greater amount of guidance than the nurse working in the community, a difference of 1,02 on a scale from 1 to 3. This was especially true of support in problem solving. This result could have been expected as the newly qualified nurse working in a psychiatric hospital worked with six registered nurses. Her colleagues were also trained in rendering support to others and were more competent to help her solve problems, than colleagues might be in the other three fields. The nurse working in the community, however, often has to work in isolation and has to seek her own solutions to her problems, as she does not always have access to other personnel for support. Four registered nurses worked with the newly qualified nurse in the community, but they might all be working at different clinics.

Nurses working in the area of interest were also more positively inclined towards senior personnel. The Pearson correlation indicated a significant positive relationship between working in the area of interest and receiving support from senior personnel, as well as being helped to solve work-related problems. Nurses working in the area of interest were more competent in ordering and maintaining supplies.

Nurses working in a maternity unit worked with more registered nurses (10) than those working in a general ward (6). This could be an indication that nursing management might be aware of the importance of support and guidance in a maternity unit where simultaneously two lives may be at stake.

It is also significant that 153 (60,7%) of the newly qualified nurses were approached as to where they would like to work, while 201 (80,4%) worked in the area of interest. This could be an indication that nurse managers are aware of the interests of their staff and take it into consideration when allocating personnel. The newly qualified nurses were also placed in the correct hierarchical position. Both the newly qualified nurse and her supervisor agreed that she should be placed in a position where she could gradually be guided to assume greater responsibilities. The supervisors and the newly qualified nurses differed markedly as to the desirability of rotation during the first six months after completion of training. Only 44,4% of the supervisors against 89,1% of the newly qualified nurses who rotated during the first six months described it as a learning experience.

The influence of orientation on the competency of the newly qualified nurse.

The null-hypothesis was formulated, that orientation did not influence the the newly qualified nurse's competency to practise. According to data analysis the factor **orientation to the service** had a

Table 1
Reasons why orientation was insufficient

Reasons for insufficient orientation	Newly qualified nurse		Supervisor	
	Number	Percentage	Number	Percentage
Lack of time	N = 115	77 (30,4)	N = 90	64 (26,9)
Too great a workload	N = 121	78 (30,2)	N = 100	69 (29,0)
Insufficient planning	N = 109	56 (22,3)	N = 90	29 (12,1)
Lack of interest	N = 101	26 (10,3)	N = 82	6 (2,5)

high correlation with the factor **setting of standards and doing a nursing audit** (p 0,005). **Orientation as to reporting on and off duty** correlated highly with **maintaining good interpersonal relations.** It is clear that being able to set standards for patient care, and to evaluate whether they have been attained, the nurse needs to know the policy, objectives and philosophy of the service. An essential requirement for good interpersonal relations is communication. The nurse should report to her supervisor when coming on duty to know which jobs have been delegated to her. When going off duty it is necessary to report as to how she managed to perform the tasks allocated to her.

The most common reasons for insufficient orientation were too heavy a workload and lack of time as given in Table 2. The shortcomings in orientation mentioned by 50% of the newly qualified nurses mentioned too much information in too short a period of time.

As far as the scope of practice is concerned there were no positive correlations between orientation and the nurses' competence.

The role of guidance in developing the newly qualified nurse towards competent practise.

Guidance played a much more important role in the development of the newly qualified nurse than did orientation. This was especially true in relation to support of senior personnel and the following four management factors - teaching personnel, evaluating job performance, organising work and setting of standards and doing a nursing audit. If the newly qualified nurse receives guidance she should have the ability to organise her service, to delegate effectively and to use her time efficiently. Acknowledging the potential of the nurse gives her the confidence to control the nursing care in the unit. Of the newly qualified nurses 56,5% always experienced support while only 2,8% claimed that they never received any support.

When senior personnel support the newly qualified nurse they are more competent maintain and promote optimal health for the patient (r = 0,16 When senior personnel support the newly qualified nurse they are more competent to (r = 0,16 ; p = 0,008); and identify physiological reactions of the body to illness, trauma, emotional stress, treatment and medication (r = 0,20 ; p = 0,001).

There was positive correlation between the support of senior personnel and the placement of personnel in their area of interest, possibly because the nurse working in her area of interest is more positively inclined towards her supervisor.

The manner in which the supervisor answered questions from the newly qualified nurse concerning problems experienced in the unit, plays an important role in her development. Such a nurse could communicate better and maintain good interpersonal relations. According to Gerrish (1990:36) communication and good interpersonal relations were aspects of behaviour that the newly qualified nurse could not handle effectively, which observation emphasises the role of guidance by the supervisor.

Nurses working in the area of interest could also promote and maintain their patients' health, providing them with sufficient exercise, rest and sleep.

The difference between the evaluation of the newly qualified nurse and her supervisor in relation to her communication skills.

The null hypothesis that there was no significant difference between the evaluation of the newly qualified nurse and her evaluation by her supervisor was rejected by the t-test. A significant difference was found on all the items under communication; the supervisor evaluated the newly qualified nurse at a lower level. The difference on the items varied between 0,184 and 0, 598 on a four point scale. The newly qualified nurse evaluated herself between 3,11 and 3,80 on the scale from 1 to 4 whereas the supervisor's evaluation varied between 2,80 and 3,46.

The competency of the newly qualified nurse to communicate with patients and the patients' family is given in Table 2.

The evaluation of both groups indicated that the newly qualified nurse had the necessary theory and some practical experience, but needed more practice to become completely competent. Nelson (1978:124) concluded that: "*Since nursing graduates and their supervisors perceived graduates' degree of competency differently, schools of nursing and agencies that employ beginning practitioners should consult concerning realistic expectations of the competency of . . . graduates*".

Table 2
Comparison of the evaluation of the newly qualified nurse to communicate with patients and their family

Communication procedures	Percentage			
	Communication with patient		Communication with the patients' family	
	Newly qualified nurse N = 253	Supervisor N = 238	Newly qualified nurse N = 253	Supervisor N = 238
Explaining procedures	59,0	35,0	56,7	34,1
Admission orientation	80,0	50,0	75,8	47,1
Support	67,2	33,9	60,6	36,4
Health education	52,2	27,4	52,6	30,6
Inclusion in planning	48,0	29,3	44,0	25,7

The difference in evaluation of the management skills according to the newly qualified nurse and her supervisor

As with communication skills the null-hypothesis was rejected. There were a significant difference in all items. The difference in the evaluation of the management skills varied between 0,228 and 0,742; this difference was slightly higher in management items than with communication. Some of the items were rated lower than those of the communication items by both the supervisor and the newly qualified nurse. The newly qualified nurses' evaluation varying between 2,54 and 3,79 and that of the supervisor between 2,28 and 3,19.

The newly qualified nurse evaluated herself more highly in regard to the solving of problems than did her supervisor. Between 219 (88,7%) and 231 (92,8%) evaluated themselves at levels 3 and 4, compared to the supervisors 138 (59,0%) and 153 (65,4%).

A larger number of both newly qualified nurses (8,6%) and their supervisors (16,3%) identified a need for more theoretical knowledge on budgetary procedures than in any of the other areas.

Few respondents evaluated the newly qualified nurse as being completely competent in the area of research; only 27 (15,0%) of the newly qualified nurses and 25 (12,1%) of the supervisors, did so. More respondents agreed that the nurse did not have the necessary theoretical background to do research than in the other items (11,2% newly qualified nurses and 27,8% of their supervisors).

The nurses' ability to provide personnel development according to the potential of the individual was rated at only 31,8% being completely competent by the newly qualified nurse and 16,8% by their supervisors. Sovie (1983:31) stressed the importance of nurses having educational skills "Programmes that prepare nurses to be effective teachers are urgently needed". In responding to an open ended question the newly qualified nurse and her supervisor agreed that delegating was an area where more experience was needed. Nurses also felt that sometimes they were given too much responsibility too soon.

Difference in the evaluation between the newly qualified nurse and her supervisor in relation to her scope of practice skills

The null-hypothesis was also rejected in relation to the scope of practice items. The newly qualified nurse evaluated herself at a higher level of competence in relation to her scope of practice than communication and management skills, (between 3,31 and 3,89). The difference between the evaluation of the supervisor and the nurse varied between 0,165 and 0,603 which is less than with the management aspects. The supervisors evaluated the newly qualified nurse at 2,75 to 3,84 on the four point scale.

Table 3 indicates the competency of the newly qualified nurse to assess the needs of the patient.

Table 3
The competency of the newly qualified nurse (ncn) to do an assessment of the needs of the patient

Competency Level	Physical needs		Psychological needs		Social needs	
	N.C.N. N = 252	Supervisor N = 230	N.C.N. N = 252	Supervisor N = 230	N.C.N. N = 249	Supervisor N = 231
	Percentage					
1	0,8	4,3	0,0	4,3	0,4	3,9
2	3,6	12,6	4,0	16,5	5,6	17,3
3	37,3	48,3	43,2	44,4	45,8	47,2
4	58,3	34,8	52,8	34,8	48,2	31,6
Total	100,0	100,0	100,0	100,0	100,0	100,0

Table 4 indicates the percentages at the different levels of competence in referring patients to other health care personnel. Horsburgh (1989:613) found that newly qualified nurses could not coordinate with other categories of personnel. " *The failure of the new graduates to be incorporated as members of a multi-disciplinary health care team ensured that they continued to be frustrated by lack of opportunity to play an equal role with other health professionals in patient management*".

Table 4
Competency of the newly qualified nurse to work with others

Competency Level	Health Care Professions		Community Workers		Family Planning	
	N.C.N. N = 234	Supervisor N = 215	N.C.N. N = 232	Supervisor N = 210	N.C.N. N = 210	Supervisor N = 188
	Percentage					
1	1,2	5,1	0,9	7,1	1,8	8,5
2	5,8	11,6	5,2	11,0	9,2	13,3
3	42,2	44,2	45,6	46,2	45,0	39,4
4	50,8	39,1	48,3	35,7	44,0	38,8
Total	100,0	100,0	100,0	100,0	100,0	100,0

The newly qualified nurse experienced a lack of competency in identifying the social needs of the patient. Only 120 (48,2%) evaluated themselves completely competent against 73 (31,6%) of the supervisors. Comparing this with the identification of the physical and psychological needs in patients, the percentages that are completely competent are lower.

The newly qualified nurse also experienced more problems in planning and evaluating nursing care than in doing nursing procedures. Her ability to monitor the reaction of the body to illness, trauma, emotional stress, treatment and medication correlated with the amount of support and guidance she has received from her supervisor. In agreement with Jacobs (1989:116), it was found that nurses were competent to give health education to patients, but experienced problems in counselling.

If supervisors would include the newly qualified nurse in discussions with other health care personnel it could help them to overcome this obstacle.

Caring for unconscious and high risk patients were rated lower by both the newly qualified nurse (43,6%) and her supervisor (36,2%) than caring for other categories of patients.

In answer to an open ended question newly qualified nurses mentioned that their expectations regarding practice were not met but they do appreciate the supervisor who supports them. Caring for the dying was an aspect the newly qualified nurse experienced negatively, although most of them 230 (96,6%) and 178 (86,8%) of their supervisors found that they were in fact competent to care for the dying.

THE SOCIAL LEARNING THEORY AND ITS RELATION TO THE DEVELOPMENT OF THE NEWLY QUALIFIED NURSE

The contribution of the support received from supervisors in regard to the development of competent practitioners cannot be over emphasised. The ability to learn desired behaviour in copying a model is supported by the findings. The social learning theory as described by Marriner-Tomey (1990:303-307) is one of the most important contributing factors in the development of competent practitioners.

receive special attention. Communication skills should be presented in an intergrated way in both management and clinical practice.

Process: After appointment as a registered nurse it is important that the nurse should be placed in the area (field) of interest. Orientation and guidance (accompaniment) is essential in acquiring the necessary skills to develop into a competent practitioner. The supervisor should be a role model which is in accordance with the social learning theory.

Output: If the newly qualified nurse is placed correctly, receives the necessary orientation and guidance the following output could be expected:

- correlation of theory and practice;
- self study, as seniors motivate the newly qualified nurse;
- willingness to poarticipate in personnel development;

role-stress they experience in their first post-registration job. If they experience job satisfaction, the process of socialisation is enhanced. If this does not happen, they tend to resign. This may be one of the reasons why many of the newly qualified nurses could not be contacted within approximately three months of having completed their training. Weisman et al. (1981:189) reported that a number of younger nurses left the geographical area of their training.

When working in their area of interest, they experienced greater job satisfaction and were better able to develop their competency. Nursing management seemed to be aware of the nurses' interests and strive to place them, wherever possible, in their area of choice. They were also placed in the correct hierarchical position, in order to receive guidance from their supervisors. Most of the nurses remained in one unit for at least three months, and experienced rotation as professional development.

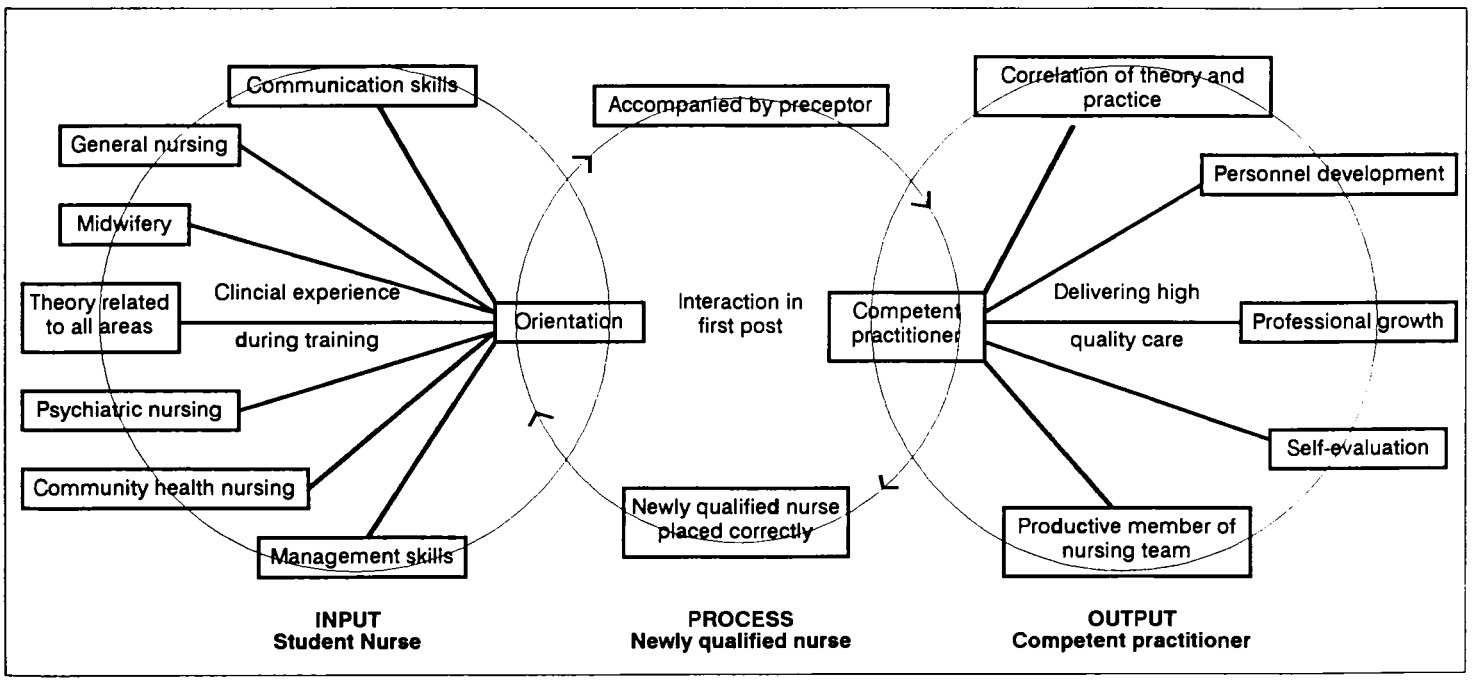

Figure 1
Model for competency development of nurses

A model for the competency development of newly qualified nurses was constructed. See Figure 1 which explains the input, throughput and output needed to ensure competent nurse practitioners.

Input: During training nurses receive education and practical learning experience in the four disciplines, general, psychiatric, community and midwifery. Practical learning experience in the management aspects is an area indicated by the research that should

- productive member of the health care team;
- professional growth;
- the final outcome will be a competent nurse delivering high quality nursing care.

Implications of findings

The fact that most newly qualified nurses are in their early twenties after completing training, could add to the

Supervisors preferred nurses to stay in the same ward for at least three months as it contributed towards stability in the unit, and is of greater value to both the patient and the nurse.

Nurses in the community services did not get the same amount of guidance as their colleagues working in other areas.

Nurses are prepared to practise in general, psychiatric, community health and midwifery services. The findings

indicated no significant differences among different areas of practice.

Newly qualified nurses who completed the degree course seemed to be more assertive and better able to exercise control.

Management skills needed more attention than clinical skills, as the nurses did not get the necessary practice in the area of management skills during their training.

A lack of orientation was experienced by a number of the nurses, especially those who stayed on in their training hospital. They were not orientated into accepting their new responsibilities.

Those nurses who received sufficient guidance in the first few months after registration did not experience any difficulty in socialising. They encountered fewer problems in performing management procedures and in becoming competent at performing their duties.

Some of the newly qualified nurses still needed practice in communication skills.

The nurses were not competent to do research or to apply research findings.

Personnel management could be improved by the correct guidance, and nurses would be better able to organise their work.

If nurses are to be retained in the service, they should be placed correctly and be given support. Nurses experienced working with the dying and their family as stressful.

Recommendations

Nurse managers must take cognisance of the fact that nurses resign if they are not socialised into their new responsibilities and therefore they should provide the necessary support systems and working environment that will contribute towards job satisfaction.

The nurses' training background and age should be considered when placing them and delegating responsibilities. They should receive the opportunity to develop their skills to become competent practitioners.

Placing nurses in the area in which they are interested leads to job satisfaction and productivity.

Rotation should be done discreetly to cause the minimum of disruption in the unit and to give the newly qualified nurse opportunity to develop into a independent practitioner.

In the community services provision should be made for support systems to help the newly qualified nurse solve problems.

Orientation programmes should be directed at the individual needs of the nurses, be given over a longer period and be followed by inservice education. Even if nurses are working in their training hospitals they still require orientation to their new responsibilities as a registered nurse. The necessary policy manuals must be available to the newly qualified nurse. It remains the responsibility of the supervisor to guide and support the newly qualified nurse in her new job.

Supervisors must realise that their conduct influences their subordinates and the training of supervisors should receive attention. A preceptor should be appointed for the newly qualified nurse in her first post as correct guidance in maintaining good interpersonal relations is essential to enable the nurse to communicate effectively.

Nurses should be trained how to write reports and keep statistical records efficiently.

Nursing management and the training school should decide on what their expectations are for the newly qualified nurses.

The nurse should be given the opportunity during her training to develop management skills. It is, however, important that they receive the necessary guidance in the work situation.

More attention should be given to research skills. This could be done as follows according to Phillips (1986:402):

- The nurse manager should be a role model.
- Personnel should be informed about and guided in interpreting research reports.
- During ward rounds nurses should be encouraged to make recommendations on ways of improving the service.
- Newly qualified nurses should be assisted in decision making.
- Personnel should be given the opportunity to attend symposia and discussions on research aspects.

RECOMMENDATIONS FOR FURTHER RESEARCH

A study to determine the competency of nurses who have completed the comprehensive training in the four disciplines could be done on a more representative basis.

A comparison between the competency of the newly qualified nurse who was allocated to a preceptor and one who was not allocated to a preceptor could be carried out.

The difference in the competency of nurses who have completed the comprehensive course and nurses who did the one year course in midwifery and/or psychiatric nursing could be explored.

CONCLUSION

According to these research findings it is clear that the newly qualified nurse is competent to practice as a registered nurse after completion of her training. Although the evaluation of the newly qualified nurse and her supervisor differs significantly, there is a certain degree of agreement, as these aspects requiring more attention are mentioned by both groups.

Placement of the newly qualified nurse plays a role in her ability to practise as a competent practitioner. Orientation should be directed more specifically towards management aspects and guidance is very important for the newly qualified nurse to develop as a mature practitioner. It seemed as though most of the nurses participating in this research received sufficient guidance from their supervisors. The competency of the newly qualified nurse is in agreement with the hypothesis as formulated, stating that the competency of the newly qualified nurse is determined by the amount of guidance she receives.

This research does not indicate a need to query the competence of the newly qualified nurse who seems to be sufficiently prepared to perform the tasks delegated to her. There is also no significant difference in their ability to function in the four disciplines in which they have been trained. It is indeed encouraging that nursing management seems to be aware of problems that could be encountered by these nurses and take the necessary precautions to protect them against such difficulties.

With correct guidance and support the newly qualified nurse could emulate Searle's description of the ward sister as

one who is "*professionally knowledgeable, up to date and competent, who is administratively adept, who projects the true role model image of a first-line manager and professional registered nurse, and who is a worthy and devoted preceptor to the student body and her subordinates, who is a loyal colleague of the doctor and of other members of the health team, who knows her own worth to the community, who serves the hospital authority with diligence and loyalty and who above all truly fulfils her role as custodian and advocate of the patient, is a pearl without price in the hospital service and indeed in the whole health service*" (Searle 1980:9).

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