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The influence of the supernumerary clinical nurse educator role on advancing graduate nurses' quality of patient care: A mixed-methods study in a private Western Australian health service

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The Influence of the Supernumerary Clinical Nurse Educator Role on Advancing Graduate Nurses' Quality of Patient Care: A Mixed-methods Study in a Private Western Australian Health Service

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Abstract

Theoretical and anecdotal evidence suggests that the presence of the supernumerary clinical nurse educator (CNE) in the acute care hospital clinical environment will positively affect patient quality outcomes. However, the supernumerary role suffers from scrutiny in response to the financial constraints of healthcare organisations, and is questioned regarding sustainability. The lack of empirical research diminishes the CNE role and its benefit for patient quality of care. This research focuses on newly qualified graduate registered nurses (GRNs) employed in a graduate programme and supported by the CNE in the clinical environment in order to articulate the effect of the supernumerary CNE on the GRNs' patient outcomes. The mixed-methods research describes the CNE role specifically related to the GRNs' transition to practice and quality of patient care. The results suggest that the CNE's value derives from the supernumerary presence—through the resource-rich educator role and the experiential learning opportunities provided. These play a significant role in the GRNs' successful transition to practice and clinical confidence. The ability of GRNs to safely engage in patient care is linked to CNE role translation into practice, promotion of evidence-based care theory and policy in practice, and progression of reflective practices influencing GRNs' professionalism and maturity. The CNE role is identified as a congruent clinical leader who is approachable, supportive, connected and passionate about patient care. Undesirable attributes of the CNE role are associated with unsuitable personal characteristics, incompatible relationships with the clinical nurse manager and GRNs, and an inability to meet the expectations and criteria of the role. The organisational demands of role reassignment and role relief produce role strain and conflict that reduce the value of the CNE role.

The audience who will profit from this research include present and future CNEs, nurses, clinical and administrative leaders, and healthcare organisations. The implications of this study not only relate to the role of CNEs in supporting GRNs' transition to practice in the acute care hospital setting, but also to CNEs' clinical leadership. CNEs are a practical solution to champion the success of the newly qualified registered nurse—our future nursing workforce.

Statement of Candidate Contribution

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This thesis is the candidate's own work and contains no material that has been accepted for the award of any degree or diploma in any other institution.

To the best of the candidate's knowledge, the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

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Tracey Heather Coventry   27.02.2017

Dedication

This thesis is dedicated to my family.

To my husband, Graham, whose wholehearted and unfailing love gave me space to study and write, and who shared every high and low throughout the journey.

To Matthew, Daniel and Molly, who kindly accepted the effect on our family life, encouraged me at every stage and learnt to cook.

To Aunt Molly, who generously supported my endeavours and kept me in her prayers.

Without this support, I could not have completed this work.

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The will of God will never take you, where the grace of God cannot keep you.

For nothing will be impossible with God (Luke 1:37).

There are many people who have shared this journey with me in many ways. I have been blessed to have supervisors who have shared with me their time, wisdom, knowledge and passion that ignited my own.

To my principal supervisor, Dr Kylie Russell, who was a divine appointment without whom I may never have made it this far—you were the encouragement, the motivation, the inspiration that I needed. Your clinical education and academic expertise provided direction and guidance—you are the mentor I aspire to be.

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List of Abbreviations

ACN	Australian College of Nursing
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHPRA	Australian Health Practitioner Regulation Agency
ANMF	Australian Nursing and Midwifery Federation
ANTS	Australian Nurse Teachers Society
AQF	Australian Qualifications Framework
CNE	Clinical Nurse Educator
CNM	Clinical Nurse Manager
CPD	Continuing Professional Development
EN	Enrolled Nurse
GRN	Graduate Registered Nurse
HEE	Health Education England
HPH	Hollywood Private Hospital
HR	Human Resources
HREC	Human Research Ethics Committee
HWA	Health Workforce Australia
IOM	Institute of Medicine
JHC	Joondalup Health Campus
NEACH	Nurse Educators in Acute Care Hospitals
NHMRC	National Health and Medical Research Council

NHS	National Health Service
NMBA	Nursing and Midwifery Board of Australia
PHC	Peel Health Campus
RN	Registered Nurse
RR	Response Rate
UK	United Kingdom
US	United States
VET	Vocational Education and Training
WA	Western Australia
WHO	World Health Organization

Definition of Key Terms

Clinical education: Education that occurs in the hospital ward setting that allows the learner to apply theory to practice (Henderson, Briggs, Schoonbeek, & Paterson, 2011).

Clinical nurse educator: A registered nurse with clinical expertise who is responsible for the clinical education of nurses in the hospital setting (Sayers, DiGiacomo, & Davidson, 2011).

Clinical nurse manager: A registered nurse in charge of the hospital ward who is responsible for patient and staff ward management and coordination of patient services (Schmalenberg & Kramer, 2009).

Continuing professional development: The learning that occurs throughout a nurse's career and is necessary for maintaining competence to practice (NMBA, 2016d).

Graduate registered nurse: A newly qualified registered nurse who has not been employed for more than 12 months as a nurse (Government of Western Australia, 2015b).

Graduate programme: A year-long programme for newly qualified registered nurses entering the nursing workforce. The programme provides exposure to a variety of clinical ward settings and consolidates theoretical learning and development of critical thinking and judgement skills, while being supported by clinical nurse educators, graduate programme coordinators and ward nursing team (Government of Western Australia, 2015b).

Leadership: The act and ability to lead a group of people or organisation (Daly, Speedy, & Jackson, 2014).

Role performance: The nurse's understanding of how other nurses, staff and senior leaders view his or her role (Brookes, Daly, Davidson, & Halcomb, 2007).

Transition to practice: A 12-month graduate programme provided by a healthcare organisation to assist newly qualified registered nurses to settle into the clinical environment through rotations to ward areas, educational and support strategies, and

study days in order to provide effective translation of theory to practice (Chang & Daly, 2015).

Prologue

My nursing journey began many years ago and has included the privilege of being a clinical nurse educator (CNE). My journey from being a naïve, young country girl starting a new career in a big city, to travelling the world and living and working with a variety of people and cultures—all alien to my own background—provided the foundation for this foray into academia. The excellent role models and mentors with whom I was blessed to work during my formative nurse training years and beyond have inspired lifelong learning and provided the motivation and desire to share my nursing knowledge and skills in Australia and abroad. The opportunity to nurse in different countries and organisational settings—in the fields of midwifery, community and general paediatrics, and intensive care specialties—provided amazing experiences and significant memories. In addition, my personal growth through theoretical and practical learning has led to greater wisdom and strength of character.

In the last decade, my teaching roles in the community sector and as sessional tutor in two universities provided the impetus to re-engage in the acute care hospital setting. As a paediatric CNE, my role included working with nursing staff, graduates and students in continuing professional development, while fulfilling the organisation's role expectations, with the promotion of a high standard of quality and safe patient care. During my time as CNE, I was awarded a postgraduate Master of Nurse Education, which provided the foundation for a personal teaching philosophy. This included an understanding of the underpinning theories; a practical teaching role; and development and application of the decision-making, problem-solving and clinical reasoning skills necessary to meet nurses' lifelong and professional development educational requirements, which focus on safe and quality patient care.

Upon examining and reflecting on my role as a CNE, I discovered that learning occurs through regular, proactive and persistent pursuit of knowledge, skills and attitudes that meet the expectations and goals of clinical confidence and professional values. Learning involves challenging the status quo with commitment to evidence-based practices, and taking social action in order to improve the quality of patient care. Curiosity is a catalyst for lifelong learning and I have pursued those topics that interest me. To that end, I have embarked on further learning to obtain my Doctor of Philosophy. I hope that a domino

effect will occur, whereby I will be able to inspire, mentor and contribute to the learning of other nurses as a consequence of my own learning journey.

Chapter 1: Introduction and Background

1.1 Introduction

This chapter presents an introduction to this research study. This includes an outline of the healthcare system (specifically, the Australian healthcare public and private services), the current nursing workforce and the predicted nursing shortage related to the acute care hospital setting. A profile of the contemporary nurse educator role in the acute care hospital will include employment opportunities, selection criteria, mode of education delivery and frameworks for practice. This chapter also distinguishes nurse educators' clinical leadership capability and relationship with quality of patient care. The chapter concludes with a justification of the study and a summary of the thesis configuration.

1.2 Background to the Study

The following sections discuss the Australian health system, including public and private hospitals, the nursing workforce and the challenges affecting staffing. The nurse educator role in the acute care hospital setting is described in relation to employment criteria, models of nurse education, frameworks for educator practice, nursing leadership and the relationship of the nurse educator to patient outcomes.

1.2.1 The Australian Healthcare System

The health system in Australia is a visibly complex entity, described as a multifaceted web of public and private providers, settings, participants and supporting mechanisms (Australian Institute of Health and Welfare [AIHW], 2016a). In 2012 to 2013, there were a total of 746 public hospitals and 592 private hospitals in Australia (AIHW, 2014). Public hospitals are provided, funded and managed at local and state/territory levels of government for all Australian residents under the universal healthcare fund, Medicare, which covers public hospital costs (AIHW, 2014). In contrast, private hospitals are owned and operated by private organisations who charge patients for treatment by a medical officer of their choice, and for accommodation and other services required. Funding for all or some of the costs of private hospital admission and

ancillary services occurs through optional private health insurance funding (AIHW, 2014).

Private hospitals can be either for-profit or non-profit, and include 11 hospitals contracted by state governments to provide public hospital services under contracted service agreements, known as public–private partnerships (AIHW, 2014). In Western Australia (WA), the population of approximately 2.4 million people are serviced by WA Health, the public health system and a number of public–private partnerships, as illustrated in Figure 1.1. These services provide clinical health services and resources for both public and private patients using an efficient funding model to support and respond to local community needs (Government of Western Australia, 2016a).
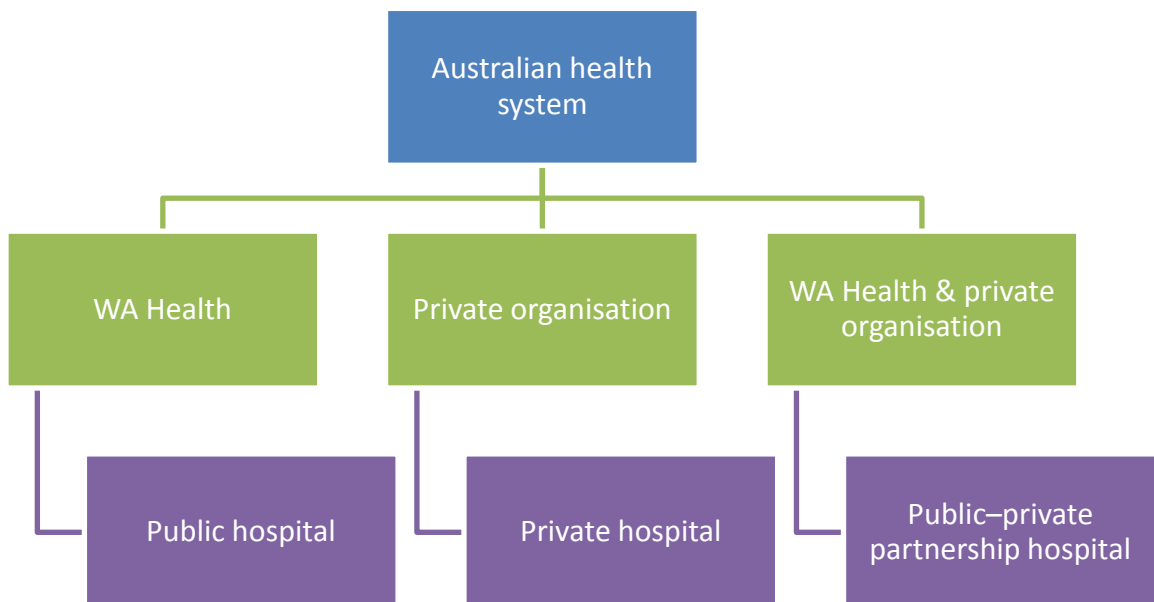
Figure 1.1: WA Health System

1.2.2 The Nursing Workforce

In 2008, the Council of Australian Governments (2016) addressed the impending healthcare workforce challenges in Australia through a number of initiatives and reforms. One health initiative was the formation of Health Workforce Australia (HWA) to address the need to develop and execute a sustainable and adaptive workforce plan in relation to the ageing population, complex and chronic conditions, increased demand and consumer expectations, and management of financial challenges and changes (HWA, 2013). In common with other developed countries, the healthcare system

continues to encounter difficulty sustaining a nursing workforce to meet the increasing demand for safe and quality care. HWA produced a number of reports and reviews on workforce planning and recruitment before its closure in 2014, when its functions transferred to the Department of Health and Ageing (Australian Government, 2016).

One report developed by HWA (2014b) in conjunction with commonwealth, state and territory key stakeholders focused on opportunities and action related to the nursing workforce retention and efficiency. This report detailed concerns related to the necessary role of recruitment and retention of newly qualified registered nurses (RNs) to sustain the current and future nursing workforce. Recommendations included providing adequate support through graduate programmes in the acute care environment, such as 'clearly specifying the expectations of the graduate role, recognising their support and mentoring needs and ensuring these are matched with planned resources and remuneration' (HWA, 2014b, p. 16). In addition, the report recognised the role of the clinical nurse manager (CNM) as defender of the graduate RN (GRN) in the clinical environment. Recommendations for action by the HWA (with input from key stakeholders and including international evidence) to improve the effectiveness of the Australian nursing workforce included leadership, improving education, balancing GRN support and clinical workplace needs, and optimising nursing roles to improve patient outcomes (HWA, 2014b).

In the acute care setting, the RN cohort is a significant percentage of the nursing workforce worldwide; thus, the nurse educator role is a necessary inclusion to meet the educational and support needs of the nurses who provide direct care to patients in the current challenging environment of healthcare delivery. It is likely that the nurse educator will have a continuing relationship with RNs based on their graduate programme and professional development needs (Ashton, 2012; Sayers et al., 2011; Sayers, Salamonson, DiGiacomo, & Davidson, 2015).

1.2.2.1 The Future Nursing Shortage

In a review of the statistics from 2015, there were 300,524 RNs working in Australia and 6,317 RNs who graduated from university with a nursing degree and were seeking employment (AIHW, 2017). In 2013, it was estimated that 3,000 nursing graduates were unable to find work (Stewart, 2014). This struggle to find employment was

highlighted by Graduate Careers Australia (2014), who noted that the number of nursing graduates finding work declined from 97.4% in 2007 to 80.5% in 2014.

HWA (2014a) predicted that the nursing shortage will reach 109,000 by 2025. The issue of temporary visas granted to overseas nurses to work in Australia remains a contentious topic related to GRN employment (AIHW, 2013; Australian Nursing and Midwifery Federation [ANMF], 2014b). Between 2011 and 2013, 3,095 temporary visas were granted to overseas nurses to work in Australia, which is roughly equivalent to the number of graduates seeking work (AIHW, 2013; ANMF, 2014b). Jobs filled by nurses with temporary skilled migrant visas are viewed as taking the place of GRN employment (Stewart, 2014). The current RNs in the workforce are also ageing. In 2012, the RN's average age was 44 years, with almost 53% of RNs aged over 45 years and 23% aged over 55 years (AIHW, 2013). The implications for future education and workforce planning were described in the HWA (2014a) reports. Specifically, the implications include a predicted large number of experienced nurses retiring, an increase in part-time hours, and nurses intending to leave the profession for reasons related to nursing shortage and workload issues (AIHW, 2013; Holland, Allen, & Cooper, 2012).

The GRNs' transition into the workforce remains difficult, despite the urgent need to meet the demand for nurses for the predicted nursing shortfall. To secure employment, GRNs combat a lack of experience, a limited number of graduate programmes and a lack of full-time employment, as part-time hours are becoming more frequently offered in the first year of employment (ANMF, 2014a). A lack of success securing a graduate programme or employment drives RNs to work in other industries to meet their financial and family needs. When there is an urgent need for RNs to fill the gaps left by ageing nurses and nurses leaving the profession, the influx of new inexperienced nurses with a lack of experienced nurse preceptors/mentors will affect the quality of patient care (Commonwealth of Australia, 2002; HWA, 2014b).

Nursing is a highly skilled and knowledgeable profession—the mainstay of the healthcare service—to provide comfort and care when people are at their most vulnerable. Therefore, as highlighted by Christopher, Waters, and Chiarella (2015), the GRN is part of the workforce shortage solution. As such, there will be a need for the nurse educator role in acute care hospitals to ensure the continuing education and

professional development of these inexperienced nurses to provide safe and quality patient care.

1.2.3 The Clinical Nurse Educator Role in Acute Care

There are a number of terms used to describe the nurse educator role in acute care hospitals in Australia and globally. These include 'clinical nurse educator', 'staff development educator', 'staff development nurse/educator', 'clinical education facilitator', 'graduate coordinator', 'learning and development nurse/educator' and 'practice educator'. For the purposes of this study, the term 'clinical nurse educator' (CNE) is used to describe this role in the acute care hospital setting. This is further discussed in Chapter 2.

Ashton (2012) stated that CNEs are situated at the centre of the clinical environment and are subsequently able to actively engage with nursing staff, promote patient safety and quality of care, provide access to resources and empower change for the benefit of patient outcomes. For all nurses, the integration of safety in all aspects of patient care requires evidence-based practice, quality improvement, teamwork and collaboration, and informatics (St Onge & Parnell, 2015). To promote the education role by recruitment and transition from the clinical workforce, selection criteria are essential to ensure the most appropriate skilled and experience clinicians are employed to meet the needs of nursing staff in the current healthcare system (Manning & Neville, 2009). The value of the role is of particular consequence to GRNs in their first year of nursing— who, without expert CNE support, may leave nursing for other career choices (Bartram, Casimir, Djurkovic, Leggat, & Stanton, 2012).

1.2.3.1 Employment Opportunities for CNEs

An active search of CNE job availabilities on the internet indicated significant opportunity for nurses seeking to develop their career in nurse education. Despite the global concerns surrounding the current and future shortage of RNs, the acute care CNE role is considered a necessary investment for retaining new generations of nurses entering the clinical environment (Pollard, Ellis, Stringer, & Cockayne, 2007). Sayers et al. (2011) indicated that the global shortage may also include the retirement of CNEs in the acute care environment. Therefore, improving current systems will provide opportunities for the nursing profession to have an education career pathway that

augments CNE recruitment and job satisfaction for the benefit of the nursing workforce and patient care (HWA, 2014b; Sayers et al., 2011).

However, the CNE role does not remove the personal responsibility of each nurse to provide education to other staff, students and patients, as indicated in registration practice standards (NMBA, 2016b). The role of being a preceptor or mentor for students, GRNs and new staff is an expectation of the nurse in the clinical setting (Hunt, 2012). Preceptors are the designated experienced nurses assigned to be the GRNs' 'buddy' during their ward rotations, and play a significant role in building and supporting the GRNs' professional development through confidence and competence (Owens, 2013; Sayers et al., 2011). One-to-one preceptors act as the GRNs' learning guide to the unfamiliar clinical environment and new context of nursing practice (Henderson & Eaton, 2013). Mentors similarly provide a supportive relationship that may be a planned or spontaneous pairing of experienced RNs and learners during the ward allocations in the graduate programme (Berezuik, 2010). This partnership may continue to enhance the GRNs' professional development beyond the transition year, with the ultimate goal of lasting job satisfaction and reduced turnover (Smith, 2013). The interest and satisfaction in being a preceptor or mentor may also provide the impetus for the RNs' interest and journey towards employment opportunities in the CNE role.

1.2.3.2 CNE Selection Criteria

The CNE is employed in the health service and individual healthcare facilities to provide a key set of responsibilities and essential role criteria. The following points provide examples of CNE employment selection criteria:

- Registration with the Nursing and Midwifery Board of Australia (NMBA) is non-negotiable. The function of the NMBA is to register nurses in Australia, supported by the overarching governing body, the Australian Health Practitioner Regulation Agency (AHPRA,2016; NMBA, 2017).
- Post-registration qualification/s are specified by each healthcare organisation and may include a graduate certificate, graduate diploma or master's level in nursing or nurse education (desirable), clinical qualifications, and/or a finished

or progressing Certificate IV in Workplace Training and Assessment (JHC, 2014).

- Demonstration of post-registration practice and experience, including at least five years of advanced clinical knowledge and clinical practice in the area of specialty (Sayers, 2013).

- Experience in coordinating clinical teaching, training and facilitation of education programmes using adult learning principles, innovative approaches and reflective practice to meet organisational goals and clinical and mandatory competencies (ANTS, 2010; McKinley, 2008).

- Demonstrated experience as a preceptor/mentor and role model for practice through supervision, assessment and feedback, and professional career development to meet staff and organisation goals and expectations (Sayers, Lopez, Howard, Escott, & Cleary, 2015).

- Commitment to a high standard of nursing care and knowledge of nursing standards for practice, policy and legislation, and patient-centred care and customer service through knowledge of continuous quality improvement by participation in quality activities and application of evidence-based practice (Milner, Estabrooks, & Myrick, 2006).

- Acting with integrity and confidentiality at all times (Nurses for a Healthier Tomorrow Coalition, 2016).

- Ongoing commitment to engage, support and promote individual and collective nursing staff and inter-professional team members in continuing professional education opportunities, and providing educational resources (Siehoff, 2003).

- Well-developed skills in written and verbal communication, with experience in negotiation and conflict resolution, analytical and problem-solving skills, and demonstrated proficiency in critical thinking and clinical reasoning (ANTS, 2010; Levett-Jones et al., 2010).

- Desirable computer literacy includes Microsoft Word and Excel skills to maintain clinical competency records and professional development activities (JHC, 2014).

This key set of responsibilities and essential role criteria is directed by nursing professional codes of conduct; ethical and legal guidelines; quality, safety and risk-management strategies; and an understanding of minimum expectations of patient care

(Hunt, 2012). In addition, knowledge of learning and teaching related to adult learners is required to ensure effective patient care (Russell, 2006). These role criteria are activated through either the central or decentralised model of nurse education in the acute care setting.

1.2.3.3 CNE Models

In order to support nursing staff in the acute care hospital setting, the supernumerary CNE works within a service model that facilitates GRN transition to practice, staff professional development, and maintenance of mandatory and optional competency. The adjective 'supernumerary' in relation to the CNE refers to their presence in excess of the requisite number of nurses required for ward and patient management. The position is not directly responsible for patient care, and has protected time to influence and support new and experienced staff and promote positive patient outcomes (Sayers & DiGiacomo, 2010a). The two models employed in the WA healthcare system are the central CNE model and the decentralised CNE model. At the three sites involved in this study, both models were used. These models are described below.

1.2.3.3.1 Central CNE Model

In this study, one of the data collection sites used the centralised CNE model, as depicted in Figure 1.2. This model situates the CNE in the specific organisational education department within the hospital. This department provides the training and development of clinical and non-clinical staff, with a financial account directed by key executives. This formal, structured support system is led by an educational specialist department manager who leads a commensurate number of CNEs. Within this central education department, the CNE may have specialised roles, such as orientation, ward-based education and organisational-wide teaching responsibilities (Henderson & Winch, 2008; Hunt, 2012). The ward-based CNEs work interactively with the ward CNM to identify areas where educational initiatives are required and to follow agreed processes for implementation (Henderson & Winch, 2008). This includes training programmes, educational and competency support, learning resources and engagement in professional development programmes for new employees (orientation) and new graduate nurses (Jeffery, Jarvis, & Sigma Theta Tau, 2014). The time spent delivering training and education is negotiated with the ward CNM and education department manager.
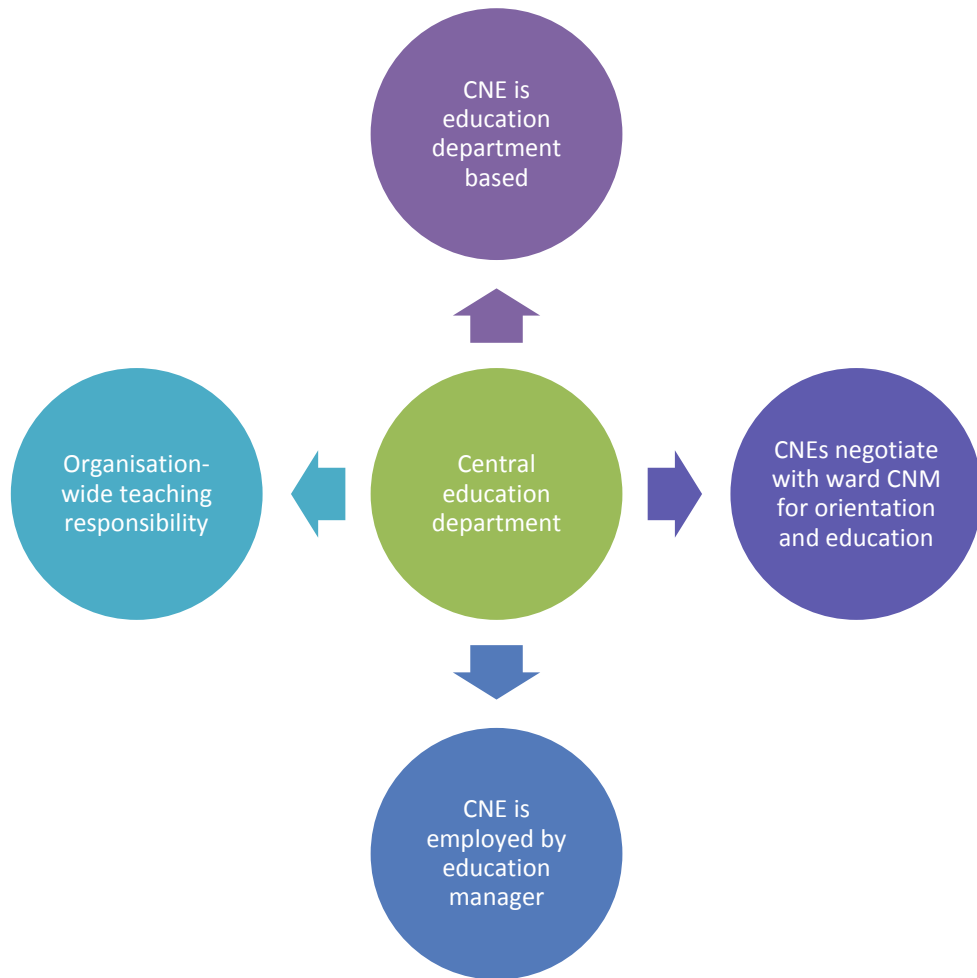
Figure 1.2: Centralised CNE Model

1.2.3.3.2 Decentralised CNE Model

In this study, two of the data collection sites used the decentralised CNE model. This model situates the specialty-specific CNE within the ward setting and is illustrated in Figure 1.3. The CNEs are employed by and answer directly to the CNM who manages the role. Within the organisation, a specific education team exists with a limited number of generalist nurse educators employed to design, plan and implement hospital programmes. The specialist ward CNE works closely with the CNM on the ward-specific vision and values; follows unit guidelines; and engages in staff orientation, continuing professional development, facilitating clinical competencies and following directives by the central education department on existing programmes (Hunt, 2012; Jeffery et al., 2014). The ward CNE works in tandem with the organisational education department, and may have site-specific reporting expectations on planned, ad hoc

education sessions and mandatory competency completion. All specialty CNEs meet regularly with the organisational education team and other ward CNEs.

Figure 1.3: Decentralised CNE model

1.2.3.4 Frameworks for CNE Practice

The following frameworks provide a structure that supports the CNEs' practice. The frameworks facilitate individual CNEs' influence in shaping the role and leadership within their own specialty areas, with the foundation of nurse education and training practices in the clinical environment. These are primarily the NMBA, Australian Nurse Teachers Society and World Health Organization. Another framework that influences CNE practice is Benner's (1984) stages of clinical competence.

1.2.3.4.1 NMBA

The AHPRA (2016) is the national body for all health practitioners and is responsible for implementing the national registration and accreditation scheme within Australia. The NMBA (2017) is one of 10 health disciplines and deals specifically with nursing and midwifery matters. These include nurse registration; standards, codes and guidelines for the nursing profession; accreditation standards and courses; assessment of international practitioners requesting registration; and complaint and issue procedures.

For the CNE and all nurses, ongoing registration occurs through the NMBA. The annual requirements of registration include meeting the RN standards for practice and registration standards for continuing professional development (CPD) (NMBA, 2016a). The RN standards for practice detail performance assessment, nursing registration and consumer expectations through areas of critical analysis of nursing practice; engagement in therapeutic and professional relationships; and continuing capability for practice, assessment, planning, provision and evaluation of safe and quality nursing care that is responsive and informs nursing practice (NMBA, 2016b).

CPD is 'the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives' (NMBA, 2016d, p. 4). This lifelong learning may occur in the setting of an individual's nursing practice and is a mandatory aspect of nurse registration for many nurses (American Nurses Credentialing Center, 2013; NMBA, 2016b, 2017). The regulation of nursing practice through mandating CPD is necessary to maintain professional, quality and safe nursing practice in order to protect the consumer. The expectation for each registration period is a minimum of 20 CPD hours. For all nurses in their context of practice, the registration expectation of CPD promotes the provision of continuing education in the clinical environment (Sayers, Salamonson, et al., 2015).

1.2.3.4.2 Australian Nurse Teachers Society

In addition to the national registration practice expectations, there are non-mandatory professional practice standards for nurse teachers developed by the Australian Nurse Teachers Society (ANTS) (2010). This society provides support and networking opportunities for nurses and midwives in clinical and academic positions who

specifically provide nurse and midwifery education. The society also addresses and evaluates contemporary changes, new curricula and governmental policy.

The ANTS professional practice standards were developed in response to the growth in international nursing specialist competencies (Guy, Taylor, Roden, Blundell, & Tolhurst, 2011). These standards support the pathway of the CNE as an advanced practice role (Billings & Kowalski, 2008; Brundt, 2014). To address the Australian nurse teacher practice requirements, three domains in the areas of teaching and learning, communication and professional practice were developed, each with sub-elements and associated performance criteria, as illustrated in Figure 1.4 (ANTS, 2010). In a study by Guy et al. (2011) on the use of the ANTS practice standards in a variety of settings in Australia, the standards were found to be a useful tool to describe the CNE professional role in the clinical practice environment.

Teaching & learning
- Plans quality learning experiences and programmes that support education and nursing practice
- Plans effective teaching strategies that facilitate learning
- Implements facilitation strategies to support learners
- Evaluates learning experiences and programmes in relation to learner needs and nursing outcomes

Communication
- Demonstrates effective communication and interpersonal skills at an advanced level

Professional practice
- Demonstrates advanced nursing knowledge and expertise in the context of teaching
- Displays management and leadership skills in shaping and implementing change
- Demonstrates a commitment to research and scholarship

Figure 1.4: ANTS Professional Practice Standards

1.2.3.4.3 World Health Organization

In 2016, the World Health Organization (WHO) (2016) developed and published the Nurse Educator Core Competencies to promote high-quality nurse education and

effective and responsive nurses to the health needs of their patients. The competencies aim to guide the educational preparation of nurse educators, improve educational quality and accountability, and highlight performance expectations. The process of development included a global literature review; a Delphi process; validation using an adapted recognised tool; and integration with cognitive, affective and psychomotor domains of learning. The competencies were drafted, reviewed, developed and refined by nurse educators to culminate in the final published version, as depicted in Figure 1.5 (WHO, 2016).

Figure 1.5: WHO Nurse Educator Core Competencies

1.2.3.4.4 Benner's Stages of Clinical Competence

CPD begins with undergraduate study and evolves with theoretical underpinnings and practical experience through five levels of proficiency: novice, advanced beginner, competent, proficient and expert—as illustrated in Figure 1.6 (Benner, 1984). Benner

(1984) described nurses developing their nursing skills and knowledge over time through understanding, CPD and practical clinical experiences. Each stage builds on the previous, as the nurse moves from reliance on past abstract principles to confidence in past concrete experience, continuously supported by active engagement in practical experience that leads to clinical expertise.
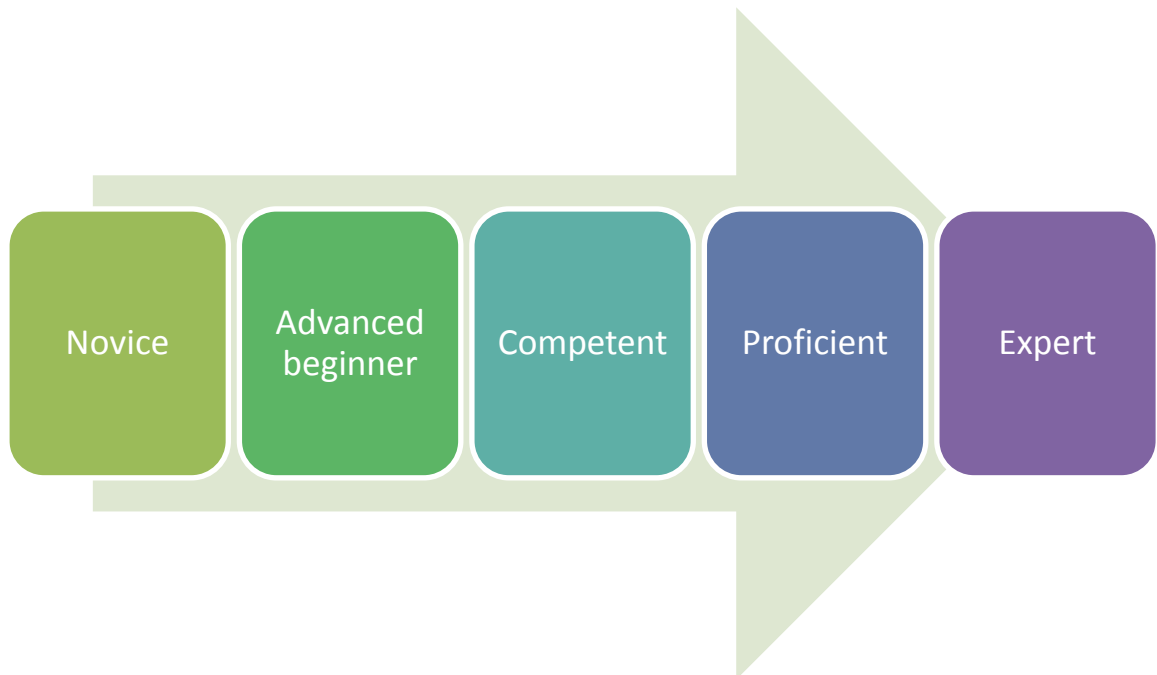
Figure 1.6: Benner's Stages of Clinical Competence

This clinical competence pathway is an integral consideration when providing support for best patient care outcomes. The CNE role is recognised for their clinical expertise in work-integrated learning of all stages of nursing staff (Sayers et al., 2011). Benner's stages of clinical competence provide a recognisable structure for the CNE to monitor the progress of the GRNs in their first year of nursing. Clinical experience consists of amassing real-life examples alongside the experienced CNE and senior nursing staff that provide the transition from novice to advanced beginner and beyond (Gardner, 2012).

The frameworks detailed above are suggested as useful for the practice of the CNE in the clinical environment to meet the expectations and requirements of the nursing profession and to promote safe and quality patient care by new and experienced nurses (NMBA, 2016a; Sayers et al., 2011).

1.2.4 Leadership

Nursing leadership seeks to serve the healthcare organisation and clinical needs of the patient through influencing others to achieve set goals (Yoder-Wise, 2011). Sayers et al. (2011) highlighted the CNE role as necessary for leadership through role modelling and providing clinical expertise and knowledge to guide and support students and newly qualified nurses in their transition to competent practitioners. This leadership also influences change through advancing the development and application of evidence-based practice. However, the authors also noted the importance of healthcare organisations' role in providing the support necessary to effectively use and maintain the capability of the CNE and to promote the role as a career pathway (Sayers, Salamonson, et al., 2015).

The review by Sayers et al. (2011) found that the CNE leadership role was pivotal to integrating theory and practice in the clinical environment, as identified by the significance of the CNEs' team approach to critical thinking and clinical reasoning. A commentary by Ashton (2012) suggested that, through leadership attributes and experience, the CNE has the capability to influence a greater number of nurses through the educator role and leadership opportunities in order to cultivate the potential of individual nurses and to empower them for the benefit of patient care. Sayers et al. (2011) identified the CNE as a clinical leader because of their educational responsibilities that provide structure to the organisation's accountability and standards of practice. The HWA's (2014b) report on nursing workforce sustainability also specified the need for ward-level leadership imbued with autonomy and accountability to improve nurses' professional development, work experiences and patient care productivity.

1.2.5 Relationship of CNE to Patient Outcomes

The significance of the CNE role for positive patient outcomes was described in Duffield et al.'s (2007) study on nurses, the nurse work environment and patient safety. The authors identified a relationship between CNE practice and safe patient outcomes, and suggested that further research was needed to ascertain the interactions influencing patient outcomes between the CNE, nursing care and patient.

The CNE role has been the subject of a limited number of studies. Pollard et al. (2007) considered the role of the CNE in a literature review and found limited empirical evidence of the effectiveness of the role, and suggested further research to determine the relationship between the CNE and patient quality of care. An integrative review by Sayers et al. (2011) on the nurse educator role in the acute care setting in Australia also found limited discussion on the role and effect of the nurse educator on patient outcomes, and indicated the need for further research to understand the influence of the CNE in achieving safe patient outcomes. Sayers, Salamonson, et al. (2015) suggested that 'given the complexities of the acute care environment CNE are pivotal in supporting nursing staff to provide competent quality care' (p. 49).

1.3 Study Justification

Increased demand for a world-class healthcare service is a common concern among developed nations, where ageing populations, increasing chronic diseases and greater life expectancy influence the provision of healthcare and hospital services (Holland et al., 2012; Twigg, Duffield, Thompson, & Rapley, 2010). Within the healthcare system, nurses comprise a significant workforce who provide care from a foundation of appropriate skills, knowledge and professional standards for practice (Sayers et al., 2011; Willis Commission, 2012). Key issues for nurses providing quality and safe nursing care include recruitment and retention issues, ageing nurses, financial constraints, heavy workloads and challenging clinical environments (HWA, 2014a, 2014b). These issues affect the continuing education in the acute care setting, making it difficult for nurses to develop and maintain their skills, knowledge and confidence (Coventry, Maslin-Prothero, & Smith, 2015). Therefore, it is vital that healthcare organisations and government services are aware of these issues and provide the necessary funding and support to achieve positive patient outcomes (Francis, 2013; Willis Commission, 2012).

The CNE role is one solution to ensure the professional development of nursing staff and particularly to support GRNs to enable successful transition to practice in their first year of nursing. The lack of empirical evidence for the supernumerary status of the CNE in relation to positive patient outcomes allows organisations to devalue and diminish the CNE role, and to remove the CNE's authority to influence and advance clinical practice (Sayers, 2010; Sayers et al., 2011). The outcome is likely to be disillusioned and

anxious nurses, which may have a negative effect on patient safety goals. One approach to this problem is to determine whether supernumerary CNEs influence patient outcomes, specifically when related to graduate nurses. This identified gap resulted in the proposed mixed-methods study to consider the perspectives of GRNs, CNEs and CNMs regarding the effect of the presence or absence of the CNE role in the clinical environment. This was undertaken in order to articulate the CNE influence on GRNs' quality patient care.

1.4 The Research Questions

The purpose of this study was to generate a richer, deeper understanding of the CNE role in relation to GRNs' safe and quality care of patients, and transition to competent and confident practitioners. To fulfil the purpose of this study, a mixed-methods research approach using a convergent parallel design was used to address the following questions.

The overarching question was:

- Does the role of the supernumerary CNE influence first-year GRN patient outcomes?

The guiding questions were:

1. Is there a link between the CNE role and GRNs' safe and quality patient care?
2. In what way does the CNE promote clinical confidence among GRNs?
3. To what extent is the CNE perceived as a clinical leader by GRNs, CNEs and CNMs?

1.5 Thesis Configuration

The thesis comprises seven chapters. Chapter 1 has provided an introduction to the study, with a background on the healthcare system and an overview of the nursing workforce, including the supernumerary CNE role, practice and association with leadership and patient outcomes. Chapter 2 presents the current research and influential global and local literature on the CNE, including role theory and leadership theory. It also describes the newly qualified GRNs' transition to practice in order to provide the lens through which the relationship between the CNE role and safe, quality patient care

is explored. Chapter 3 describes the research context, methodological approach and phases of the study, including the chosen data collection methods, analysis and implementation. Chapter 4 analyses and assesses the quantitative data collection, and reviews and discusses the interview demographic information. Chapter 5 comprises the qualitative data collection from the perspectives of the three subgroup interviews (GRNs, CNEs and CNMs), which are analysed and the findings discussed. Chapter 6 compares the study findings to the relevant literature, and provides a synopsis of the added new knowledge. The final Chapter 7 outlines the study implications and presents recommendations from the study findings.

1.6 Chapter Summary

With the current healthcare system challenges and continuing nursing workforce issues, it is valuable to undertake research on the CNE in relation to continuing professional education, patient outcomes, and the direct or indirect effect of the CNE role on nurses' clinical competence in the acute care environment. Nursing staff support for high-quality patient care in the acute care hospital setting is intrinsically linked to nurse retention in healthcare organisations. Therefore, partnerships between CNMs and education providers—such as education and training departments and dedicated CNEs—may provide added value and options for developing flexible ways to maximise nurses' practice and quality of patient care.

This thesis focuses on the supernumerary CNE role in relation to patient outcomes in the hospital acute care setting. The supernumerary CNE does not have a direct patient care role; thus, it is difficult to quantify the influence of the supernumerary role directly on patient safety and quality of care. Therefore, in order to appraise the effect of the CNE in the clinical environment, this study uses the newly qualified GRN as the lens through which the CNE role and clinical leadership can be evaluated.

The following Chapter 2 examines the literature on the CNE role and CNEs' connection with the newly qualified GRNs' first year of nursing in the acute care hospital.

Chapter 2: Literature Review

2.1 Introduction

The previous chapter presented a synopsis of the contemporary CNE position, leadership and association with quality patient care in the acute care hospital setting in light of the current challenges in the healthcare system and nursing workforce. Anecdotal evidence suggests that the CNE is a pivotal role in the nursing team, where a supportive clinical work environment can influence the delivery of safe and quality patient care.

This chapter presents the current research and influential literature from a global and local perspective on the role of the supernumerary CNE in the context of quality patient outcomes in the acute care hospital setting. The CNE role is profiled in relation to clinical education and scope of practice, with a focus on the specific role support given to newly qualified GRNs in their first year of nursing. In this research, GRNs provide the lens through which the relationship between CNEs' role and quality of patient care is explored.

2.1.1 Search Strategy

A search of electronic databases was conducted from 1980—the period following the commencement of undergraduate student supernumerary status, when the education of RNs was transferred from hospitals to universities in Australia and the majority of Western countries (Conway & Elwin, 2007). The following databases were searched: Cumulative Index for Nursing and Allied Health (CINAHL) Plus full text, MEDLINE (the National Library of Medicine's bibliographic database covering the fields of medicine, nursing, dentistry, veterinary medicine, the healthcare system and the preclinical sciences), Education Resources Information Center (ERIC), ProQuest Health & Medical Complete, ProQuest Dissertations & Theses, and Google Scholar. Book catalogues from university and hospital libraries were also searched.

The search terms covered the variables under consideration and were as follows: 'nurs*', 'role theory', 'leadership theory', 'clinical nurse educator', 'staff development nurse', 'staff development educator', 'staff educator', 'nurse educator', 'clinical

educator', 'graduate coordinator', 'nursing role', 'nurse leader', 'graduate', 'junior', 'beginner', 'learner', 'trainee', 'novice', 'clinical environment', 'clinical setting', 'hospital', 'acute care' and 'patient safety'. To capture relevant papers, the search was conducted using Boolean logic to allow for a broader pursuit of search results. The reference lists of retrieved papers were hand-searched to ascertain further literature not identified via the electronic database search.

Relevant papers were included if they addressed the topic of interest: the CNE role in the acute care hospital setting, including the CNEs' leadership, supernumerary status, scope of practice and career path, and the newly qualified university-trained GRNs' first year of practice, transition, retention, patient safety and patient quality of care. Papers were eliminated if they included nurse educators or graduates from non-acute care clinical environments, such as clinics, community settings or faculties. The search strategy included seminal works, peer-reviewed journals and grey literature, and encompassed papers from all countries, but was limited to those written initially in English or translated to English.

This review outlines the literature on the theoretical perspectives of role theory and leadership theory and styles. Thereafter, it reviews the position, role expectations and clinical practice of the supernumerary CNE in the acute care hospital, from past to present. This review also includes the CNE role in RNs' graduate programmes, associated with transition to practice, the context of learning, practice readiness, socialisation, retention and patient safety.

2.2 Theoretical Perspectives

This section considers role theory and leadership theory and styles. The discussion of role theory includes a short history, the connected processes and roles in organisations, and the key concepts. Leadership theory and styles are considered in relation to the variety of styles, with a specific focus on the congruent leadership style. Both role theory and leadership are considered with respect to the discipline of nursing in the clinical healthcare environment.

2.2.1 Role Theory

Role theory is a collection of ideas that explain the behaviours of individuals in specific situations, as well as the anticipated consequences related to expectations and responsibilities (Conway, 1988). Role theory was described in the early twentieth century, with the structuralist perspective focusing on social structure, such as rights, responsibilities, expectations, behaviours (Linton, 1945), role clarity (Cottrell, 1942), role recognition, the effect of culture (Nye, 1974) and changes over time (Turner, 1990). The interactionist perspective first described in the 1930s by Mead (1934) is connected to the ability of the individual to adopt and act in a role, similar to performing as an actor on stage (Goffman, 1959). This process encompasses relationships, interactions and verbal and non-verbal communications occurring in the pursuit of a common goal (Hardy & Conway, 1988; Lambert & Lambert, 2001). The extension of the interactionist viewpoint is the dramaturgical perspective, in which role-play is used to describe variances in the way an individual acts when placed in different settings and situations (Moreno, 1934).

According to Fellows and Kahn (2013), role theory encompasses all social life settings, including organisations, where a role is a position in a larger social system that continually grows and changes as individuals come and go. Roles are not isolated, but exist in an interconnected way that is known as the 'role set' because of the roles' effect and reliance on others (Fellows & Kahn, 2013). Role participants comprehend their place in the organisation (role set) and, by using reflection and action (role-taking), engage and meet their role expectations with acceptable behaviour (Fellows & Kahn, 2013). The organisational hierarchy formally recognises positional roles by title and a reporting structure that maintains continuity, despite personnel changes. Functional roles arise from social interaction within the organisation, which may be informal roles related to isolated tasks (such as a project manager) or repetitive assignments that require status and position with greater delegated responsibility and authority (Lambert & Lambert, 2001). The day-to-day negotiations of the roles in the organisation (role-playing) follow the overarching policies and standards for performance, while allowing some personal creativity (Fellows & Kahn, 2013). The key concepts in role theory include role identity, role strain and role conflict (Fellows & Kahn, 2013).

In a healthcare organisation, role identity is important to the individual nurse. The way nurses view themselves as a professional in terms of status, approval, job description and expected daily tasks, combined with the influence of the clinical environment, is central to their role (Brookes et al., 2007; Hercelinskyj, Cruickshank, Brown, & Phillips, 2014; Phillips, Kenny, Esterman, & Smith, 2014b). Role strain occurs when 'various sets of expectations associated with the role interfere with one another' and role conflict occurs 'where expectations associated with multiple roles are incompatible' (Fellows & Kahn, 2013, p. 672). Both role strain and role conflict are an accepted consequence of the continual changes occurring in healthcare related to new nursing positions and changes in organisational and consumer patient care expectations (Brookes et al., 2007).

Nursing roles are significant elements of healthcare organisations, where responsibilities are revealed through formal processes (such as the organisation's vision and values, job descriptions, performance appraisals and policies) and less formal processes at local level through attitudes, skills, inter-professional relationships and education (Kahn, 2013; Marquis & Huston, 2012). Nurses are first introduced to the nursing role in their undergraduate and graduate years (Marquis & Huston, 2012). Nursing roles (related to nurses' scope of practice) are determined by education, clinical training and competence, and are approved in the clinical setting by the employing healthcare organisation's mandatory requirements and policies (NMBA, 2015). The literature on the hospital clinical acute care setting identifies nursing roles from a more formal leadership role perspective, such as chief nursing officers (Clement-O'Brien, Polit, & Fitzpatrick, 2011; Irurita, 1988) and CNMs (Schwarzkopf, Sherman, & Kiger, 2012; Swearingen, 2009), rather than the informal role of nurses at the frontline of patient care. However, there is now greater attention devoted to this more informal bedside leadership role, which is more overtly associated with and has significant influence on patients' safety and quality of care (ACN, 2015; Daly et al., 2004; Stanley, 2006d; Wolf, 2015).

The following section describes leadership theory and styles, ranging from a general perspective to a specific focus on the varieties of nursing leadership in the healthcare clinical setting. Clinical leadership is identified and further explicated through the role of the bedside nurse.

2.2.2 Leadership

In 1974, Stogdill wrote in his *Handbook of Leadership* that 'there are almost as many definitions of leadership as there are persons who have attempted to define the concept' (p. 259). In searching the nursing literature on leadership, it is apparent that authors find a precise definition of nursing leadership difficult to determine because of the broad nature of the concept (Marquis & Huston, 2012; Reilly & Perrin, 1999). Researchers have explored many different paradigms of leadership, including, but not limited to, influence, authority, dynamic personality, goal attainment, knowing and creativity (Curtis, de Vries, & Sheerin, 2011). Simply stated, leadership is centred on achieving common goals though influence, vision and collaboration to improve the standard and quality of life (Christmas, 2009; Yalong, 2012; Yukl, 2010).

2.2.2.1 Leadership Theory and Styles

Since the early twentieth century, leadership theory has sought to explain successful leadership through the analysis and understanding of reality, intentions, beliefs and attitudes (Marquis & Huston, 2012). The trait theory highlights the personal abilities that contribute to effective leadership, without acknowledging follower characteristics and situational variations, whereas the great man theory describes an exceptional leader who is able to influence a great number of followers using intellect, dynamic influence and ethical code (Curtis et al., 2011). From the 1940s to the present, a number of theories have highlighted the process of influence, goal achievement, context and culture of organisations, and relationships between leaders and followers. These leadership theories are also known as 'styles' because of their particular focus on the attributes and behaviours of leaders related to the overarching theory of leadership (Marquis & Huston, 2012). The behavioural styles of leadership known as authoritarian, democratic and laissez-faire correlate to a dominant decision-making style, while situational and contingency styles describe a leadership approach that adapts to the people and the setting involved, and interactional style considers the influence of personalities and situations (Marquis & Huston, 2012).

The diversity in organisations means that the adoption of a leadership style is significantly influenced by the organisational culture, vision and values (Kumar, 2010). In common with generic leadership definitions, nursing leadership uses nursing

knowledge resulting from expert nursing practice to create a basis for authority to influence and advance clinical practice (Curtis et al., 2011). Behavioural styles of leadership in nursing are often individual and related to diverse values shaped by the nurses' own perceptions, educational level, culture and life experiences (Christmas, 2009). For example, transformational leadership encourages a connection between leader and follower, with the foundation of this relationship sharing vision through individual attention, inspiring creative solutions, and providing meaning and direction (Drenkard, 2012).

The dynamic clinical environment appears to suit the transformational leadership style (Valentine, 2002), which encourages adaption to change and belonging to the organisation, thereby leading to positive nurse retention and patient satisfaction (Smith, 2011). However, it has been noted in the literature that transformational leaders also need to include qualities from the transactional leadership style, such as setting goals, giving direction and using rewards to be successful in the clinical environment (Marquis & Huston, 2012; Stanley, 2011). Transformational leaders direct their focus towards the organisation, whereas servant leadership (another modern leadership style) directs focus towards the follower (Stone, Russell, & Patterson, 2004). The servant leader naturally aspires to serve and, through this action of service to others, inspires others to serve (Greenleaf, 1970). Although viewed as a paradox, where servant and leader are usually at the opposite ends of the continuum, assimilation occurs by the very act of power—the leader placing others before his or herself (Robinson, 2009). In the clinical environment, servant leadership recognises colleagues' concerns and patients' quality of care as primary considerations through decision making and nursing action (Waterman, 2011).

The review of the literature also revealed congruent leadership style—an alternative leadership style more recently proposed by Stanley (2005). This style is demonstrated in the clinical environment by influential nurses who do not necessarily have a formal position of leadership in the organisation (Stanley, 2008). The clear values and investment in relationships espoused by congruent leaders encourage harmony and positive cultural change (Stanley, 2009). Clinical leadership and the congruent leadership style are expanded further in the following sections.

2.2.2.2 Clinical Leadership

Clinical leadership is described in a variety of ways and contexts in the nursing literature (Murphy, Quillinan, & Carolan, 2009; Stanley, 2006c). Harper (1995) identified a clinical leader as one who uses clinical expertise and communication skills to inspire others to deliver safe and quality patient care. The American Association of Colleges of Nursing (2007) views the clinical leader as accountable for a specific cohort of patients, who leads by coordinating, delegating and supervising the care provided by healthcare teams. A white paper on nurse leadership by the Australian College of Nursing (ACN) (2015) indicated that the clinical leader is involved in evidence-based practice, evaluating outcomes, assessing and reducing risk, and advocating for patients. What is significant to clinical leadership is the patient-centred philosophy that connects the multifaceted challenges of the clinical environment and the nursing profession in the wider health system, and is necessary for retaining and developing future generations of nurses (ACN, 2015).

2.2.2.3 Congruent Leadership

The congruent style was developed from the doctoral research of David Stanley and confirmed through a subsequent series of studies exploring clinical leadership in a variety of health professional disciplines (Cuthbertson & Stanley, 2013; Stanley, 2004, 2005, 2006b, 2006c, 2008, 2014; Stanley, Cuthbertson, & Latimer, 2012). The initial research was conducted with nurses in a large acute care hospital in the United Kingdom (UK) from 2001 to 2004, with the ensuing WA-based studies exploring clinical leadership in paramedics (2008), senior RNs and managers in aged care (2012), ambulance volunteers (2013) and allied health professionals (2014). Stanley (2011) proposed congruent leadership theory as a way to explain and understand leadership as enacted in the clinical arena by clinically focused staff in all healthcare-related disciplines. At the time of these studies, the most prominent leadership style supporting clinical healthcare leadership was transformational leadership. However, Stanley (2016, in press) found that the attribute of 'visionary' was infrequently used to describe clinically focused leaders, and concluded that established leadership theories based on 'vision' were inadequate to explain the type of leadership displayed by leaders with a clinical focus.

2.2.2.3.1 Leadership Measurement Tool

The Perceptions of Clinical Leadership Questionnaire tool was created by Stanley (2016, in press) for his original doctoral research. The purpose of the tool was to determine the type of leadership in healthcare disciples, and the qualities and characteristics of clinical leaders. The original tool was designed after locating literature on varied types of leadership and leadership theories and traits, reviewing other leadership tools, and colleague consultation. The initial study, using grounded theory methodology, tested the original tool (Stanley, 2004), which was then further refined and modified for use in a number of other studies demonstrating criterion-related validity (Cuthbertson & Stanley, 2013; Stanley, 2005, 2006b; Stanley et al., 2012; Stanley, Hutton, & McDonald, 2015).

Stanley's self-reporting tool consisted of demographic questions related to length of service, area of practice, position, leadership education, age and gender. Twelve questions related to clinical leadership perceptions (Stanley, 2006b), while two questions contained 54 qualities or characteristics, with participants asked to choose any number of qualities or characteristics that they 'most' and 'least' associated with clinical leadership, and one question regarding other qualities or characteristics identified with clinical leadership not on the list. Five dichotomous questions with additional space for text entry asked about the respondents' role as a leader. Two questions with a total of 18 items used a five-point Likert scale to measure the attitudes surrounding the respondents' clinical leadership, while three questions allowed for open-ended responses. Stanley's Perceptions of Clinical Leadership Questionnaire tool is included in Appendix A.

The Perceptions of Clinical Leadership Questionnaire tool was used in a variety of quantitative, qualitative and mixed-methods research studies over 10 years to identify and confirm the qualities and characteristics of congruent leadership. From the initial study population of nurses, other healthcare disciplines were included (ambulance officers and volunteers and allied health staff). Five research studies and their findings led to the development of congruent leadership theory. Each of these studies are summarised below.

1. In Command of Care: Clinical Nurse Leadership (Doctoral Thesis)

This grounded theory doctoral thesis study conducted from 2001 to 2004 in England, UK, aimed to identify the clinical leaders in a large National Health Service (NHS) trust hospital in England to explore and critically analyse the experience of being a clinical nurse leader. The population included RNs in 36 clinical areas across one NHS acute trust. The research method involved a questionnaire (n = 188, response rate [RR] 22.6%) and interviews (n = 50). The results indicated that the top-ranked qualities most associated with clinical leadership were being approachable, clinically competent, a motivator and supportive; inspiring confidence; coping well with change; evaluating the performance of staff; and setting direction. The top-ranked qualities least associated with clinical leadership were being controlling, artistic/imaginative and conservative; dealing with routine; taking calculated risks; dealing with reward/punishment; being an administrator; and being a regulator/supervisor. These results supported a new theory on clinically focused leadership—congruent leadership—in which leaders are followed because their leadership actions are viewed as being their values and beliefs translated into practice.

2. Leadership at Home: Perceptions of Clinical Leadership at Swan Care Group Bentley Park

This qualitative study in 2012 at Swan Care residential facility in Bentley Park, Perth, WA, aimed to investigate the perceptions of leadership and approaches to leadership development of senior nurses and care home managers in an aged care residential facility. The population were senior clinical nurses and residential care home managers. The research methods included questionnaires (n = 10, RR 50%) and interviews (n = 8). The results indicated that the top-ranked qualities most associated with clinical leadership were being clinically competent, approachable and supportive; having integrity/honesty; being an effective communicator; coping well with change; considering relationships valuable; and inspiring confidence. The top-ranked qualities least associated with clinical leadership were being controlling, being artistic/imaginative, working alone, being an administrator, having relevant postgraduate training, dealing with reward/punishment, being conservative, and dealing with routine.

3. Allied Health Staff: WA Allied Health Professionals' Perceptions of Clinical Leadership

This mixed-methods study in 2014 aimed to identify how the concept and application of clinical leadership is perceived by allied health professionals, and the implications for service improvement, the adoption of quality initiatives, and innovations for change. The population surveyed were allied health professionals employed in the WA Department of Health, including dietitians, occupational therapists, physiotherapists, podiatrists, social workers and speech pathologists ($n = 307$), using an online questionnaire. The results indicated that the top-ranked qualities most associated with clinical leadership were being an effective communicator, setting direction, being clinically competent, having integrity/honesty, being approachable, being a role model for others in practice, coping well with change, being supportive and being a mentor. The top-ranked qualities least associated with clinical leadership were being controlling, working alone, being conservative, having relevant postgraduate training, being artistic/imaginative, dealing with routine, being a regulator/supervisor and dealing with reward/punishment.

4. St John Ambulance Service: Perceptions of Clinical Leadership in the St John Ambulance Service in WA

This qualitative study in 2010 aimed to identify how clinical leadership is perceived by paramedics and ambulance personnel in the course of their everyday work, and the effectiveness and consequences of the application of clinical leadership in pre-hospital care delivery. The population surveyed were employed paramedics and ambulance officers ($n = 104$, RR 41.6%). The results indicated that the top-ranked qualities most associated with clinical leadership were being approachable and clinically competent; having integrity/honesty; being a role model for others in practice; being supportive, a mentor, consistent, an effective communicator and a critical thinker; directing and helping other people; being a decision maker; inspiring confidence; and being visible in practice. The top-ranked qualities least associated with clinical leadership were being controlling, working alone, being conservative, being artistic/imaginative, being an administrator, dealing with reward and punishment, being responsible for others, and taking calculated risks.

5. Volunteer Ambulance Officers' Perceptions of Clinical Leadership in the St John Ambulance Service in WA

This qualitative study in 2012/2013 aimed to investigate the perceptions of clinical leadership in volunteer ambulance officers. The population surveyed were volunteer ambulance officers in metropolitan, rural and remote areas of WA ($n = 61$, RR 12.2%). The results indicated that the top-ranked qualities most associated with clinical leadership were being clinically competent, a role model for others in practice and an effective communicator; inspiring confidence; being approachable; having integrity/honesty; being flexible; and setting direction. The top-ranked qualities least associated with clinical leadership were being controlling, working alone, having relevant postgraduate training, being a regulator/supervisor, taking calculated risks, being conservative, dealing with reward/punishment and being an administrator.

2.2.2.3.2 Confirmation of Theory

The results from these five studies led to the development of the leadership theory of congruent leadership, described by Stanley (2006c) to refer to leaders who demonstrate a match (congruence) between their values, beliefs and actions. The congruent leader is guided by concern and compassion, demonstrates clear values, communicates effectively and invests in relationships without the need for a formal position of leadership in an organisation (Stanley, 2008). Bedside nurses easily recognise the congruent leaders' tacit clinical influence, which stimulates loyalty and creates harmony in the clinical team (Bishop, 2009; Stanley, 2009). Congruent leadership style drives clinical leaders' professional accountability and responsibilities (Stanley, 2006c, 2008) and can be seen as a significant factor in encouraging positive cultural change in the clinical environment via leaders' demonstration of values in action, reflected in nursing staff (Stanley, 2009). These clinically focused leaders highlight the importance of values in action in simple everyday nursing work—not to change the world, but because doing the right thing for patients makes a difference (Stanley, 2016, in press). Figure 2.1 depicts the congruent values described by Stanley (2011) that are patient-care centric.

Figure 2.1: Congruent Leadership Patient-centric Values

The following section explores the role and leadership of the CNE in relation to healthcare, clinical education, job description, qualification, and current role and scope in the clinical setting.

2.3 CNE

To provide a numerical context, this study accessed statistics from the AIHW (2013) about the general nursing population in public and private hospitals in Australia. According to the AIHW *Nursing and Midwifery Report*, in 2015 the total number of RNs in Australia was 235,470, with twice as many RNs working in the public sector than in private healthcare organisations (AIHW, 2017). Of the total number of RNs, 5,321 identified their principal nursing role as educator/teacher, which included clinical and non-clinical roles. Worldwide CNE statistics were difficult to obtain due to the inability to differentiate between nurse educator roles in the acute care hospital setting

and tertiary sector non-clinical teachers of undergraduate nurses (National League for Nursing, 2016; Taylor, Irvine, Bradbury-Jones, & McKenna, 2010).

2.3.1 Clinical Education

The significance of ward-based clinical education for improving the quality of patient outcomes has emerged over the last 30 years, and is directly related to the establishment of nursing education in universities in Australia (Conway & Elwin, 2007), the United States (US) (Nowicki, 1996) and the UK (Gillespie & McFetridge, 2006). Prior to university education, students' and newly qualified nurses' education and professional development in the hospital setting was performed by clinical experts, such as the ward sisters (Scheckel, 2009; Tobin & Beeler, 1988). Clinical teachers (employed by schools of nursing) also contributed to the new nurses' education and were required to consult with ward staff regarding times to meet with students (Brennan & Hutt, 2001; Clifford, 1999).

In Australia in the mid-1990s, in conjunction with changes to undergraduate education, the critical care areas were experiencing a shortage of nurses with the necessary experience in intensive care or emergency nursing (Considine & Hood, 2000). In these areas, the skill mix (the proportion of RNs available for patient care) disparity was considered a risk to safe patient and staff outcomes (Considine & Hood, 2000; Pollard et al., 2007). The CNE role was seen as the answer to meeting the education needs of inexperienced nurses in these critical care areas (Considine & Hood, 2000). In the UK, the CNE role similarly supported the safe clinical progression of inexperienced nurses in critical care areas to ensure a high standard of care in a timely manner (Brennan & Hutt, 2001; Haines & Coad, 2001). Following the success of CNEs in critical care areas, general medical and surgical wards adopted the role to provide nursing staff with additional education and practice support (Haines & Coad, 2001). The CNE role has continued to progress as nurses involved in education embrace clinical expertise and a passion for teaching with a patient-centred focus. However, there are contemporary role challenges related to the functions, preparation and scope that affect the advancement of the CNE practice. In addition, there is a lack of research evidence on the relationship between the CNE role and the achievement of safe and quality patient outcomes in the clinical setting (Sayers et al., 2011).

2.3.2 Title and Job Description

CNEs globally and within Australia have a number of different titles and job descriptions, which may relate to the differing expectations, clinical ward specialties and classifications of nurses who have education as part of their portfolio (Conway & Elwin, 2007). The language used in the literature to describe nurses working in nursing education is confusing, and terms often appear interchangeable. The term 'nurse educator' is used frequently to describe both university faculty staff (Adelman-Mullally et al., 2013; Billings, 2003) and hospital ward-based educators (Sayers, Salamonson, et al., 2015). In contrast, the terms 'CNE', 'staff development educator', 'staff development nurse/educator', 'clinical education facilitator', 'graduate coordinator', 'learning and development nurse/educator' and 'practice educator' describe a role that primarily concentrates on the education needs of nursing staff, and functions across general and specialty units in the hospital clinical environment (McCormack & Slater, 2006; Milner et al., 2006; Sayers, 2010; Sayers & DiGiacomo, 2010b; Sayers, Salamonson, et al., 2015).

The literature highlights differing CNE role expectations and responsibilities between hospitals and states in Australia (Conway & Elwin, 2007; Guy et al., 2011; Sayers et al., 2011) and between countries (Girard, 2009; McCormack & Slater, 2006; Pollard et al., 2007; Sprinks, 2015). Role differences include the physical locations of the educator (ward or central education department—see Chapter 1 for more detail), direct or indirect clinical education, clinical patient allocation, level of remuneration and scope of education practice. In more recent years, other nursing roles have also integrated nurse education as part of their portfolios, such as clinical nurse specialists, clinical nurse consultants and nurse practitioners (Davidson & Sayers, 2009). These additional roles have compelled the need to re-examine the professional scope and contribution of the CNE in the current healthcare system (Conway & Elwin, 2007).

2.3.3 Qualifications

The CNE contemporary role describes an intentional and ongoing pursuit of clinical expertise and knowledge acquired through postgraduate studies in clinical or education in order to contribute to the professional development of nurses (Billings & Kowalski, 2008; Sayers, Salamonson, et al., 2015). The role provides a natural career progression

for the nurse with clinical expertise and an interest in teaching (Donner, Levonian, & Slutsky, 2005). However, the literature suggests the incumbent may or may not have formal training, and may specifically lack a postgraduate qualification (Donner et al., 2005; Guy et al., 2011). The nursing regulatory body in Australia does not dictate postgraduate educational requirements for the CNE (Guy et al., 2011; Pollard et al., 2007), despite a recurring debate on whether clinical competence alone is sufficient for nurse educators to perform their role (Sayers et al., 2011). The ability to effectively engage nurses in knowledge and skill growth requires an understanding of adult education principles and commitment to learning and teaching gained from further study (Sayers et al., 2011).

The number of CNEs without postgraduate qualifications in Australia was further highlighted in the findings of the Nurse Educators in Acute Care Hospitals (NEACH) study, which demonstrated that only 22% had completed an education or clinical qualification at master's level (Sayers, 2012). The lack of clarity around post-registration requirements for the CNE role is emphasised in the literature as a particular concern that affects role credibility and identity (Guy et al., 2011; Sayers et al., 2011). This may affect the capacity to provide an appropriate level of professional development for nurses in the clinical environment, and subsequently affect the safety and quality of patient care (Sayers et al., 2011; Sayers, Salamonson, et al., 2015). A participant in the NEACH study noted that the common idea of 'every nurse is a teacher' diverts from the need to have CNEs with teaching qualifications, rather than generic qualifications (Sayers, Salamonson, et al., 2015). To best serve the contemporary professional development needs of all levels of clinical nursing staff, Pollard et al. (2007) and Swearingen (2009) suggested that the CNE career pathway requires close alignment with postgraduate qualifications, specifically in education.

2.3.4 Current Role and Scope

The CNE has a supernumerary status independent of ward and patient management—a position that is not directly responsible for patient care and has protected time to support new and experienced staff and promote positive patient outcomes (Sayers & DiGiacomo, 2010b). The contemporary CNE role is described in the literature as a diverse discipline of multiple intersecting education and clinical leadership functions (ACN, 2015). The role descriptions are listed in the following table.

Table 2.1: CNE Role Descriptions

Educational Function	Leadership Function	Reference
Maintaining a close rapport with nurses at the point of care		Ashton (2012)
	Connecting with and being passionate about frontline patient care	Stanley (2006b)
	Assessing, planning, implementing and evaluating professional development programmes	NMBA (2013), The Nursing and Midwifery Council (NMC) (2015)
	Ward facilitator of the graduate programme to progress GRNs from novices to competent and confident practitioners	Sayers, Salamonson, et al. (2015)
Supporting and encouraging quality improvement initiatives based on evidence-based practice	Innovative quality improvement initiatives envisioned and enacted in the clinical environment for the benefit of patient care	Stanley (2014)
Translating broader organisation clinical governance processes, policies and risk-management initiatives at local level to nursing educational initiatives to benefit patient safety and quality of care	Implementing and evaluating organisation clinical governance processes, policies and risk-management initiatives at local level to benefit patient safety and quality of care	Duffield et al. (2007), Sayers (2012)
Providing ad hoc evidence-based teaching, skills and reflective practice sessions for nurses in groups or one-to-one		Conway and Elwin (2007)
	Acting as ward change agents to implement local guidelines and evidence-based practice	Sayers, Salamonson, et al. (2015)
Availability as the educational resource expert and 'go-to' person for all nursing and inter-professional staff		Ashton (2012); Kelly, Simpson, and Brown (2002)
Supporting organisational focus on national and local government commitments to the healthcare policy through quality and safety initiatives	Leading local organisational accreditation initiatives to meet government commitments to the healthcare policy through quality and safety initiatives	Australian Commission on Safety and Quality in Health Care (ACSQHC) (2015b), Health Education England (HEE) (2015)
	Investing in graduates as inter-professionals and supporting followship as important to organisational growth	HWA (2012b)
Being the familiar support person available to counsel staff in relation to confidential issues, experiences and clinical needs		D'Addona, Pinto, Oliver, Turcotte, and Lavoie-Tremblay (2015)

Ensuring education on new products and technology		Wall (2006)
	Involved in the recruitment of new staff and retention of staff through performance appraisal and professional development support	Welding (2011)
Collaborating in clinically focused research		Sayers et al. (2011)

Thus, the role of the contemporary CNE encompasses many different domains within the clinical environment, where education and leadership intersect. Stanley (2014) suggested that the clinical leader does not need to be in a management position to lead and influence colleagues. Conway and Elwin (2007) described the CNE role as 'consistent with leading enhanced professional practice through education' (p. 193). Girard (2009) illuminated the CNE role as a leader in an evidence-based practice example, where flexibility and responsiveness to current education needs reduce hospital-acquired complications. McKinley (2008) asserted that the CNE is a leader because of their multifaceted and demanding role. In a review of the literature on the CNE role in relation to the current Australian healthcare policy, Sayers et al. (2011) viewed the CNE as 'well placed to assume a clinical leadership role' (p. 51) in the clinical environment. Ashton (2012) strongly presented the CNE as the appropriate clinical leader to move the nursing profession forward by leading, empowering and motivating the large numbers of active nurses in the workforce. However, despite this support of the CNE role and their actual and potential leadership, there is limited research examining the CNE's leadership role in the real world of continual change, consumer expectations and healthcare bureaucracy.

The CNE supernumerary role in the clinical setting also suffers from scrutiny in response to the financial constraints of healthcare organisations (Sayers et al., 2011) and is questioned regarding sustainability (Conway & Elwin, 2007). The CNE frequently experiences redeployment to primary patient care because of inadequate staffing, such as relieving in other nursing roles and undertaking work that is not part of the CNE role (Conway & Elwin, 2007). This leaves the planned and spontaneous education needs of nurses unmet (Conway & Elwin, 2007; Harris, Tornabeni, & Walters, 2006; Lambert & Glacken, 2005; Sayers, 2010; Sayers & DiGiacomo, 2010b; Sayers, Salamonson, et al., 2015) and creates the perception of the CNE role as relatively expendable, unprotected and vulnerable when financial savings can be made quickly by reallocating the role to

direct patient care and thereby reducing total nursing staff numbers (Aiken et al., 2014; Sprinks, 2015).

McKinley (2008) and Sayers et al. (2011) suggested that the CNE role is poorly defined and the occurrence of competing priorities, expectations and redeployment issues limit the advancement of nurse educational practice. An evaluation of the role in the UK by McCormack and Slater (2006) indicated that the diverse expectations placed on the role by GRNs, nursing staff, CNMs, nursing administration and the CNEs themselves contribute to the uncertainty of the CNE role function. These expectations also include differences in the amount, type and level of educational support required for new and experienced staff (Guy et al., 2011). Such expectations can become a source of conflict for the CNE, resulting in role dilemmas and frustration (McKinley, 2008). In Australia, Sayers (2012) noted that these concerns are 'adding to the confusion about the expectations and responsibilities of nurse educators' (p. 45) and lead to the ward-based CNE feeling devalued in the role.

The following section discusses the role and expectations of the CNE in the newly qualified GRNs' first year of practice.

2.3.5 CNE Role in the Graduate Programme

One specific area of leadership and CNE role responsibility is facilitating the graduate programme and overseeing newly qualified GRNs in the ward setting. A GRN has successfully completed an undergraduate or postgraduate entry to practice nursing degree, and meets the standards of education and clinical competence to register to practice with the NMBA (Government of Western Australia, 2015b). A graduate programme assists the newly qualified nurse to transition from novice to competent and confident practitioner in the nursing and/or midwifery workforce (Levett-Jones & Fitzgerald, 2005). This occurs through exposure to a variety of clinical settings, while being supported to consolidate theory, enhance clinical practice skills, strengthen judgement and improve time management (Government of Western Australia, 2015b; McKenna & Newton, 2008; O'Kane, 2012; Sayers, Lopez, et al., 2015).

In WA, a local hospital graduate programme generally consists of a 12-month competency-based preceptor-supported programme consisting of at least two rotations in a general or specialty clinical area (Jackson & Payne, 2014). Graduate coordinators

are generally nurse educators based either in the central training and development department of the hospital or in the ward, who have overarching responsibility for the programme (Missen, McKenna, & Beauchamp, 2015). The initial rotation includes a supernumerary orientation period, during which generic hospital orientation, graduate programme and ward orientation occurs. For the remainder of the rotation, the GRN learning and development is facilitated by the graduate coordinator and supervised by the CNE, with additional support by the ward preceptor(s). Subsequent rotation(s) may include a number of supernumerary days for orientation to the new clinical area and programme guidance, support and education by the CNE and preceptors (Henderson, Ossenberg, & Tyler, 2015). The content of the graduate programme consists of compulsory study days, tutorials, workshops and self-directed learning modules (Henderson et al., 2015; Missen et al., 2015; Rush, Adamack, Gordon, Lilly, & Janke, 2013). Ward-specific continuing education development sessions are run by the CNE, with nursing staff attendance expected when possible (Gallagher, 2007). Performance appraisals and regular meetings review progress to ensure goals and objectives are achieved and concerns are managed (Chandler, 2012). Collaboration may occur between the graduate nurse, graduate coordinator, CNE, CNM and (where necessary) an executive team member and human resources when GRN performance issues arise (Owens, 2013). Completion of the programme requires satisfactory clinical and behavioural performance throughout the 12-month programme, achievement and maintenance of competencies, and meeting the outcomes related to the job description of the GRN in the organisation and the standards for practice of the RN (Henderson et al., 2015; NMBA, 2016b).

The graduate year highlights the 'theory–practice gap' identified by Romyn et al. (2009) as a post-study lack of readiness to practice or inability to 'hit the ground running'. This gap affects the successful transition of the GRN from novice to competent nurse, meeting the organisational expectations and criteria of the role of RN (Romyn et al., 2009). There is an identified need for a formal partnership in the clinical environment that can encourage and inspire GRNs to consolidate theory in practice that is flexible and spontaneous, as well as planned to maximise opportunities and purposeful learning (ACSQHC, 2011b; HEE, 2015; Henderson et al., 2011; Willis Commission, 2012). To understand the unique role of the CNE in relation to patient outcomes, this literature review focuses on the CNE role in the graduate programme supporting the GRN from

novice to competent and confident practitioner (Hussein et al., 2015; Missen, McKenna, & Beauchamp, 2014b; Oates, 2012). The GRN in the graduate year is the lens through which patient outcomes can be explored in relation to the CNEs' presence and influence on the GRNs' clinical confidence, competence and safe and quality patient care.

2.3.5.1 Transition to Practice

The graduate transition period is portrayed in the literature as ranging from satisfying and fulfilling to stressful, overwhelming and traumatic (Cheng, Liou, Tsai, & Chang, 2014; Morales, 2014; Nash, Lemcke, & Sacre, 2009; Romyn et al., 2009). Many GRNs find this transition—the period of change and shift in culture from student to graduate role—a time of valuable experiences, and acknowledge the positive contribution of all nursing staff in their professional development (D'Addona et al., 2015). However, many GRNs find this transition challenging and difficult. Romyn et al. (2009) described this period as the disconnection between theory and practice, and aspiration and reality. Kramer (1974) studied the reactions of trainee nurses who spent time preparing for the RN role in the educational setting, and subsequently found themselves unready for the clinical environment pressures. Kramer expressed this as 'transition shock'. Transition shock is built on the theory of transition, reality shock and cultural shock, and embraces the theories related to professional role adaptions and development (Kramer, 1974). Duchscher (2009) further explained the transition shock model and proposed a conceptual framework consisting of emotional, physical, intellectual and socio-developmental elements related to relationships, responsibilities, roles and knowledge. Simply, GRNs become aware of the discrepancy between their prior perceptions and aspirations of the role of the professional RN and the reality of their actual graduate role in the clinical environment (Missen, McKenna, & Beauchamp, 2014a; Missen et al., 2014b; Parker, Giles, Lantry, & McMillan, 2014; Romyn et al., 2009).

Lord Willis—the UK author of the *Shape of Caring* (a review of future education and training of RNs and care assistants) (HEE, 2015)—stated that the newly qualified nurse is 'not the finished product—investment in the development of all registered nurses throughout their career is important to ensure safe and quality care, to retain high-calibre staff and to educate the future workforce' (p. 50). To help future-proof the nursing profession and manage the predicted nursing shortage (HWA, 2012a), the CNE is an important and necessary factor in promoting the vulnerable GRNs' clinical

confidence and competence during the first year of clinical practice in the acute care setting (Baumberger-Henry, 2012; HEE, 2015; Oates, 2012).

2.3.5.2 The Clinical Environment

The inpatient clinical environment is described in the literature as an entity that is constantly changing, unpredictable and affected by adverse variables that influence the GRNs' learning (Berkow, Virkstis, Stewart, & Conway, 2009; Koontz, Mallory, Burns, & Chapman, 2010; Romyn et al., 2009). These variables are identified as nurse supply issues, skill mix discrepancies, heavy workloads (Daly, Clark, Lancaster, Orchard, & Bednash, 2008), increasing patient acuity and complex conditions, rapid advancement of technology (Covell, 2009; Linsley, Kane, McKinnon, Spencer, & Simpson, 2008), high patient and organisational expectations (Salminen et al., 2010) and the overarching financial constraints of healthcare (Girot & Albarran, 2012). These variables create a workplace culture that affects the GRNs' continual learning and ability to provide safe and quality patient care. When patient care demands take priority over planned or spontaneous time, intensive learning and knowledge and skill development do not occur, and patient safety may be compromised (Lambert & Glacken, 2005). However, the presence of the CNE in the workplace—in partnership with graduate coordinators and preceptors—can provide an antidote to the challenges experienced during this year of adjustment, transition and socialisation, and can support the successful completion of the graduate programme (ACN, 2015; Ashton, 2012; Kramer & Schmalenberg, 2008; Phillips et al., 2014b; Swearingen, 2009).

For GRNs to practice effective learning during transition, a healthy work environment is essential. This favours positive role modelling, relevant educational approaches, individual and collective learning assistance, a variety of resources and a level of comfort (Germain & Cummings, 2010; Price, 2004; Wolak, Klish, Smith, & Cairns, 2006). In the study by Chandler (2012), GRNs attributed their autonomy and accountability progress to friendly, proactive staff, preceptors and peers who were there for them, did not view any question as senseless, and nurtured and encouraged their knowledge development. The preceptor provides the daily motivation necessary to positively progress the GRNs in areas such as clinical decision making, delegation and time-management skills (Cleary, Horsfall, Muthulakshmi, Happell, & Hunt, 2013; Freeling & Parker, 2015). However, not all preceptors are deeply invested in the GRNs'

progress, with difficulties surrounding rostering and insufficient time related to practical teaching preparation and managing allocated patient workload (Lambert & Glacken, 2005). There is often insufficient preceptor training for nurses, which results in a lack of clarity around the preceptor role (Henderson & Eaton, 2013; Lambert & Glacken, 2005). Grochow (2008) noted that the 'sink or swim' mentality of many preceptors leads to GRNs' failure to progress and may compromise patient safety. Henderson et al. (2015) noted that, in times outside normal working hours, the GRNs often had new challenging experiences and identified the lack of a supernumerary resource person as a particular issue. Nonetheless, it is clear that the presence of the CNE in the clinical setting positively reinforces and empowers the GRNs' patient care values, encourages socialisation and provides oversight of the preceptors to improve the likelihood of successful assimilation into the clinical environment (Germain & Cummings, 2010; IOM, 2010; Wangensteen, Johansson, & Nordstrom, 2008).

2.3.5.3 Practice Readiness

Newly qualified GRNs are novices, yet many nurse managers and organisations expect them to perform at experienced nurse levels (Johnstone & Kanitsaki, 2008; Parker et al., 2014). Many GRNs are expected to 'hit the ground running', without any time to consolidate their previous learning, which results in the perceived gap between theory and practice (Morrow, 2009; Romyn et al., 2009). The most realistic expectation for the first year of nursing is for the graduate to become an advanced beginner—that is, demonstrating a minimum acceptable performance related to gaining experience in actual situations, and showing evidence of developing knowledge and skill, yet still requiring support and cues.

The time required to gain confidence, gain experience and meet expectations is a concern not only for graduate coordinators, CNEs and CNMs, but also for employing organisations and national health systems, who need to counter the effect of the regular numbers of newly qualified nurses entering the workforce (Berkow et al., 2009; Romyn et al., 2009). In a typical organisation in the US, the number of new GRNs can be more than 10% of all nursing staff (Berkow et al., 2009). This presents a significant challenge and concern for organisations where there may be a reliance on inexperienced staff joining the current demographic of an ageing nursing workforce (Berkow et al., 2009; Buerhaus, DesRoches, Donelan, & Hess, 2009). However, in Australia, the AHPRA

(2014/2015) report for 2014/2015 indicated that new registrations only comprised 2.6% of the total registrations. Despite the lower percentage of new nurses, there are a limited number of graduate programme places available in the health service. Numbers are dictated by the availability of full-time equivalent hours and designated support (Government of Western Australia, 2015b). Regardless of the variable numbers of new GRNs in the workplace worldwide, the practice readiness of new nurses affects the nursing team, patient workload and continuity of care; thus, patient outcomes may be significantly affected (Duffield et al., 2011).

2.3.5.4 Socialisation

It takes at least a six-month period of socialisation for GRNs to develop confidence and independently apply their knowledge from undergraduate study to practice (Benner, 1984; Cowin & Hengstberger-Sims, 2006). Rush et al. (2013) suggested that the first six to nine months is the most stressful time of transition, while Chandler (2012) found that, after nine months, there is an increase in confidence, competence and decision-making ability. To prevent stress from unrealistic views of nursing practice during transition, GRNs need to achieve a degree of connection—described as feeling secure or confident to ask any question without feeling or appearing foolish with their new colleagues (Hussein et al., 2015; Malouf & West, 2011). The literature has described the less-than-supportive attitudes of some nursing staff towards graduates (Pellico, Brewer, & Kovner, 2009; Teoh, Pua, & Chan, 2013). This can occur to the extent that treatment can be described as being unfriendly and aggressive, to displaying bullying and discrimination (Clark & Springer, 2012; Laschinger, Grau, Finegan, & Wilk, 2010; Parker et al., 2014; Phillips et al., 2014b). Similarly, the phrase 'nurses eat their young' is a popular expression and highlights the incivility experienced by some new nurses when exposed to a culture for which they are unprepared (Baumberger-Henry, 2012; Douglas, 2014; Hippeli, 2009). When GRNs experience positive reinforcement and feel included as a team member, they are more likely to adjust to the clinical environment and have positive patient outcomes (Chandler, 2012; Phillips, Esterman, Smith, & Kenny, 2013; Rush et al., 2013; Wangensteen et al., 2008).

The CNE is part of the solution for enhancing GRN socialisation. Strategies used by the CNE include practical approaches underpinned by a philosophy based on passion for teaching and engagement (Spurr, Bally, & Ferguson, 2010), consistent positive

affirmation (Chandler, 2012), and regular debrief and stress management (Missen et al., 2014a). These strategies improve the process of transition, boost retention rates and help GRNs manage and survive the pressures of the clinical environment (Dyess & Sherman, 2009; Rush et al., 2013). Such resourceful practices also support the activation and adoption of the full expectations and responsibilities of the professional RN role during the GRNs' first year of practice (Parker et al., 2014; Wu, Fox, Stokes, & Adam, 2012).

2.3.5.5 Graduate Retention

A recent Australian study by Parker et al. (2014) on graduate retention found that 10% of newly graduated nurses intended to pursue a career outside of nursing, and 32% were unsure how long they would stay in nursing. Some GRNs who had difficulty adjusting to the clinical environment decided to leave nursing and subsequently did not complete their graduate year (Cowin & Hengstberger-Sims, 2006). Their reasons for leaving included the absence of expected support, stress related to patient safety and care, responsibility overload and the emotional effect of poor treatment by other nursing staff (Chandler, 2012; Parker et al., 2014; Phillips et al., 2014b). Similarly, a national study in the US by Pellico et al. (2009) reported that 37% of newly licensed RNs indicated that they were ready to change career path. Parker et al. (2014) considered the designated CNEs' ward-based clinical support role as pivotal in aiding graduates' transition to professional practice and retention. In their study of new graduates (*n* = 282), 71% indicated reliance on the CNE, compared with 63% relying on mentors or preceptors. This comparison of the preceptors at the point of care who carry a full patient load highlights the need for additional clinical support. Owens (2013) described the supernumerary CNE as the accessible, available and consistent resource person to address discrepancies in the theory–practice gap and promote long-term graduate retention.

Patient safety and quality of care is an overriding concern for all nurses, including GRNs. The next section links clinical incidents occurring as a result of healthcare to GRNs' quality of patient care and the support of the CNE.

2.3.5.6 Clinical Incidents

The AIHW (2015) defines clinical incidents as harm to a person as a result of receiving healthcare. The Government of Western Australia (2015a, p. iii) further explains clinical

incidents as 'an event or circumstance resulting from healthcare which could have, or did lead to unintended and/or unnecessary harm to a patient/consumer'. Clinical incidents (also known as adverse events) include two categories:

1. 'near miss'—an event that did not cause harm due to chance or timely intervention
2. 'sentinel event'—an occurrence involving death, serious physical or psychological risk, or injury (Government of Western Australia, 2015a; WHO, 2015).

The effective management of clinical incidents includes the prevention and reduction in patient harm by hazard identification, interventions to minimise harm, and education on preventative actions (Government of Western Australia, 2015a). It is the responsibility of all healthcare staff, including GRNs and CNEs, to report and participate in investigations, be active in implementing and evaluating recommendations, provide feedback, access education and share lessons learned (Vincent, 2007; WHO, 2015). When a patient error occurs or is discovered by the GRN or CNE, the immediate action is to provide the patient with appropriate treatment, followed by notifying the shift coordinator and CNM. It is the responsibility of the nurse involved to complete the online incident report and, with the nursing team, identify and manage any additional actions that are required at the time to reduce the risk of the same or a similar incident (Knight, 2004; WHO, 2011). The voluntary and confidential incident reporting systems are universally accepted by all healthcare personnel as necessary for identifying hazards for the organisation (Agency for Healthcare Research & Quality, 2016). The statistics of adverse events occurring in Australian hospitals are concerning. In 2013 to 2014, statistics indicated that 5.6% of patients discharged from hospital reported a diagnosis or clinical description that indicated an adverse event had occurred during their hospital stay (AIHW, 2015). Thus, the GRN—as one of the healthcare professionals who spend the most time at the patient's bedside—has a significant influence over patient experiences and outcomes (ACN, 2015; WHO, 2015).

In focusing on the GRNs' safety and quality of patient care, the literature provides many examples. An integrative review by Saintsing, Gibson, and Pennington (2011) described newly qualified GRNs as being at risk of errors in medication administration, delaying ordered treatment, patient falls and critical thinking issues related to real or perceived

time constraints. A study by Berkow et al. (2009) suggested that new GRNs are at greater risk of making these errors than experienced nurses; however, human error theorists suggest that errors are not related to inexperience, but to the conditions of the clinical environment (Reason, 2000, 2001). Other authors have suggested that errors are more likely to occur due to a combination of graduate inexperience and difficult clinical conditions, such as increasing technological advancement, high patient acuity, low staffing levels and shorter lengths of stay (Clark & Springer, 2012; McBride-Henry & Foureur, 2006).

The ACN (2015) recommends a high level of support and accessible resources as necessary to self-report and prevent patient errors. It is recommended that graduate programmes concentrate on and engage GRNs in understanding and improving attitudes to quality initiatives, while also focusing on error prevention strategies and educational support in the clinical environment (Saintsing et al., 2011; Unver, Tastan, & Akbayrak, 2012; Wilkinson, Powell, & Davies, 2011). The CNM facilitates, empowers and assists GRNs by ensuring CNEs and preceptors are available to guide implementation of quality improvements, and reduction and elimination of unsafe practice (Brennan & Flynn, 2013). Duffield et al. (2007) examined the predictors of patient outcomes, and confirmed the presence of the CNE on the ward as one of the factors that lowered nurses' medication errors. Education and learning positively affect GRNs' capacity for medication safety; thus, there is a need for an available, visible CNE as the resource nurse to support and maintain the medication competence, skills and knowledge necessary for patient safety (Sahay, Hutchinson, & East, 2015). In a study by Bowcutt, Wall, and Goolsby (2006), the ward-based clinical leader (a variant of the CNE role) was instrumental in supporting GRNs to identify and improve patient pain management, and thereby provide holistic and timely care with positive outcomes on discharge. Romyn et al. (2009) concluded that protected supernumerary time for CNEs to champion GRNs is a necessary strategy for safe patient care. However, Pollard et al. (2007) noted that the relationship between the quality of patient care and the CNE has been 'largely unexplored' (p. 320). Sayers et al. (2011) suggested that further study is necessary to understand the influence of the CNE on attaining safe and positive patient outcomes.

2.4 Chapter Summary

This chapter has reviewed and critiqued the literature on the CNE role, CNE leadership and association between the CNE and GRN. The CNE has a highly developed understanding of the adverse variables affecting the current clinical environment, where the new normal is a fast-paced, economically challenged, culturally diverse and unpredictable world. In contrast, the new graduate nurse may be idealistic and suffer from a lack of practice readiness, where transition to professional nurse remains problematic. Of critical importance to GRNs is the development of confidence, competence and capabilities for safe and quality patient care, and their subsequent retention to become a permanent organisation employee.

It is unclear whether the CNE role has a measureable effect on GRNs' clinical confidence, and subsequently on quality and safe patient outcomes within healthcare organisations. Thus, further research is required to consider, determine and evaluate the CNE role and influence on nurses in the acute care hospital environment. In the following Chapter 3, the research context and methodological approach will be described.

Chapter 3: Methodology

3.1 Introduction

The previous chapter reviewed the literature on the CNE's clinical, educational and leadership role, and assessed the knowledge, skills and attitudes essential to guide and support the professional development of nurses. In their first year of nursing, newly qualified GRNs have identified specific support needs for their successful transition from novices to capable practitioners, with the subsequent evolution of confidence and competence in the provision of safe patient care.

Directly measuring the effect of the CNE role on patients' safe and quality care is problematic because of the complexity of CNEs' contemporary scope in healthcare organisations. An innovative solution to this difficulty is the use of the GRN cohort as the lens through which the effect of the CNE role and clinical leadership can be evaluated. This chapter describes and discusses the research context and researcher's methodological approach to this study.

3.2 Research Justification

3.2.1 Research Aim

The aim of the study was to explore and generate new knowledge and ideas about the influence of the role of the supernumerary CNE in the context of safe and quality patient outcomes in the acute care hospital setting. The CNE role was profiled in relation to clinical education and current scope, with a focus on the specific role support given to newly qualified GRNs in their first year of nursing.

3.2.2 Research Objective

It is unclear whether the CNE role has a measureable effect on GRNs' clinical confidence and safe patient outcomes in healthcare organisations. This research was formulated to describe and evaluate the CNE role for potential or actual leadership, and to determine its influence on newly qualified nurses' clinical confidence and subsequent patient safety and quality of care in the acute care hospital environment.

3.2.3 Research Purpose and Rationale

The research study purpose was to generate a richer, deeper understanding of the influence of the CNE role in relation to GRNs' safe and quality patient care and transition to competent and confident practitioners. The rationale for combining quantitative (the process of measurement converted to numerical data) and qualitative (the process of gathered information based on words) research approaches was to answer the research questions using the most appropriate method to corroborate, integrate and optimise findings (Collins, Onwuegbuzie, & Sutton, 2006; Greene, Caracelli, & Graham, 1989). This methodology will be explored in further detail as it applies to this study.

3.3 Philosophical and Theoretical Foundations

Creswell and Plano Clark (2011) identified the following four levels required for developing a research study: worldview, theoretical lens, methodological approach and methods of data collection. This section defines and describes these four levels historically, in relation to general research and specifically in relation to this research study (see Figure 3.1). The research design is explained through the philosophical assumptions that support the research, the use of role theory and leadership theory as the theoretical lens, the related strategy of enquiry, and an outline of the specific methods that were used to translate the research from theory to practice.
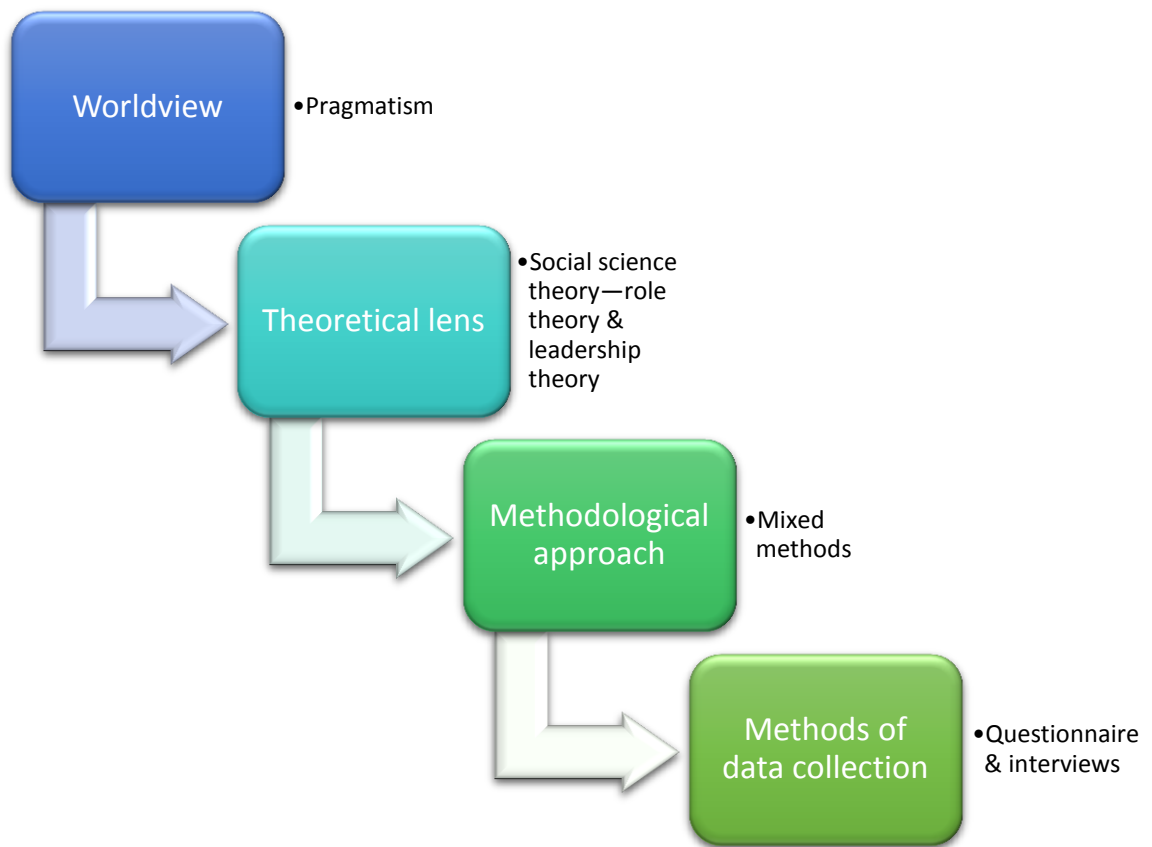
Figure 3.1: Four Levels of the Study

3.3.1 Worldview

Worldview is defined as a particular philosophy of life or conception of the world (Creswell, 2014). It is also expressed as 'providing a way of thinking about, researching and understanding the social world' (Tadajewski, 2011, p. 177). Kuhn (1970) noted that worldviews vary and change over time, with dominant forms emerging and replacing the former. Creswell and Plano Clark (2011) suggested that, when designing and conducting research, communication of philosophical assumptions requires 'acknowledging the worldview(s) thereby providing the foundation for the study, describing the elements of the worldview, and relating these elements to specific procedures in a research project' (p. 38), such as the nature of the phenomena under study, the way the study is conducted, and the optimal study design and methods chosen to answer the research questions (Parahoo, 2014).

Four philosophical worldviews—postpositive, constructivist, participatory and pragmatist—are considered by Creswell and Plano Clark (2011) as useful for conducting research, where each view has a different perspective on a range of common elements. The postpositive worldview's basic characteristics are commonly aligned with approaches that relate to measuring quantity, focusing on fundamental elements, using observation or experiment, and continual testing and confirmation. The constructivist worldview's basic characteristics are aligned with participant understanding through social and historical interaction. The participatory worldview's characteristics are influenced by a political position related to improving society by collectively working to address issues through change (mainly qualitative strategies). The pragmatist worldview's characteristics are related to the consequences of actions— a focus on the problem being studied using a mix of data collection processes to achieve the research outcomes (quantitative and qualitative strategies or mixed-methods research).

For this research, pragmatism was the worldview—and thus the philosophical assumption—chosen to underpin this mixed-methods study and to link the theory and practical characteristics of the research. Pragmatism concentrates on the 'what' and 'how' of the research enquiry, places the research question central to the study, and chooses a method central to answering the research question (Punch & Oancea, 2014). The characteristics of pragmatism that were relevant and attractive to the researcher broadly related to the CNE role diversity and situational consequences of patient outcomes in real-world nursing practice, as illustrated in Figure 3.2 (Denzin, 2012). The specific elements used to provide the best understanding of the CNE role specifically related to GRNs were multiple participant perspectives; a variety of methods, techniques and procedures; and deductive (quantitative) and inductive (qualitative) approaches for data collection and analysis (Creswell, 2014). The pragmatic approach in this mixed-methods study combined the reliability of empirical counts and the credibility of lived experience, while embracing the researcher's expertise, experience and insight into the CNE role.

Purpose of research	Facilitate problem solving	Change in practice
To investigate solutions to the real-world problem of safe and quality patient outcomes in the nursing context	Research knowledge of CNE role specifically related to the GRNs' first-year transition to practice	Inform institutional and organisational nursing policy, practice and education

Figure 3.2: Application of Pragmatism to the Study

3.3.2 Theoretical Lens

The theoretical lens functions at a more focused perspective than the broader worldview, and provided direction for the phases (each of the distinct periods) in the process of research in the project. Of the types of theories that inform a mixed-methods study, a social sciences theory was considered the best fit. Social science—the study of human society and social relationships—guides the examination of society behaviour, development and change, power and social structure, gender, culture, revolutions and ideals (Harrington, 2005). Modern social theory focuses on themes such as the relationship between individuals and society, and the structure of organisations and roles relative to social change (Elliot, 2014). The history and current study of role theory and leadership theory—as discussed in greater detail in the literature review in Chapter 2—are used in this study as frameworks to explore the role of the supernumerary CNE in relation to first-year GRNs' safety and quality of patient care and clinical confidence.

3.3.2.1 Role Theory

Nursing roles are significant elements in healthcare organisations by virtue of the size and effect of the nursing workforce. This begins with the student nurse role in the

undergraduate years, followed by the first-year graduate and beyond (Marquis & Huston, 2012). Nursing roles at the frontline of patient care have a greater focus on patient safety and quality of care (ACN, 2015; Daly et al., 2004; Stanley, 2006d; Wolf, 2015). These roles are defined by clinical education, RN standards for practice, and the healthcare mandatory requirements and policies (ACSQHC, 2015b; NMBA, 2015). Schuler, Aldag, and Brief (1977) suggested the use of role theory as a conceptual framework to explain the perceptions of individuals within larger organisations in relation to identity and engagement. In a similar manner, a project by Brookes et al. (2007) reviewed the literature around role theory at the beginning of their study to inform and explore community nurses' perceptions of their role-related professional issues. A qualitative study by Hercelinskyj et al. (2014) used role theory as the scaffold to explore perceptions of mental health nurses on professional identity related to role changes over two decades.

This study selected role theory as the framework for a new way of thinking about the role of the supernumerary CNE in the acute hospital setting—specifically, the role related to GRNs' first year of nursing in the context of clinical confidence and safe and quality patient outcomes. The rationale for using role theory to explain the CNE role and social interactions with the GRN included the following:

- CNEs work in a dynamic healthcare social and clinical environment
- interactions occur at individual and organisational levels
- the CNEs' identity is linked to their values and beliefs and to role expectations in the organisation (Sayers, 2013) (see Figure 3.3).

Figure 3.3: CNE Role Interactions in Healthcare

Role theory is a way of understanding the communication and behaviour of individual nurses in the healthcare organisation. The CNE responsibilities in providing and supporting nurses' CPD are varied and complex, with an increasingly significant focus on patient safety and quality of care (ACN, 2015; Daly et al., 2004; Stanley, 2006d; Wolf, 2015). CNEs work and define their role in the context of their clinical specialty, the needs of the staff as directed by mandatory requirements, and organisational vision and values.

3.3.2.2 Leadership Theory

Leadership theory is useful to describe and explain leadership in healthcare organisations and specifically relates to the beliefs, values and intentions of the workforce and the reality of the dynamic clinical environment (Marquis & Huston, 2012). The diversity and culture of healthcare organisations influences the leadership styles adopted (Kumar, 2010). The behavioural theory of leadership describes styles focused on individual attributes and behaviours related to perceptions, educational level and life experiences. This theory is popular in healthcare, with transformational,

authentic and servant leadership featuring in the literature (Drenkard, 2012; Robinson, 2009; Smith, 2011). The chosen leadership framework for this study is a more recent style known as congruent leadership. Stanley's five research studies—as detailed in Chapter 2—explored the attributes of clinical leaders in healthcare in the UK and Australia, and led to the development of the congruent leadership theory (Stanley, 2005, 2011). Stanley (2014) determined that clinical leaders in nursing are followed because their actions are matched (or congruent) to their values and beliefs. Followers identify with their concern, compassion, ability to communicate effectively, and ability to invest in relationships without the need for a formal position of leadership in the organisation (Stanley, 2008).

This study's rationale for choosing congruent leadership theory to explain the CNE leadership in a healthcare organisation included the following:

- CNEs' clinical educational focus and commitment to patient safety and quality of care
- CNEs' relationship with GRNs through the graduate programme
- CNEs' role in the healthcare organisation.

The congruent leadership theory was chosen as the framework to explore the actual and potential leadership of the CNE, specifically relating to GRNs' first year of nursing. Figure 3.4 depicts the focus areas of the actual or potential leadership role of the CNE.
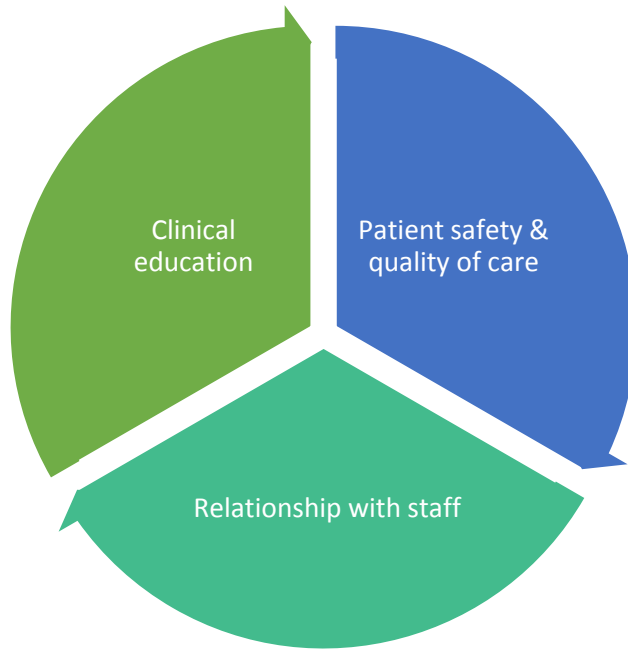
Figure 3.4: CNE Focus Areas

3.3.3 Mixed-methods Research

Mixed-methods research is defined as the combination of quantitative and qualitative research to answer a research question (Flick, Garms-Homolová, Herrmann, Kuck, & Röhnsch, 2012). Mixed-methods research is further described in relation to the combination of elements of quantitative and qualitative research approaches, such as philosophy, data collection, analysis and interpretation (Creswell & Plano Clark, 2011; Flick et al., 2012). Historically, given their roots in the pragmatic evaluation research field, mixed-methods designs usually combined at least one quantitative and/or one qualitative method without a fundamental link to a worldview (Greene et al., 1989). Later designs mixed phases, which included worldviews, stances, understandings and analysis of results (Creswell & Plano Clark, 2011). More recent discussion on what is increasingly referred to as the 'third methodological approach' to research emphasises core characteristics, rather than a specific definition, in order to express diverse viewpoints related to data collection and analysis (Greene, 2007; Johnson, Onwuegbuzie, & Turner, 2007; Parahoo, 2014; Punch & Oancea, 2014; Tashakkori & Creswell, 2007).

The principles of mixed-methods research are illustrated by the following: (i) combining quantitative and qualitative research strengths; (ii) compensating each

method's weakness while embracing complementary similarities; (iii) the logic of approaches with the acceptance of multiple paradigms; and (iv) the rise of pragmatism (Punch & Oancea, 2014). This method of enquiry is based on assumptions about the nature of the reality being studied, which are known by the term 'paradigm'. A paradigm is described by Punch and Oancea (2014) as 'a set of assumptions about the world, and about what constitutes proper techniques and topics for inquiring into that world' (p. 16). An understanding of paradigms related to research enquiry is necessary to illustrate the connection of methods to their philosophical and theoretical foundations. Therefore, to understand the application of mixed methods in a research study, the researcher must appreciate the foundations of the quantitative and qualitative research paradigms (Borbasi, Jackson, & Langford, 2015).

3.3.3.1 Quantitative

Quantitative research is a process characterised by a systematic, logical and objective approach to the collection and analysis of data (Borbasi et al., 2015). The researcher studies a large sample, and then data are measured by an instrument and converted to numerical data to produce statistical trends (Rebar, Gersch, MacNee, & McCabe, 2011; Topping, 2010). The quantitative researcher uses the process of reason to reach a firm conclusion that can be generalised to larger populations, with a focus on describing, exploring, explaining or predicting conditions that are measureable (Borbasi et al., 2015; Parahoo, 2014).

Quantitative research begins with a hypothesis (a possible explanation based on limited evidence) or a question (an answerable enquiry into a specific interest or concern) (Polit & Beck, 2014). The process is structured, pursues objectivity and produces results that are unambiguous and easily interpreted (Borbasi et al., 2015). The aim of the quantitative researcher is to restrict the variables not being studied, minimise bias and present results that are valid (to the extent to which the instrument measures what it claims to measure) and reliable (consistency over time and within the instrument itself) (Punch & Oancea, 2014; Topping, 2010). A limitation of this study approach includes the inability to measure complex issues with large numbers of elements and concepts that are not able to be measured numerically (Borbasi et al., 2015).

The quantitative research design is further divided based on the quantity of manipulation, control or randomisation involved in a study (Borbasi et al., 2015; Wolfer, 2007):

- The experimental group includes manipulating one concept under study in order to see how this will change or affect another concept under study. The three characteristics of experimental designs are randomisation, the use of an experiment and control group, and the involvement of pre- and post-tests.
- The non-experimental group is less formal and does not include manipulation or randomisation. The concepts are studied in their natural environment.
- The quasi-experimental group is similar to experimental design, but uses a criterion other than the element of randomisation. This is a useful alternative when an experimental design is not feasible, and implementation time is unreasonable or not ethically viable.

The presentation of information through numerical data is supported and explained through using descriptive statistics. Statistics are used to describe and summarise the data from the sample (Polit & Beck, 2014). These procedures enable researchers to organise, interpret and display numerical data in the form of tables, charts and graphs that provide a visual way to identify similarities and differences, and highlight characteristics and tendencies (Polit & Beck, 2014; Punch & Oancea, 2014; Wolfer, 2007). Tables also allow large quantities of statistical data to be displayed in a compact space and can highlight the frequency distribution, central tendency and variability (Polit & Beck, 2014).

Quantitative research may be pure (establishing knowledge or theories) or applied (practical and useful to identify and solve problems) (Borbasi et al., 2015). Applied research links closely with nursing research, which highlights measurement consistent with nursing practice, where the goal is patient safety and quality of care in clinical practice (Parahoo, 2014). In this study, the quantitative data were obtained using a non-experimental group in an online questionnaire with closed-ended questions, and from demographic data attained from interviews. These data were reported using descriptive statistics. This enabled the researcher to arrange, interpret and communicate numeric information pertinent to the study. In nursing research, quantitative data—presented in

the form of tables and figures—are useful to facilitate and inform nursing policy, practice and education (Parahoo, 2014).

3.3.3.2 Qualitative

Qualitative research is a subjective process characterised by multiple data collection procedures that involve the researcher in studying smaller samples of people and their experiences (Borbasi et al., 2015; Rebar et al., 2011). The results of qualitative research are presented in a variety of flexible approaches that examine lives, stories, experiences, behaviours, relationships, cultures and communications, both individually and within organisations, for the purpose of producing rich descriptive data (Borbasi et al., 2015; Parahoo, 2014). The researcher is interactive in seeking to explore the holistic, deep and complex nature of the phenomena under study in a particular context; thus, qualitative data are not considered transferable to other settings (Borbasi et al., 2015; Parahoo, 2014; Topping, 2010). Rigour in qualitative research is reflected in the consistency of data analysis and interpretation, trustworthiness of the data collected, and credibility or confidence in the truth of the data (Rebar et al., 2011).

Classification of qualitative research includes theoretical perspectives and research designs that are clearly identified at the beginning of a study (Borbasi et al., 2015). The inductive approach is reflected in the process of selecting setting, samples, data collection and analysis methods (Parahoo, 2014). Thematic data analysis is described in relation to data immersion and management techniques, and the results are compared, are contrasted, and have their similarities and differences highlighted (Borbasi et al., 2015; Braun & Clarke, 2012).

In this study, thematic analysis was used to determine the similarities and differences in the data from the three different subgroups. Braun and Clarke (2012) suggested thematic analysis as a method for 'identifying, analysing and reporting patterns (themes) within data'. This flexible framework is characterised by dynamic choices in the analysis and reporting phases to describe the data in rich detail (Braun & Clarke, 2006, 2012). The qualitative research in this study sought to understand nursing behaviours, experiences, perceptions, intentions and motivations (Parahoo, 2014). In this manner, thematic analysis assisted the researcher to reflect and understand the

reality by using a process of consistent clarification and generation of themes (Braun & Clarke, 2012).

3.3.3.3 Application of Mixed-methods Research

The researcher required skills to execute the mixed-methods research appropriately (Borbasi et al., 2015). A familiarity of the terms used to describe mixed-methods research and designs was necessary, alongside an understanding of the historical changes related to stances and designs (Creswell & Plano Clark, 2011). Johnson et al. (2007) suggested that combining quantitative and qualitative approaches is 'for the purposes of breadth and depth of understanding and corroboration' (p. 123). The focus on dimensions of timing, priority and mixing related to variations, strengths and challenges illustrates different perspectives and qualities, and provides greater depth and rigour (Borbasi et al., 2015; Creswell & Plano Clark, 2011; Flick et al., 2012; Parahoo, 2014; Punch & Oancea, 2014). Reflection—a necessary skill in nursing and other disciplines—is also a requirement of the mixed-methods design process, where the steps ahead are considered in light of their relationship to the previous steps (Brannen & Moss, 2012).

Planning is a vital element of conducting mixed-methods research. The project requires a purpose and focus, with clear identification of timing requirements related to samples, data collection, analysis and ethical considerations (Bell & Waters, 2014). It is also necessary to clearly describe the rationale for the mixed-methods study. Greene et al. (1989, p. 115) listed the reasons for employing a mixed-methods approach as follows:

- triangulation—seeking convergence and corroboration of results from different methods studying the same phenomenon
- complimentary—seeking elaboration and enhancement of the results from one method with the results from the other method
- development—using the results from one method to help inform the other method
- initiation—discovering paradoxes and contradictions that lead to a reframing of the research question
- expansion—seeking to expand the breadth and range of enquiry by using different methods for different enquiry components.

The rationale for the current study's mixed-methods approach included the following:

- triangulation—to merge and confirm the results from the online questionnaire and interviews in order to explore and generate new knowledge and ideas about the role of the supernumerary CNE in the context of safe and quality patient outcomes in the acute care hospital setting

- complimentary—to expand on the interview data with the questionnaire data to generate a richer, deeper understanding of the effect of the CNE role, specifically related to GRNs' safety and quality of patient care and transition to competent and confident practitioners

- initiation—to ascertain new knowledge and ideas about the influence of the CNE in relation to GRNs' first year of nursing

- expansion—to develop an understanding of the presence or absence of a link between the CNE role and GRNs' safety and quality of patient care using quantitative methods for a larger number of participants.

Prior to choosing a mixed-methods design for this study, the typology-based and dynamic approaches were considered. The typology-based approach selects and adapts useful classifications of mixed-methods designs to a study's purpose and questions (Creswell & Plano Clark, 2011). These major mixed-methods designs are the most commonly used in practice, and provide the researcher with the framework to execute the study and ensure the rigour and quality required (Creswell & Plano Clark, 2011). The six typology-based design options are known as the convergent parallel design, explanatory sequential design, exploratory sequential design, embedded design, transformative design and multiphase design. A positive influence on the choice of design was the significant emphasis in literature around the typology-based approach in nursing and education disciplines and social and behavioural research. As explained by Creswell and Plano Clark (2011), the dynamic approach has merit based on the blend of structure and flexibility. However, this type of design is associated with a variety of different elements and is suggested by Creswell and Plano Clark (2011) as an option for more experienced mixed-method researchers.

Further consideration of the design was centred on the way the quantitative and qualitative phases (the process of asking the question, collecting and analysing data, and interpreting the results) related to each other (Teddlie & Tashakkori, 2009). This

required evaluating the level of interaction between the phases, relative priority and timing of the phases, and procedures for mixing the quantitative and qualitative phases (Onwuegbuzie & Collins, 2007). The decision was made to adopt the typology-based approach, which would provide the features and framework necessary to guide the researcher to integrate the quantitative and qualitative data and address the research question. For this study, the convergent parallel design was chosen as the best fit to address the research goal, objectives, purpose and questions, and as being best suited to the timing and priority of the data collection and analysis (see Figure 3.5).
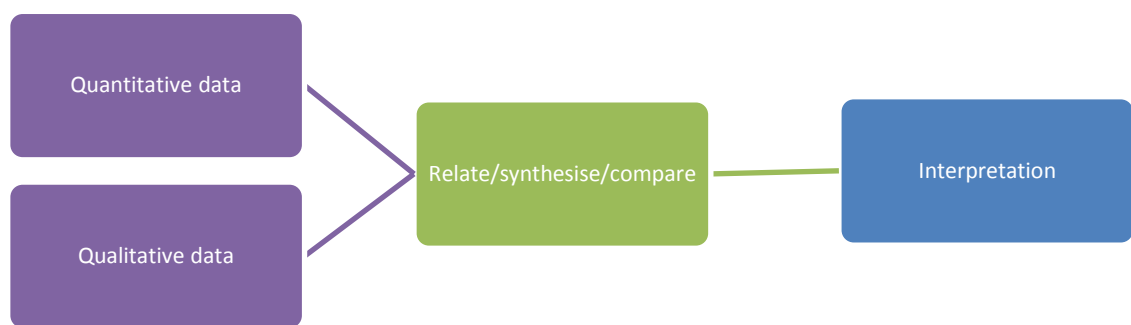
Figure 3.5: Convergent Parallel Design

3.3.3.4 Convergent Parallel Design

In this study's convergent parallel design, the interaction between the phases was independent, whereby the phases remained separate. The quantitative and qualitative methods had equal priority, timing was concurrent (occurred during a single phase) and the data were merged after separate analysis with further comparisons during the overall interpretation (integrative) stage.

The purpose of this study was to collect different yet complementary data on the same topic, which brought together the characteristic strengths and weaknesses inherent to each approach (Creswell & Plano Clark, 2011). Patton (1990) suggested that quantitative data provide a large sample, direction and generalisation, while qualitative data provide a small sample, depth and detail. Creswell and Plano Clark (2011) described collecting separate yet complementary data concurrently on the same topic, with comparing, contrasting, illustrating and synthesising quantitative statistical results and qualitative findings to provide a more complete understanding of the phenomenon. This mixing of data guided the researcher to determine whether ideas, viewpoints or

perspectives had a tendency to be similar or different, or whether a combination of both occurred. The data in this study are represented as datasets and numbered and described by data collection type in Table 3.2.

Table 3.1: Datasets

Dataset Number	Data Collection Type
1	Online questionnaire GRN closed-ended questions
2	Interview GRN/CNE/CNM demographic information
3	Online questionnaire GRN open-ended questions
4	Interviews with GRN
5	Interviews with CNE
6	Interviews with CNM

The application of the convergent parallel design to this study directed the flow of the phases, and indicated the timing and priority of the data collection, method of analysis, merging and comparison of the two sets of results (Chapter 6), and interpretation of the merged results (Chapter 7). This is demonstrated in Figure 3.6. The procedures of the convergent parallel design were indicated by the timing of the data collection in the same period, the value of both the quantitative and qualitative data to understand the phenomenon, acknowledgment of the limitation of the researcher's available time and resources, and the potential to publish the results of the data analysis separately (Creswell & Plano Clark, 2011; Onwuegbuzie & Collins, 2007).
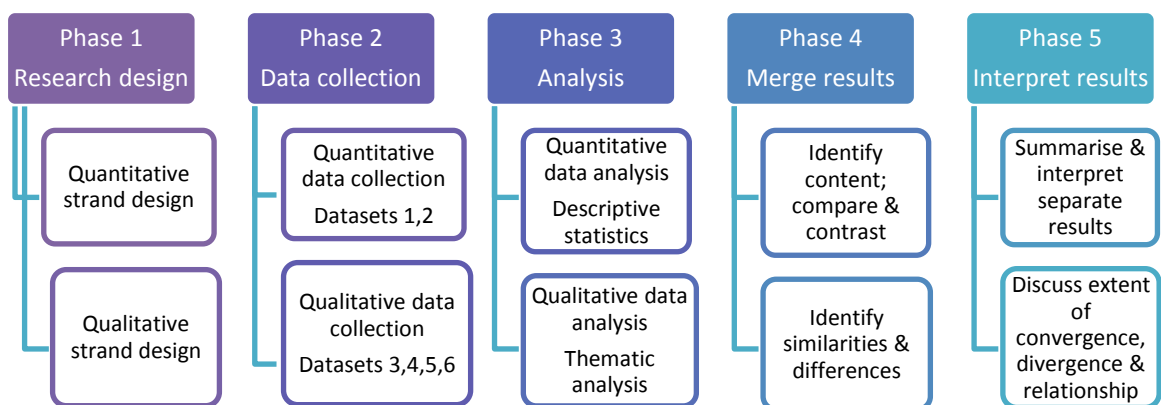
Figure 3.6: Phases of the Convergent Parallel Design

The convergent parallel design was used in this study to achieve research validity and enhance credibility with a blend of quantitative and qualitative methods (Polit & Beck,

2014). The use of a number of approaches to data collection and analysis in a mixed-methods research design is known as triangulation.

3.3.3.5 Triangulation

Traditionally the term 'triangulation' was used in navigation and geography to refer to the use of measurements from three or more points that converge to identify a precise position (Simons & Lathlean, 2010). Triangulation in the context of research is described in a variety of ways in the literature. Bryman (2004) identified triangulation as a way to corroborate findings from two or more different methods to enhance confidence in the study. Adami and Kiger (2005) described the process of using a number of data collection methods within a research design in order to produce a more complete picture. Turner and Turner (2009) suggested that triangulation presents a more rounded perspective that can 'validate, challenge or extend existing findings' (p. 171) in the practice of research.

Denzin (1978) described four different forms of triangulation: data triangulation, investigator triangulation, theory triangulation and method triangulation. According to Turner and Turner (2009), the basis of triangulation is the reduction of bias in a dataset or methodological approach through multiple data sources, investigators, theoretical frameworks and methodologies. The initial aim and focus of the four forms of triangulation described by Denzin (1989) was to increase the validity of an analysis. However, over time and following critiques from the wider research world, triangulation has been further clarified to include the extension of knowledge capacity (Flick et al., 2012; Patton, 1990); to develop an in-depth understanding of the phenomena by studying more than one perspective (Cohen & Manion, 1986; Denzin, 2012; Flick et al., 2012); and to promote quality in research through confidence, validity and credibility (Bryman, 2004; Flick et al., 2012; Rebar et al., 2011). The following sections further describe triangulation and its relationship to this study.

Data triangulation is the use of quantitative and qualitative data sources, or the same data collection method from different sources or across different times and settings (Denzin, 1978). In this study, the data collection included source and setting triangulation (Polit & Beck, 2014). The participants who provided the data were nurses at different levels in a healthcare organisation. The GRNs were at the beginning of their

professional nursing careers, the CNEs had chosen a specialist pathway in nursing education and the CNMs were managers of nursing staff (including the CNEs and GRNs) in the wards and areas in the healthcare organisation. The data collection included the GRN online questionnaire with closed-ended (quantitative) and open-ended (qualitative) questions, and one-on-one interviews (qualitative) with the GRN, CNE and CNM subgroups. The data collected from the different sources and levels of nurses were compared to identify convergence and/or divergence (Flick et al., 2012) and to provide confirmation (Adami & Kiger, 2005). In addition, the data provided a deeper understanding and overarching view of the specific role support given to newly qualified GRNs in their first year of nursing (Williamson, 2005). The setting was a private healthcare service in WA, with three participating hospitals that were chosen to provide a variety of GRN experiences of the CNE role in relation to their safety and quality of care. This provided a more holistic picture of the phenomena (Adami & Kiger, 2005).

Investigator triangulation involves multiple independent researchers investigating the phenomena (Denzin, 1978). This form of triangulation is found in qualitative research where more than one researcher evaluates the findings, or there are multiple observers and researchers who are careful to protect against narrow interpretations or blind spots in the interpretation (Creswell, 2013). During this study, the data collection and analysis were conducted under close supervision of the faculty supervisors and university biostatistician; thus, this form of triangulation was not included for the interpretation of the data (P. Turner & Turner, 2009).

Theory triangulation is the use of more than one theoretical framework to interpret the data (Denzin, 1978).The elements of theoretical triangulation in this study included the use of role theory and leadership theory in the analysis and interpretation of the qualitative data from the online questionnaire and interviews. This type of triangulation provides depth and rigour in the discussion of the findings (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014).

Methodological triangulation uses a number of methods from the same or different paradigms to study the same phenomena (Denzin, 1978). According to Turner and Turner (2009), the most common methodological triangulation approach to a study identified in the literature is the use of both quantitative and qualitative paradigms.

There are two different strategies in the methodological triangulation process (Denzin, 1989). The first is known as within-method, where different data collection methods are used within one research paradigm (Lathlean, 2010). The second is across-method, where both quantitative and qualitative data collections methods are used to investigate the same phenomena (Williamson, 2005). The weaknesses inherent in these strategies are related to dataset bias and the methodological approach that leads to confirmation bias (Turner & Turner, 2009).

In this study, the within-method of methodological triangulation was used to check the qualitative results from the GRN interview data against the quantitative results from the GRN questionnaire data (Bryman, 2006). The across-method strategy employed the quantitative approach by using the questionnaire's closed-ended questions to explore the GRNs' perspectives of the CNE role using systematic and measurable methods, and employed the qualitative approach whereby the questionnaire's open-ended questions and interviews described and explored the GRNs', CNEs' and CNMs' opinions and experiences of the CNE role (Begley, 1996). The combination of the quantitative and qualitative methods allowed the researcher to use multiple perspectives of the same topic to extend knowledge beyond that of one subgroup alone in order to provide quality and complete data on the CNE role in relation to the GRNs' first year of nursing (Flick et al., 2012). The inherent weaknesses of each method were strengthened to provide a holistic view with persuasive data that highlighted divergent perspectives (Casey & Murphy, 2009). Figure 3.7 depicts the use of triangulation in this study.
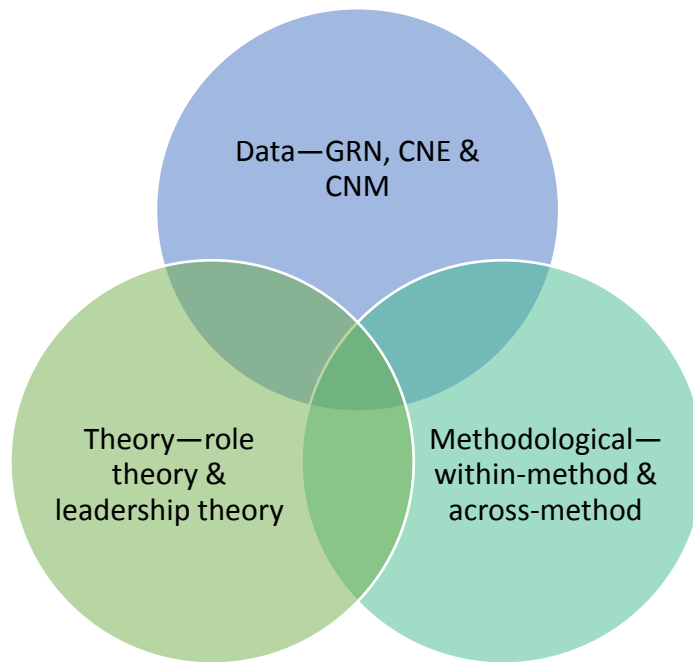
Figure 3.7: Application of Triangulation

3.4 Setting

This study was conducted in a private global hospital group operating in WA. This organisation operates three exclusively private hospitals and two private hospitals under the Public Private Partnership (a service agreement to treat public patients). The total number of public/private beds in this organisation in WA is 1,736 (Ramsay Health Care, 2016). The two private/public acute care hospitals and one private acute care hospital were the selected sites for data collection. These three hospitals were chosen for the study because of their location in the metropolitan area and the researcher's experience, knowledge and familiarity with the hospitals, systems and employees. The features of the public and private health services in WA were described in Chapter 2.

3.4.1 Participants

3.4.1.1 Population

The population for this study were both full-time and part-time employees at the three hospitals. The newly qualified GRNs had recently completed a nursing degree and were employed in a nursing graduate programme, with completion dates ranging between 2012 and 2015. The supernumerary CNEs facilitated or supervised the graduate learning of the GRNs in the clinical environment as part of the nursing graduate programme. The

CNMs directed, organised and were responsible for the CNEs and GRNs employed in their clinical area.

The researcher worked with and relied on the GRN, CNE and CNM participants to share their views through concurrent quantitative and qualitative methods. The overall intent was to gather accounts, experiences, understandings and opinions of the CNE role in relation to its influence on the GRNs' patient outcomes in their first year of nursing. The quantitative (deductive) approach tested the variables selected by the researcher to determine the presence or absence of a relationship, and explored factors related to the effect of the CNE role (Parahoo, 2014). The qualitative (inductive) approach developed concepts through emerging ideas, constant reflection and analysis of the data from the GRN, CNE and CNM participants (Parahoo, 2014). Greene (2007) described the combination of these approaches as 'multiple ways of seeing and hearing' (p. 20).

3.4.1.2 Sample Selection

The choice of sampling strategy was essential to ensure quality of data, data analysis and synthesis. Therefore, the convergent parallel design required a strategy that involved appropriate quantitative and qualitative sampling decisions (Onwuegbuzie & Collins, 2007). To ensure the sampling size and selection processes were suitable for the study design, the researcher met with the university biostatistician and faculty supervisors. A non-probability sampling technique (a variant of convenience sampling) was used to recruit and identify participants (Rebar et al., 2011). The sample size is an important consideration necessary for the researcher to make statistical and analytical generalisations (Onwuegbuzie & Collins, 2007). The size of the samples in this study related directly to the research objective, purpose and questions. Strategies were adopted to determine the size of the online questionnaire and interview samples.

3.4.1.2.1 Quantitative Sample

The size of the convenience sample for the quantitative component considered the total estimated population of GRNs in the graduate programme or who had completed a graduate programme and remained employed in the three hospitals from the beginning of 2012 to the end of 2015. This population numbered 195 GRNs. However, the accessible GRN population—as determined by employment and availability by email contact—was determined for this study as 122. This reduced number of accessible

GRNs was directly related to the lack of current email contact details, as the GRNs' short-term contracts had ended and employment ceased.

In collaboration with the biostatistician, the simplified formula for proportions by Yamane (1967) was used to determine sample size in relation to population size, confidence interval, degree of variability and acceptable sampling error. The GRN population size for the online questionnaire was 122. The confidence interval was determined at 95% and the degree of variability was assumed maximum variation ($p = 0.5$). The number of returned questionnaires was 40, which equalled a response rate of 33%. According to Yamane (1967), the sampling error determined for this sample size was 13%. The sampling error was indicative of the small number of responses to the online questionnaire invitation. This level of sampling error was considered acceptable by the researcher, biostatistician and faculty supervisors to meet the research interest in the GRNs' perspectives on the role of the CNE in relation to their first year of nursing. Further consideration was related to the practical and realistic nature of exploring the newly qualified GRN population in their first year of nursing (Wolfer, 2007) and for the purpose of descriptive statistics (Hayat, 2013). According to Israel (1992), if descriptive statistics are used, then 'nearly any sample size will suffice' (p. 4).

It is possible that the response rate for this study was affected by a number of sampling issues. At the distribution stage of the online questionnaire, sample numbers were likely to have been affected by the lack of current and accurate email addresses, the use of multiple email addresses and the lack of routine checks of email accounts (Cope, 2014; Gray, 2014). A third party (the Manager of Training and Development WA) was appointed by the private health organisation hospital executive and Human Research Ethics Committee officer to endorse the project and eliminate any perceived bias. The third-party distribution of the email invitations may have affected the response rate by removing the researcher's direct involvement in the data collection (Chapple, 2003). This prevented the researcher from providing regular and frequent email follow-up to encourage questionnaire completion and promote the research and professional development benefits to nursing staff. In addition, the researcher was unable to respond to queries related to the research and participation in the online questionnaire. On receipt of the questionnaire, respondents may have declined the invitation during the process of obtaining informed consent, withdrawn during the questionnaire in response

to a lack of time or interest, or been affected by interruptions or distractions (Rebar et al., 2011).

In addition to the common obstacles highlighted, the reduced response rate was also considered to have been affected by organisational operational issues related to the email invitation distribution process at the participating hospitals. This included a perceived clash with the healthcare organisations' continuous quality improvement projects and other organisational surveys scheduled concurrently to the proposed research data collection. Cleary et al. (2011) identified a variety of reasons for nursing staff being indifferent to research, including the conduct of concurrent quality and other projects. In addition, despite well-crafted research that adheres to ethical principles—including informed consent of the intended research participants—senior staff's perception of the burden or bother of research to participants may sabotage a project via deliberate behaviours to undermine the development of a positive research culture (Cleary et al., 2011). Positive patient outcomes are the goal of nursing research through new knowledge (Drenkard, 2013). In undertaking research on the supernumerary role of the CNE specifically related to GRNs' safety and quality of care, the goal of patient safety and quality of care was considered a priority. To attain this goal, it was necessary to have the mutual trust and respect of nursing professionals who have the responsibility and obligation to support the processes that ensure the engagement and advancement of research activities (Drenkard, 2013).

3.4.1.2.2 Qualitative Sample

For the qualitative component of the mixed-methods study, a purposeful sample was used for the GRNs' online questionnaire, which gathered information from the open-ended questions. The interview phase used purposeful sampling as the strategy that provided the richest source of information through subgroup selection (Creswell, 2009). Using this multilevel sampling relationship, the three subgroup samples (GRN, CNE and CNM) were chosen to provide the richest source of information and to obtain understanding of and insight to the role of the CNE (Creswell, 2009; Onwuegbuzie & Leech, 2007).

The size of the qualitative sample should be small enough to achieve data saturation without compromising the depth of analysis (Sandelowski, 2000). Guest, Bunce, and

Johnson (2006) suggested that an interview sample of 12 participants is considered adequate for a data collection procedure. Baker and Edwards (2012) concluded their review paper on the question of the number of interviews required for a qualitative study by stating 'it depends' (p. 42)—indicating that the size of the sample is often guided by the research question. The criteria for the answer to this question lies with the nature and purpose of the research, focus of the analysis, practical issues related to time and requirements, and saturation of responses. The answer is not definitive. The qualitative sample size in this study was guided by the saturation of the data—that is, an in-depth understanding of the phenomena occurred when themes in the data became repetitive and no new information was collected (Polit & Beck, 2014). The researcher interviewed nurses from each subgroup until saturation occurred (Mason, 2010). Overall, this research involved 10 interviews with the GRN subgroup, 11 interviews with the CNE subgroup and nine interviews with the CNM subgroup.

3.4.1.3 Recruitment Strategy

Recruitment of GRNs occurred through the nursing graduate programme run at the three hospitals. Current GRNs and GRNs who had completed the programme since 2012 and were re-employed in the three hospitals were invited to participate by email. The GRNs were identified by the third-party representative (Manager of Training and Development WA) from the training and development and human resources (HR) departments at each hospital, who maintained a shared database of current and re-employed GRNs. Each potential GRN participant received an email invitation (Appendix C) that contained the study information and a link to the questionnaire forwarded by the third party. The GRNs were also asked to forward the email with the questionnaire link to their graduate colleagues to encourage participation. The email was resent by the representative at two months and four months from the date of commencement. Following interviews, the interviewees were encouraged to pass on the email invitation to their GRN colleagues. Recruitment of GRNs for the voluntary interviews occurred when participants responded to the invitation at the end of the anonymous questionnaire. The participants who wished to be interviewed were directed to the researcher's email contact details. On contact, the participant and researcher negotiated a convenient date, time and place for the interview.

The CNEs and CNMs were identified through the training and development/HR departments' shared database of hospital-assigned email addresses. The prospective interviewees were invited to participate by email forwarded by the third-party representative (Appendix E). Interested participants responded to the invitation by emailing the researcher, who negotiated a date, time and place for the interview. The email invitation for all GRN, CNE and CNM participants contained the information sheet, including a summary of the research benefits and a reminder that participation time was counted as continuing professional education for the purposes of reregistration with the NMBA (2015). A certificate of participation was offered to each participant.

3.5 Data Collection

The data collection commenced with the GRN questionnaire incorporating closed- and open-ended questions to collect quantitative and qualitative data. The survey was available over a six-month period. During this same period, qualitative interviews with the three subgroups of GRNs, CNEs and CNMs were completed (see Figure 3.8). The purpose of the quantitative data collection was to gather factual information on the characteristics of the population in numerical form, use measurement scales to identify information, and provide a baseline with which the collected primary data results could be compared (Creswell & Plano Clark, 2011). The purpose of the qualitative data collected through the GRN online questionnaire's open-ended questions and the in-depth one-on-one interviews with the GRNs, CNEs and CNMs was to describe and explain the role of the CNE specifically related to the GRN. The articulation of concepts and connections from the interviews to describe new meaning of the studied phenomenon added more clarity and depth, rather than relying on the discrete quantitative data obtained from the questionnaire.
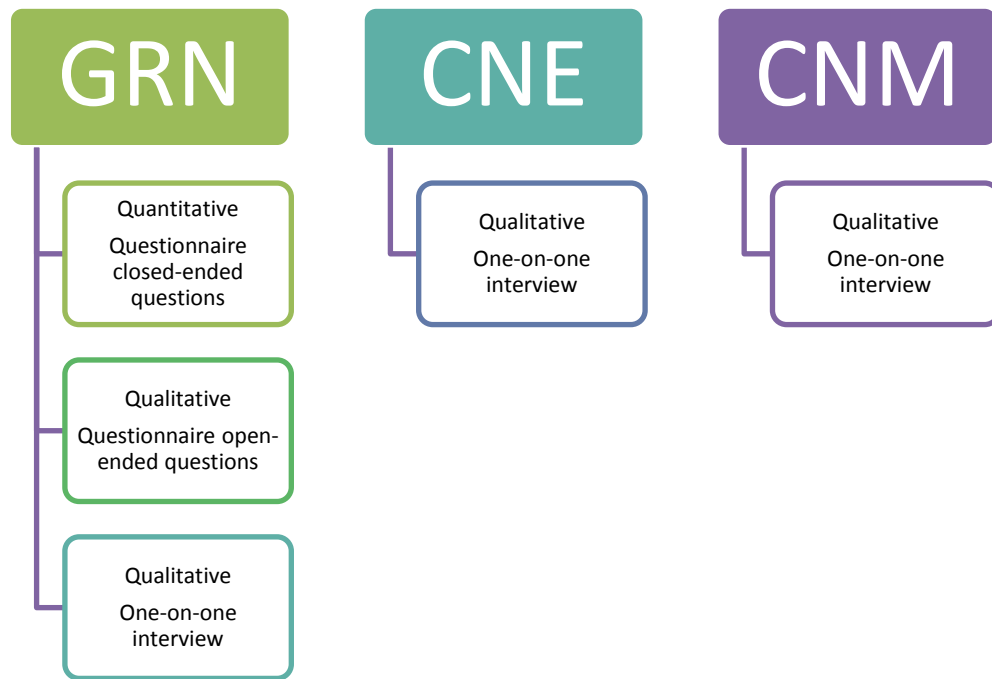
Figure 3.8: Participant Data Collection Strategy

3.5.1 Questionnaire

3.5.1.1 Justification for Use of Questionnaire

The first stage of data collection was a questionnaire for the GRNs using the Qualtrics platform. Qualtrics is a web-based company offering online survey capability to capture, analyse and describe insights from a population. The survey features easy-to-build multiple question types, with sharing capabilities and results from web-based reports exported to Word and PDF (Qualtrics LLC, 2016). An online questionnaire was chosen as the data collection method, as it provided the practical convenience of obtaining a large amount of information from a significant number of graduates over a short period by one researcher, with minimal cost (Gordon & McNew, 2008; Gray, 2014). The questionnaire was used to elicit demographic data and the GRNs' views and insights into the CNE role (including leadership traits), and provided a private and anonymous forum for open and honest responses that may not have been elicited in face-to-face interviews (Cope, 2014). Qualtrics is simple to design and build, attractively formatted, and easy for self-administration with a variety of question types. It enabled both multiple-choice and open-ended questions to be asked. Qualtrics

allowed the researcher to create and distribute the questionnaire online, collect and export data in multiple formats, and analyse the data and generate reports.

3.5.1.2 Development of the Questionnaire

The CNE role is a formal position reporting directly to the CNM of a specific clinical area. The role has a job description that states the clinical and educational expectations and the employing healthcare organisation's and nursing regulatory body's mandatory requirements, policies and standards for practice (NMBA, 2015). The literature review presented in Chapter 2 described the underpinning theories of role theory and leadership theory, which provided the basis for the question planning and development process.

This study conducted a search for pre-existing questionnaire scales and instruments related to role theory and leadership in healthcare, and identified a number of existing validated scale and index instruments, with estimates of reliability and validity related to leadership. Each of the questionnaires were considered for use in full, partial or with modifications. These included the Nursing Work Index Revised (Aiken & Patrician, 2000), Multifactor Leadership Questionnaire (Bass & Avolio, 1990), Leadership Practices Inventory (Posner & Kouzes, 1988) and Perceptions of Clinical Leadership Questionnaire (Stanley, 2004, 2014). None of these tools completely covered the areas of interest; however, one instrument contained questions that met some of the requirements for this study. The Perceptions of Clinical Leadership Questionnaire (Appendix A) contained four questions that were pertinent and useful to explore the leadership of the CNE as perceived by the GRNs. To meet the outstanding requirements of the tool, three additional questions were constructed from the literature on congruent leadership related to leadership values, culture, change and care (Stanley, 2006a, 2006b, 2008). The author of the questionnaire was contacted by email and permission was granted (Appendix B) to use the updated tool with the modified changes (D. Stanley, personal communication, September 24, 2014).

The questionnaire (Appendix D) also included the online questionnaire information and consent question; questions on demographic information, the supernumerary CNE role and CNE leadership role; and a final comment. These questions were constructed by the researcher using role theory and leadership literature on the key concepts of leadership (influence, vision and attitudes) in consultation with four clinical experts—two clinical

educators and two graduate programme coordinators, in addition to faculty supervisors. The online questionnaire sought information from the GRNs' perspective on the CNE role's identity, strain and conflict, and actual or potential leadership in the clinical environment in relation to their first year of nursing—specifically:

- the supernumerary CNE role expectations and actual role availability and influence on the GRNs' patient care and graduate programme
- the relative position of the supernumerary CNE as a support in times of need in relation to other roles in the clinical environment
- the importance of the supernumerary CNE role as a support person in the GRNs' first year of nursing
- the role of the supernumerary CNE in relation to GRNs who make a patient error
- the supernumerary CNE's leadership qualities and values
- the supernumerary CNE's leadership in the clinical area and hospital.

The formulated questions were inserted into Qualtrics and formatted to allow participants to provide quantitative information through structured self-report methods. The chosen options were five-point Likert scale, dichotomous, multiple-choice and rank-order questions. The Likert scale was used to measure participants' viewpoint by indicating the extent of their agreement or disagreement with a declarative statement (Polit & Beck, 2014). The scales used were 'never', 'rarely', 'sometimes', 'most of the time' and 'always' (eight questions) and 'strongly disagree', 'disagree', 'neither agree nor disagree', 'agree' and 'strongly agree' (two questions). Both scales provided a balanced number of positive and negative responses, with a neutral option for participants who did not have a positive or negative response. The six dichotomous questions and four multiple-choice questions provided an understanding of participants' experience and viewpoints, while the three rank-order questions asked participants to place in order of preference the person they would most likely choose in relation to a specific scenario (Burton & Mazerolle, 2011). For the qualitative data, some of the question options provided additional space to collect responses related to additional explanations if desired (three questions), while seven questions asked for text entry only and were created to encourage participants to provide a response with greater depth and meaning (Polit & Beck, 2014).

The questionnaire consisted of the following 33 items:

1. one item—online questionnaire information and consent question
2. four items—demographic questions
3. 18 items—supernumerary CNE role
4. nine items—CNE leadership role
5. one item—final comment.

Table 3.3 links the items to the research questions, method and question origin.

Table 3.2: Online Questionnaire Tool Development

Question Number	Research Question	Data Collection Tool	Method	Question Origin
1 **One item**		Questionnaire information and consent question		Researcher and faculty supervisors, clinical nurse education experts and graduate programme coordinators
2–5 **Four items**	**1.** Does the role of the supernumerary CNE influence first-year GRN patient outcomes? **2.** Is there a link between the CNE role and the GRNs' safe and quality patient care? **3.** In what way does the CNE promote clinical confidence among GRNs? **4.** To what extent is the CNE perceived as a clinical leader by GRNs, CNEs and CNMs?	Demographic questions Dichotomous and multiple-choice questions	Quantitative Qualitative	Researcher and faculty supervisors, clinical nurse education experts and graduate programme coordinators
6–23 **18 items**	**1.** Does the role of the supernumerary CNE influence first-year GRN patient outcomes? **2.** Is there a link between the CNE role and the GRNs' safe and quality patient care? **3.** In what way does the CNE promote clinical confidence among GRNs?	Supernumerary CNE role Dichotomous, multiple-choice, Likert-scale, rank-order and text-entry questions	Quantitative Qualitative	Researcher and faculty supervisors, clinical nurse education experts and graduate programme coordinators

24–32 Nine items	1. Does the role of the supernumerary CNE influence first-year GRN patient outcomes? 4. To what extent is the CNE perceived as a clinical leader by GRNs, CNEs and CNMs?	Leadership role of the supernumerary CNE Multiple-choice, Likert-scale and text-entry questions	Quantitative Qualitative	Items 29, 31 and 32 Researcher and faculty supervisors Items 24–28 and 30, the Perceptions of Clinical Leadership Questionnaire Tool, and literature on congruent leadership
33 One item	1. Does the role of the supernumerary CNE influence first-year GRN patient outcomes? 2. Is there a link between the CNE role and the GRNs' safe and quality patient care? 3. In what way does the CNE promote clinical confidence among GRNs? 4. To what extent is the CNE perceived as a clinical leader by GRNs, CNEs and CNMs?	Supernumerary CNE role and leadership Text entry	Qualitative	Researcher and faculty supervisors

3.5.1.2.1 Questionnaire Validity

To minimise the potential for question misinterpretation or misunderstanding, and to improve confidence in the results obtained from the questionnaire, the validity and reliability of the instrument were assessed. Procedures for establishing validity include face, criterion and construct validity (Burton & Mazerolle, 2011). Reliability testing to assess the consistency of the questions includes test–retest, alternate form testing and split-half tests (Parahoo, 2014). The following processes were used to assess the usefulness of the questionnaire to produce valid and reliable data.

Two faculty supervisors and two nurse educators experienced in questionnaire development and the research topic assessed the user friendliness, clarity and readability of the questions, thereby providing face validity. Further refinement required rewording, logical sequencing, increasing scales from four to five point, and confirming terminology. The final results of the closed- and open-ended questions were transferred to and formatted in Qualtrics using the user-friendly functions of skip logic, forced answer and request answer to promote data entry (Qualtrics LLC, 2016).

Polit and Beck (2014) defined criterion-related validity as demonstrating the accuracy of the instrument scores via comparison to a previously established and valid instrument

or another external measure. For the study questionnaire, no reliable and valid criterion was found that related to the 16 items on the CNE role—see Table 3.3 for a summary of data collection tools related to the research question. However, the 10 items related to leadership from the inclusion of the Perceptions of Clinical Leadership Questionnaire tool had established criterion-related validity (Stanley, 2005, 2006a, 2006b, 2008).

Construct validity is the degree to which the measures relate to the theoretical concepts being investigated, and provide confidence that the questionnaire measures what it is intended to measure (Polit & Beck, 2014). This is a difficult validity measure to achieve without testing in a number of settings with different populations over diverse times (Parahoo, 2014). Thus, this measure was not included in this study.

To assess the reliability of the questionnaire—that is, the degree of consistency of the questions—a cognitive pilot formed the final phase of questionnaire development (Parahoo, 2014). The Qualtrics questionnaire was previewed online using the test collection survey function by three graduate nurses (completion date prior to 2012), two staff educators and two faculty supervisors. This small group of respondents provided an efficient method to check quality (Parahoo, 2014). The Qualtrics response data display was analysed to identify and highlight common errors and weaknesses in the formulations of the question types, and to examine the clarity, strength, simplicity, specificity and independence of the questions to avoid ambiguous, misleading and biased questions (Bradburn, Sudman, & Wasink, 2004). The test participants' feedback directed further changes prior to finalisation (Polit & Beck, 2014). The changes included clarity around instructions, reduction in the age categories, rewording one perception-based question, modification to eliminate one leading question and formatting changes to ensure question flow. Reliability testing—such as test–retest, alternate form testing and split-half test—were not used for this questionnaire, as the cognitive pilot procedure was considered sufficient with the addition of comprehensive and structured notes on the development process (Gray, 2014). The time expected to complete the online questionnaire was 20 minutes, which was considered by the test participants sufficient time to reflect and provide considered responses.

3.5.2 Semi-structured Interviews

3.5.2.1 Justification for Interviews

Interviews were used to explore in greater depth the opinions, beliefs and experiences of the GRN, CNE and CNM subgroups, and to identify the context, meaning and characteristics of the phenomena under study. The interviews enabled the researcher to pursue a greater depth of understanding and more detailed description of the GRNs' perceptions of the supernumerary CNE role in relation to their patients' safety and quality of care. The collection of rich data through interviews from the three subgroups was necessary to facilitate the emergence of new concepts and ideas through the open nature of the questioning, prompting and probing (Doody & Noonan, 2013), and was an appropriate method to examine sensitive areas, such as clinical incidents, and to probe interesting individual responses (Clarke, 2006). For this study, the research questions and researcher's prior knowledge of the topic directed the structure, direction and depth of the interviews (Tod, 2010).

The interview type chosen was semi-structured, face-to-face, individual and one-on-one. The semi-structured interview was composed of predetermined open-ended questions, written based on a topic guide and presented verbally in a conversational style (Morse & Niehaus, 2009). This method allowed the researcher to maintain direction and control and have the flexibility to follow topics in-depth, vary the question order and wording, ask additional questions, expand on issues raised by the participant, and seek clarification (Doody & Noonan, 2013; Tod, 2010). The interviews were face-to-face with each individual participant. This allowed the researcher to observe body language and facial expressions, interpret feelings, relieve interview anxieties and use directed probing to investigate more sensitive views and experiences (Tod, 2010). The interview, conducted at one point in time, was considered to generate good quality data. It required the researcher to quickly establish a positive relationship of rapport and trust with the participant, which was facilitated partly by the researcher's knowledge of the hospital environment (DiCicco-Bloom & Crabtree, 2006; Tod, 2010). For the GRN subgroup, the interviews explored the topic in greater depth than the questionnaire was able to provide.

3.5.2.2 Development of Topic Guide

The underpinning theories of role theory and leadership theory provided the foundation for the topic guide planning and development process. The literature review detailed in Chapter 2; researcher's knowledge of the role; and collective experiences of educational and clinical staff education experts, graduate nurse coordinators and faculty supervisors provided the forum for the initial discussion on the parameters of the topic guide (Doody & Noonan, 2013). The purpose of the semi-structured interview was to explore the GRNs' views and experiences of the CNE role in the clinical environment during their first year of nursing.

The topic guide questions were formulated with the first five questions related to demographic information. This information allowed for comparisons between subgroups on response variations. The questions drew on role theory ideas of the responsibilities, expectations, behaviours and constraints of the supernumerary CNE role in the clinical environment (Conway, 1988). Leadership theory—incorporating values, attitudes, intentions and reality—was demonstrated in the questions related to the participants' views on the supernumerary CNEs' leadership in the clinical area and in the wider healthcare organisation (Marquis & Huston, 2012). The questions also pursued an understanding of the supernumerary CNE role and leadership in the contemporary culture of the healthcare organisation.

The questions progressed from a general perspective to a more explicit direction. This presentation style allowed the participants to answer easy questions and feel at ease, before more complex or sensitive topics were introduced (Gill, Stewart, Treasure, & Chadwick, 2008). Consideration was given to the phrasing of the questions (ensuring relevant language for clinical-based nurses) and to the introduction of the sensitive topic of patient care errors, while avoiding leading questions (Doody & Noonan, 2013). The same topic guide was used for the GRN, CNE and CNM subgroups.

To confirm that the topic guide questions were clear, understandable and able to answer the research questions, three graduate nurses (completion date prior to 2012), two staff educators and two faculty supervisors reviewed the topic guide. This provided face validity, where the questions were deemed to be suitable and relevant (Polit & Beck, 2014). Revisions occurred prior to data collection and included enhancing clarity and

question order (Gill et al., 2008). The final topic guide (Appendix F) was determined to achieve the desired balance of flexibility and direction, while encouraging new and interesting concepts and ideas (Tod, 2010).

3.5.2.3 The Interview Process

Thorough planning is essential to completing successful interviews (Doody & Noonan, 2013). In addition to the recordings, supplementary handwritten field notes were used to identify primary or secondary accounts, assess data source reliability and body language, and provide context and insight to the interview data (Creswell, 2009; Hsiung, 2010). A transcription service was contracted to transcribe the data from each recorded interview because researcher transcribing is time intensive; however, each interview was replayed after the interview as an opportunity to build on interviewing skills and identify early themes (Doody & Noonan, 2013). This method made the interviewer aware if questions were being misinterpreted or if there was unwitting use of leading questions. Doody and Noonan (2013) also suggested that researchers may compromise the data depth and strength by their inability to recognise opportunities to ask questions and prompt or probe responses.

The interviews were scheduled in advance at a designated time and suitable location outside the clinical environment (DiCicco-Bloom & Crabtree, 2006). The desired setting was a private unoccupied office in the hospital that provided comfort for the participant and had reduced risk of interruption (Tod, 2010). The interview times were each scheduled for 60 minutes. By creating the right interview conditions—such as a quiet space, minimal noise or disruptions, and comfort—the participants felt free to share information at length. The ability of the researcher to elicit the depth and quality of the data desired required the development of a degree of sensitivity, trust and rapport with the interviewee in the short time available for the interview (Spencer, Ritchie, Lewis, & Dillon, 2003). The researcher was aware of the need to listen attentively, be interested, be sincere and confident, be skilful around sensitive issues, use humour when appropriate, and be flexible and responsive to the mood and body language of the individual participants (Hsiung, 2010; Tod, 2010). The skills used by the researcher included maintaining eye contact, summarising, and using silence to encourage participant reflection and response (Tod, 2010). The interviews were completed within the designated time period allocated in the study plan.

3.5.3 Validation Strategies

Validity in mixed-methods research was defined by Creswell and Plano Clark (2011) as 'employing strategies that address potential issues in data collection, data analysis, and the interpretations that might compromise the merging or connecting of the quantitative and qualitative phases of the study and the conclusions drawn from the combination' (p. 239). Potential issues were identified in the data collection phase. There was a greater number of the GRN subgroup who contributed to the qualitative data through the online questionnaire open-ended questions ($n = 40$) and interviews ($n = 10$). However, this was a deliberate selection to ensure that the GRN perspective was considered both through an anonymous source and a face-to-face interaction (Oei & Zwart, 1986). The limitations of the short-answer open-ended questions in the online questionnaire were also avoided by the additional GRN interviews (Creswell & Plano Clark, 2011). Therefore, there were more qualitative data available from this subgroup than from the CNE and CNM subgroups who participated in the interviews only. The use of a purposeful sampling method to select nurses' representative of the population for the questionnaire provided a consistent approach (Creswell, 2014).

During the data analysis phase, effort and skill were required to analyse the topic under consideration using deductive and inductive methods. The researcher was aware that inadequate convergence of the data, unsound comparisons of the results of analysis and insufficient data transformation approaches could alter final outcomes (Creswell, 2014). In the interpretation of the data, the researcher determined to resolve any divergent findings, address the mixed-methods research questions, and avoid unequal weight to the two types of data to prevent any interpretation issues. The use of rich and thick description to express findings, clarification of the researcher's bias, presentation of any contradictory information, and peer debriefing where necessary prevented a narrow researcher focus on the study (Creswell, 2014).

Triangulation—as a strategy to enhance the validity of the mixed-methods study—provided greater confidence and credibility to the findings by using multiple approaches to investigate the research question (Bryman, 2012). The use of across-methods triangulation was a means to offset the weaknesses inherent in one method with the strengths of the other method, and conversely where the strength of one added to the strength the other (Creswell, 2014).

Member checking—a strategy to improve the accuracy, credibility and validity of transcribed interview data—is specifically related to the qualitative enquiry method (Lincoln & Guba, 1985). Member checking was used in this study as a quality process, where participants were provided with a copy of the interview transcript and asked to verify the accuracy and authenticity of the reflection of their experiences to ensure that the meaning and intent of the transcription was clear (Lathlean, 2010). These strategies reduced potential issues related to the data analysis merge and interpretation phase.

3.6 Data Analysis

The datasets for this research were characterised by their statistical measures and attributes related to their analysis and to the quantitative and qualitative data analysis method used. Table 3.4 lists the six datasets with their analysis methods and phase of study.

Table 3.3: Datasets, Analysis Method and Phase of Study

Dataset Number	Data Collection Type	Analysis Method	Phase of Study
1	Online questionnaire GRN closed-ended questions	Descriptive statistics	2
2	Interview GRN/CNE/CNM demographic information	Descriptive statistics	2
3	Online questionnaire GRN open-ended questions	Thematic analysis	2
4	Interviews with GRN	Thematic analysis	2
5	Interviews with CNE	Thematic analysis	2
6	Interviews with CNM	Thematic analysis	2

The following sections describe the steps of the data analysis undertaken for the quantitative and qualitative data.

3.6.1 Quantitative Analysis

3.6.1.1 Qualtrics Data

The quantitative data obtained from the GRN online questionnaire using the Qualtrics platform were identified as dataset 1. Statistical analysis of the demographic data from the questionnaire was undertaken using Qualtrics (Qualtrics LLC, 2016). Simple descriptive statistics were used, as described by Polit and Beck (2014), to provide an

easily understandable way of explaining the data and presenting the results. These included frequency distributions, where the numerical values were systemically organised from lowest to highest, with each value counted the number of times it occurs. Central tendency was used to describe how typical the set of values were, and included the mode (the value that occurred most frequently in a distribution of scores), the median (the exact middle value in a score distribution) and the mean (the sum of all values and division by the number of subjects). Variability indicated the degree to which values on a set of scores were dispersed, and included range (calculated by subtracting the lowest from the highest value) and standard deviation (summarised the average amount of deviation of values from the mean) (Polit & Beck, 2014).

On completion of the data collection period, the data were accessed through the Qualtrics platform in the following manner (Qualtrics LLC, 2016):

1. the GRN online questionnaire was opened on summary 'My Surveys' page
2. the 'View Reports' tab was accessed for the initial report, which generated all response data for the questionnaire
3. basic descriptive statistics for each question were accessible from the report
4. for each score, rank or multiple-choice question, simple charts and tables were generated by the Qualtrics program to view responses
5. statistics on the survey duration, start times, dates, question completion and survey completion percentages were accessed
6. cross-tabulation between two categorical variables was generated for specific questions
7. subgroup filtering occurred by selecting subgroups and generating a new report formed with the subgroup filter
8. all data generated were exported to both Microsoft Word and Excel.

The results were represented in statements summarising the statistical results and figures to present the quantitative results in a visual form using a variety of charts.

3.6.1.2 Interview Demographic Data

The interview demographic data, identified as dataset 2, included the following information:

- length of time as an RN

- length of time as a GRN/CNE/CNM

- number of clinical hours worked per fortnight

- number of hours worked per fortnight in CNM or CNE role

- postgraduate qualifications.

The demographic data were entered into a Microsoft Excel spreadsheet, and descriptive statistics were generated using Excel to produce tables and figures to display the participants' characteristics.

3.6.2 Qualitative Analysis

The researcher's data analysis and synthesis approach was inductive to identify emergent ideas and themes with conscious and repeated reflection to derive meaning from the data. The process was progressive, with active data analysis informing the early phase of analysis and occurring concurrently with the interview process. After the first five interviews of each subgroup, the researcher listened to the audio recordings and made notes for the purpose of acquiring emergent themes and refining ideas (Lathlean, 2010). This was useful to direct and engage the participants in subsequent interviews and to use as prompts to further explore interests, concerns and understandings related to the topic guide questions (Johnson & Copnell, 2002).

To aid the data analysis process, this study used a qualitative data analysis computer software package produced by QSR International (2014), known as NVivo. The NVivo version 10 software (NVivo 10) is designed for qualitative researchers with text-based data, where deep levels of analysis are required for either small or large volumes of information. Alabri and AlYahmady (2013) suggested that NVivo provides a more methodical, focused and systematic tool to improve the data analysis quality process. Bazeley (2007) identified the five data analysis tasks that NVivo features in this quality process: managing data, managing ideas, answering queries, creating visual representations of data to demonstrate relationships, and reporting the data results.

For this study, NVivo 10 was used to organise, code and categorise the text entry data from the GRN online questionnaire identified as dataset 3 and the interview transcribed data from the GRN, CNE and CNM subgroups identified as datasets 4, 5 and 6. The text entry data exported from the Qualtrics online questionnaire and transcribed interviews

from the subgroups were imported to NVivo 10 from Microsoft Word. The software allowed the researcher to prepare and store texts for analysis, block and label text segments with codes for easy retrieval, and organise codes (known as parent and child nodes) into a visual hierarchy that made it possible to identify and examine relationships in the data. In addition, the ability to use the search and query functions to identify words or segments of text and cross-examine the data in multiple ways enabled further detailed coding and interpretation, comparison and merging of data. From NVivo 10, thematic maps and charts were created and exported to present data visually and display the results with node summaries.

3.6.2.1 Principles of Thematic Data Analysis

According to Braun and Clarke (2006), thematic analysis is a foundational approach to work with data by creating codes, categories and themes to produce a perceptive analysis that answers the research questions. The thematic analysis method is:

- congruent with a variety of theoretical and epistemological approaches
- inductive, where the researcher examines data critically and finds patterns propelled by the data
- deductive, where theoretical interest allows for a more specific analyst-driven approach
- a flexible research tool to describe and detail patterns and find similarities and differences between the data
- reflective and understanding of reality by using a process of consistent clarification and generation of themes.

The iterative thematic analysis process chosen for this study was the step-by-step guide described by Braun and Clarke (2006). Table 3.5 illustrates the thematic analysis phases and application of the thematic analysis process. This analysis process was used to code, categorise and find themes from the GRN online questionnaire text entry questions and the GRN, CNE and CNM subgroup interview data.

The result of this analysis was a final report of named themes, with extracts and examples to provide a well-organised interpretation and illustration in a convincing and balanced account (Braun & Clarke, 2012). This creation of knowledge and ideas

generated pathways to comprehend the CNE role specifically related to the GRN in their first year of nursing, within the context of the clinical environment (Thorne, 2000).

Table 3.4: Thematic Analysis and Application

Thematic Analysis Phases	Application of Thematic Analysis to Qualitative Data
Becoming familiar with the data	• Checking transcription accuracy and becoming familiar with the data • Immersion by reading and rereading questionnaire text entry responses and transcription of interviews with notes on initial ideas • Active data analysis by reviewing first five interview audio recordings in each subgroup to acquire emergent themes and ideas for subsequent interview prompts
Generating initial codes	• Producing initial codes (nodes) using NVivo 10 for the interview subgroups and online questionnaire text entry • Organising data into meaningful groups (parent and child nodes) • Further refining groups using the hierarchical node strategy
Searching for themes	• Data in parent and child nodes sorted into potential themes • Visual representations (such as thematic maps) used to refine the theme process • Relationships between codes and themes considered
Reviewing themes	• Potential themes considered and refined for coherence and fit • Themes checked for credibility of individual themes and to ensure reflections of meanings in data are accurate • Recoding continued to ensure all data are coded • Reviewing continued until final themes agreed
Defining and naming themes	• Themes and subthemes defined and further refined • The essence of each theme captured to ensure a coherent and consistent account • A detailed analysis including data extracts to identify and explain the interest within the wider context • Themes and subthemes named in a concise manner to identify the theme
Producing the report	• Themes completed • Final analysis written up in the report in a concise, coherent and interesting account • Data extracts provided sufficient evidence of the prevalence of the themes • The report provided an argument in relation to the research questions

3.7 Ethical Considerations

This research project demonstrated the principles of honesty, integrity, respect and ethical behaviour through safe and secure practices guided by the *Australian Code for Responsible Conduct of Research* (Australian Government, 2007). The conduct of this original and creative project was to gain further knowledge on and insight to the influence of the CNE role on first-year GRNs' patient outcomes. The research followed the guidelines and appropriate planning expected of a responsible and accountable researcher, and each component was considered carefully from an ethical context

(Australian Government, 2007; National Health and Medical Research Council [NHMRC] & Australian Research Council, 2007).

3.7.1 Ethics Approval

Ethics approval is necessary to ensure that the conduct of the research protects the participants, researcher, university and participating healthcare organisation (Australian Government, 2007). The application and proposal to undertake research involving human subjects was completed, submitted and approved by the University Human Research Ethics Committee (HREC) for a period of three years (Appendix G). Immediately following the ethics approval of the study, further applications and proposals were submitted to individual hospital HRECs at the Joondalup Health Campus (JHC), Peel Health Campus (PHC) and Hollywood Private Hospital (HPH). Approval and endorsement from each hospital's HREC and executive were obtained before the study commenced (Appendix H). University approval of PhD candidature transfer between universities was also confirmed (Appendix I).

3.7.2 Informed Consent

Consent involves respect for the decision-making capacity of the participants (Australian Government, 2007; NHMRC & Australian Research Council, 2007). Sufficient information was provided in the email invitation (Appendices C and E) on the aim of the project; the reason for the invitation; the risks and benefits; how participant confidentiality would be protected; and contact details for the opportunity to ask questions, discuss the information or complain about the project if required (Australian Government, 2007; NHMRC & Australian Research Council, 2007).

Consent was given voluntarily with no coercion applied to gain agreement to participate. The information was provided to the GRN questionnaire subgroup as the first page of the online questionnaire (Appendix D). The agreement to participate in the questionnaire involved the participants clicking on the link in the email, proceeding to the online questionnaire and marking a check box question at the end of the information section. This question explained informed consent and stated that, by selecting the 'yes' answer, the participant consented to participate in the questionnaire. The questionnaire was set up in such a way that if the answer 'no' was selected, skip logic was used to disallow any participant who did not consent to complete the questionnaire. Those

participants who wished to participate in the interviews were directed to an email link at the end of the anonymous questionnaire, where they were able to provide their contact details to the researcher. Separating the contact information for the interview from the questionnaire reduced the need for a hardcopy of a written/signed consent form, and ensured that the identity of the participants of the online questionnaire remained anonymous.

The GRNs, CNEs and CNMs who agreed to participate in the interviews were emailed a copy of the information sheet prior to the agreed date of interview. The participants were able to make an informed decision about interview participation. At the interview, the subgroups were provided with a copy of the information to keep. At the beginning of the interviews, the participants were read an information statement after the audio recorder was activated. The statement included reiteration of the study information, including an explanation of consent process, with an opportunity to discuss participation further; the use of audio recording and transcription of the interview; the process of member checking; the use of anonymity and codes in analysis; and the participant's right to terminate, suspend or postpone the interview. At the end of the information statement, the interviewee was asked to verbally consent to participation in the interview, and this was recorded and transcribed. Only the researcher knew the identity of the interviewees, who were coded as 'GRN1', 'CNE1', 'CNM1' and so forth to minimise identification potential in the data, thesis or subsequent publications or presentations. No financial inducement to participate was offered and no disadvantage occurred for participants who declined to be involved in the project (Polit & Beck, 2014).

3.7.3 Risk and Benefit

The potential for harm, discomfort and inconvenience existed during the interview and questionnaire components of the project. The participants could feel discomfort when reliving or retelling incidents that had occurred in the clinical setting. A risk assessment involved identifying risk, estimating the probability and severity of risk, assessing the extent of how risks could be minimised, justifying the risk balanced by the benefit of the research, and deciding how to manage the risk (NHMRC & Australian Research Council, 2007). The level of risk was identified as low; however, each participant was given a leaflet detailing the professional, confidential and free counselling sessions

available to the participants at no cost through the Employee Assistance Program (Optum, 2015). Prior to the interviews, the participants were also informed of their right to terminate or suspend the interview.

3.7.4 Privacy and Confidentiality

The participants' right to privacy and confidentiality was protected and maintained by removing any identifying information throughout the process of the research. The de-identified digital data and documents in the computer files were coded to minimise identification potential (Polit & Beck, 2014) and were only available to authorised people, such as the researcher, supervisors and transcriber, who maintained the confidentiality of participants and their information. The external data transcriber service signed a confidentiality agreement. A list that identified interview participants and linked to the allocated code was necessary for member checking, and was deleted from the researcher's computer after the data collection and analysis was completed.

3.7.5 Conflict of Interest

A conflict of interest is a consideration that relates to the power differential between the researcher and participant (O'Leary, 2005). The researcher held a formal role in the healthcare organisation while conducting the project; however, she did not supervise the GRNs or have direct work relationships with the CNEs or CNMs. The researcher was known to some of the participants through a previous role in nurse education and as the student undergraduate coordinator. Any real or perceived abuse of authority or power imbalance was minimised through ensuring and maintaining the ethical principles of research, including informed consent, risk and benefit, privacy and confidentiality (Australian Government, 2007; NHMRC & Australian Research Council, 2007).

3.7.6 Data Security

Field notes and audio recordings were transcribed and kept digitally on a password-protected computer in locked offices, with access by the researcher and university faculty project supervisors. The audio recordings were deleted once the transcriptions were completed and checked. An electronic copy of the interview transcripts was retained by the researcher on the computer in the locked office for member checking. The questionnaire data responses collected using Qualtrics were stored in the Qualtrics

secure database. All digital files, including the NVivo database, were saved in an orderly and understandable manner by using files and folders for ease of locating and identifying information. Backups were made regularly using an external hard drive kept in the locked office. Digital data and project records will be deleted appropriately after a minimum of five and maximum of 10 years.

3.8 Chapter Summary

This chapter has reviewed the justification for the research, rationale for the chosen design, and processes for data collection and analysis. The application of the mixed-methods research was clearly articulated to provide a demonstration of the researcher's knowledge of the principles of research, with a particular emphasis on the progress of each phase of the design and the triangulation procedures. Each stage of the research described the role of the researcher, with a particular focus on adherence to ethical considerations of approval, consent, risk, privacy and confidentiality.

With the completion of the quantitative and qualitative data collection, the researcher was able to commence the data analysis process. The following Chapter 4 presents the quantitative data analysis and subsequent findings.

Chapter 4: Quantitative Data Analysis and Findings

4.1 Introduction

The previous chapter described the methods and phases of the study. This included the online questionnaire tool and development of questions and validity testing. The online questionnaire collected GRNs' demographic data and perspectives on the supernumerary CNE role related to the GRNs' safety and quality of patient care. The current chapter presents the analysis and discusses the findings of the quantitative data collection phase of the mixed-methods research.

As discussed previously in Chapter 3, the methodology of this mixed-methods research involved the separate and parallel collection and analysis of the quantitative and qualitative data, prior to the subsequent relate/compare and interpretation phases. This chapter presents the demographic details from the three subgroup interview participants collected at the time of interviews, followed by the GRN online questionnaire data analysis, and a discussion of the findings.

4.2 Study Population

For this study, the quantitative data were collected from the GRN subgroup through the online questionnaire and interview demographic questions, and through the demographic information provided by the CNE and CNM subgroups at the time of interview. The newly qualified GRNs had recently completed a nursing degree and were employed in a nursing graduate programme, with completion dates ranging between 2012 and 2015.

4.3 Analysis of Quantitative Data

The quantitative data for this study were analysed using descriptive statistics that described the basic characteristics of the GRN, CNE and CNM interview subgroups and the GRNs' questionnaire responses, and included cross-tabulations of demographic data (Polit & Beck, 2014). The data were presented in numerical and graphical diagrams that enabled the researcher to summarise, analyse and discuss the findings. These procedures provided a visual way to identify similarities and differences, and highlight

characteristics and tendencies (Polit & Beck, 2014; Punch & Oancea, 2014; Wolfer, 2007).

4.3.1 Interview Participant Demographic Findings

Profile information was obtained during the semi-structured, individual, one-on-one interviews conducted with the GRN, CNE and CNM subgroups. This section details the quantitative interview data results of six questions related to the demographic and educational profile of the GRN, CNE and CNM interview participants. These findings include gender, length of time as an RN and in the current role, contracted work hours, ward specialty, highest level of postgraduate education, and previous training or work in the health service.

4.3.1.1 Profile of GRN Participants

Ten GRNs were interviewed. Table 4.1 summarises the sociodemographic characteristics of the GRN interviewees.

Table 4.1: GRNs' Sociodemographic Characteristics

Variable	n	%
Sex (female)	10	100
Length of time as RN		
< 1 year	7	70
1–2 years	1	10
> 2 years	2	20
Contracted work hours		
56 hours	2	20
63 hours	2	20
70 hours	6	60
Graduate ward specialty		
Medical	1	10
Surgical	4	40
Orthopaedic	2	20
Emergency department	1	10
Rehabilitation	1	10
Mental health	1	10
Highest level of postgraduate education		
Graduate Certificate in Clinical Nursing	8	80
Previous training/work in health service		
Enrolled nurse	4	40
Orderly	1	10

4.3.1.1.1 Gender

All GRN interview participants were female. No male graduates responded to the invitation to interview.

4.3.1.1.2 Length of Time as RN

The length of time in years as an RN was an average of 1.25 years, with a minimum of 0.17 years and a maximum of four years. Of the 10 interview participants, seven were still engaged in their graduate programme, one had recently completed the graduate programme and two had completed their graduate programme over two years previously. All GRNs interviewed had experience with at least two CNEs, except one GRN (who was still engaged in the first half of the graduate programme) who had experience with only one CNE. The graduate programme offered in the healthcare

organisation chosen for this study was conducted over 12 months with two ward or department allocations (Jackson & Payne, 2014).

4.3.1.1.3 Contracted Work Hours during Graduate Year

The number of hours worked per fortnight was an average of 66 hours, with a minimum of 56 hours and maximum of 70 hours. That is, 60% of GRNs worked the maximum hours (70 hours), with 20% each working 63 and 56 hours. The graduate programme minimum requirement for contracted work hours per fortnight was 56 hours, with a maximum 70 hours considered full time. On employment in the graduate programme, the GRNs were offered a choice of a minimum of 56 hours, 63 hours, or a maximum of 70 hours, as per the hospital work hours allocation to the graduate programme.

4.3.1.1.4 Graduate Ward Specialty

The ward specialty at the time of interview, as specified by the GRN, was one GRN in each of the rehabilitation, mental health, emergency and medical ward specialties, and six GRNs working in surgical, including orthopaedics. The allocation of wards in the graduate programme did not include any acute care medical or intensive care areas.

4.3.1.1.5 Highest Level of Postgraduate Education

Of the 10 GRNs interviewed, 80% had completed a Graduate Certificate in Clinical Nursing. This postgraduate qualification was offered through a partnership between the hospital and a WA university, and provided a work-integrated graduate learning programme (Drysdale, McBeath, Johansson, Dressler, & Zaitseva, 2016). The opportunity to complete this academic qualification was offered during orientation to graduates of one of the participating hospitals; however, this postgraduate course was not compulsory and ran in tandem with the hospital certificate for the first year of the nursing programme.

4.3.1.1.6 Previous Training/Work in Health Service

The percentage of GRNs who indicated previous registration and experience as an enrolled nurse (EN) was 40%. This included three graduates who had qualified and worked as an EN, and one graduate who completed the EN registration pathway as part of her Bachelor of Science (Nursing) course. Having previous experience as an EN was

reflected in the interview data findings. One other GRN had prior experience in the health industry by working as a hospital orderly.

4.3.1.2 Profile of CNE Participants

Eleven CNEs were interviewed. Table 4.2 summarises the sociodemographic characteristics of the CNE interviewees.

Table 4.2: CNEs' Sociodemographic Characteristics

Variable	n	%
Sex (female)	11	100
Length of time as RN		
< 10 years	1	9.1
10–20 years	4	36.4
> 20 years	6	54.5
Length of time as CNE		
< 2 years	2	18.2
2–5 years	8	72.7
> 5 years	1	9.1
Graduate ward specialty		
Medical	2	18.1
Medical/surgical	1	9.1
Mental health	1	9.1
Paediatrics	1	9.1
Rehabilitation	3	27.3
Surgical	3	27.3
Highest level of postgraduate education		
Master of Nursing	2	18.2
Graduate Diploma in Nursing	3	27.3
Graduate Certificate in Nurse Education	1	9.1
Graduate Certificate in Nursing	1	9.1
Diploma in Specialty	1	9.1
Certificate IV in Training and Assessment	4	36.4

4.3.1.2.1 Gender

All 11 interview CNE participants were female. The gender distribution of the accessible CNE population in the three participating hospitals was unknown due to the third-party representative preventing access to contact information.

4.3.1.2.2 Length of Time as RN

The time in years as a RN was an average of 20.4 years, with a minimum of nine years and a maximum of 34 years.

4.3.1.2.3 Length of Time as CNE

The length of time in years as a CNE was an average of 3.8 years, with a minimum of five months and a maximum of seven years. The majority of CNEs (72.7%) had been in the CNE role for between two and five years. The CNE role has been an established position in the participating hospitals since 2006.

4.3.1.2.4 Graduate Ward Specialty

The CNEs worked in a variety of ward specialties. One CNE was employed in each of the mental health, paediatrics and combination medical/surgical wards, two were in medical wards, three were in the medical/rehabilitation ward, and another three were in the surgical wards.

4.3.1.2.5 Highest Level of Postgraduate Education

Of the 11 CNEs, seven had completed postgraduate university nursing qualifications. Of these, two had gained a Master in Nursing and three had a Graduate Diploma in Nursing. Of the two CNEs with a graduate certificate, one was in general nursing and one was specifically in nurse education. The other qualifications noted were one CNE with a specialty diploma and four CNEs who had completed the Australian Vocational Education and Training (VET) Certificate IV in Training and Assessment. According to the job description for the CNE role in the participating hospitals, the minimum qualification required was the VET Certificate IV in Training and Assessment. If the CNE appointed did not have the Certificate IV, the expectation was for this to be completed as soon as practicable. Only one CNE had more than one postgraduate

qualification (one graduate certificate and two graduate diplomas) and one CNE had no postgraduate qualifications and had yet to commence the VET certificate.

4.3.1.2.6 Allocated Educator Work Hours

The number of hours worked per fortnight was an average of 47.6 hours, with a minimum of 35 hours and a maximum of 76 hours. The number of assigned educator hours varied between the wards represented in accordance to financial considerations, bed allocation and specialty requirements. Table 4.3 details the participants' allocated work hours.

4.3.1.2.7 Rostered Educator Days

In as much as each CNE had allocated work hours, these were assigned to a number of days per fortnight, with the actual hours per day varying between CNE and wards. These rostered educator days varied in accordance with the ward specialty needs and CNM directives. The majority of CNEs (54.5%) worked six days per fortnight. Of the other four CNEs, two worked five days, two worked 10 days (full time) and one worked seven days per fortnight (Table 4.3).

4.3.1.2.8 Rostered Clinical Days

The number of clinical days rostered for the CNE per fortnight was an average of 11 hours, with a minimum of seven hours and a maximum of 21 hours. These rostered clinical days were in addition to the rostered educator days. Of the 11 CNEs, seven (63.7%) worked as part-time educators with additional clinical shifts. The other four CNEs worked only as ward educators in either a full-time or part-time capacity (Table 4.3).

Table 4.3: CNE Educator and Clinical Hours/Days

CNE allocated hours per fortnight	n	%
76 hours	1	9.1
70 hours	1	9.1
48 hours	1	9.1
49 hours	1	9.1
42 hours	5	45.4
35 hours	2	18.2
Number of educator days rostered		
5 days	2	18.2
6 days	6	54.5
7 days	1	9.1
10 days	2	18.2
Number of clinical days rostered		
0 day	4	36.3
1 day (7 hours)	1	9.1
2 days (14 hours)	2	18.2
2 days (16 hours)	1	9.1
3 days (21 hours)	2	18.2
4 days (28 hours)	1	9.1

4.3.1.3 Profile of CNM Participants

Nine CNMs were interviewed. Table 4.4 summarises the sociodemographic characteristics of the CNM interviewees.

Table 4.4: CNMs' Sociodemographic Characteristics

Variable	n	%
Sex (female/male)	2/7	22/78
Length of time as RN		
< 10 years	0	0
10–20 years	4	44.5
> 20 years	5	55.5
Length of time as CNM		
< 2 years	2	22.2
2–5 years	2	22.2
> 5 years	5	55.6
Graduate ward specialty		
Medical	3	33.4
Mental health	1	11.1
Paediatrics	1	11.1
Rehabilitation	2	22.2
Surgical	2	22.2
Highest level of postgraduate education		
Graduate Certificate in Specialty	2	22.2
Graduate Certificate in Frontline Management	1	11.1
Graduate Certificate in Occupational Health and Safety	1	11.1
Certificate Business Administration	2	22.2
Certificate in Health Service Management	1	11.1
CNM hours per fortnight		
Full time 76 hours	9	100

4.3.1.3.1 Gender

Of the interviewed CNM participants, seven were female and two were male. This distribution of female to male managers in the clinical environment is consistent with the higher percentages of males in non-direct patient care roles (HWA, 2014a).

4.3.1.3.2 Length of Time as RN

The length of time in years as an RN was an average of 20.2 years, with a minimum of 11.5 years and a maximum of 29 years.

4.3.1.3.3 Length of Time as CNM

The length of time as a CNM was an average of seven years, with a minimum of seven months and a maximum of 16 years.

4.3.1.3.4 Graduate Ward Specialty

The ward specialty specified by the CNM was as follows: one CNM in each of the mental health and paediatric areas, two CNMs in medical/rehabilitation, two CNMs in surgical, and three CNMs in medical wards.

4.3.1.3.5 Highest Level of Postgraduate Education

Of the nine CNMs interviewed, six had completed postgraduate nursing studies. Of these six with qualifications, four CNMs had completed a Graduate Certificate in Nursing or Business Management and two CNMs had completed graduate certificates in their specialty. Only three CNMs did not have any postgraduate or other qualifications.

4.3.1.3.6 Highest Level of Postgraduate Education

All nine of the CNMs worked full-time 76 hours per fortnight, as per the participating hospitals' job description and directives for the CNM role.

4.3.1.4 Summary

In summary, the previous sections have described the quantitative findings of the demographic and educational profiles of the GRN, CNE and CNM interview participants. This synopsis of the participants provides a representation of this level of nurse in the health service population. The following section focuses on examining the GRNs' online questionnaire findings related to the participant demographics and responses associated with the CNE role.

4.3.2 GRN Online Questionnaire

The link to the online questionnaire was emailed to the GRNs with an invitation to participate, and resent at two and four months from the commencement of data collection. The online questionnaire was open for a total period of six months. The

GRNs were asked to answer the questions in relation to their time on the wards as a newly qualified RN.

4.3.2.1 Questionnaire Response Rate

Chapter 3 presented the method for the online questionnaire distribution. Data collection occurred over the six-month period between February and July 2015, with a response rate of 33%. Of the participants accessing the online questionnaire, 40 GRNs commenced the questionnaire and 31 completed all items, with a completion rate of 78%. The incomplete questionnaire responses were included, as the sample size was accepted as adequate for the purpose of descriptive statistics (Israel, 1992)

4.3.2.2 Questionnaire Participant Demographics

The GRN participants were from the three participating hospitals in WA. The participants were full-time or part-time employees of these three hospitals, employed in a nursing graduate programme, with completion dates ranging between 2012 and 2015. These participants may have had both public and private ward experiences.

4.3.2.2.1 Response Rate by Hospital

All three participating hospitals were represented in the responses. Table 4.5 indicates the number of participants from each hospital.

Table 4.5: Response Rate by Hospital

% of Total GRNs in each Hospital Graduate Programme	Hospital	Participant	%
46%	Hospital 1	30	77%
16%	Hospital 2	7	18%
38%	Hospital 3	2	5%
100%	Total	39	100%

Hospital 1 was significantly over-represented (see Figure 4.1). This may be partly due to the larger size of hospital being able to take more GRNs in their graduate programme, and partly due to the participants' awareness of the researcher's previous educator role in Hospital 1, which may have increased recruitment. The appointment of a third-party representative (Manager of Training and Development WA) eliminated the direct

involvement of the researcher in the questionnaire data collection. This may have affected the response rates in Hospitals 2 and 3, despite the researcher's correspondence with the training and development staff to encourage participation.
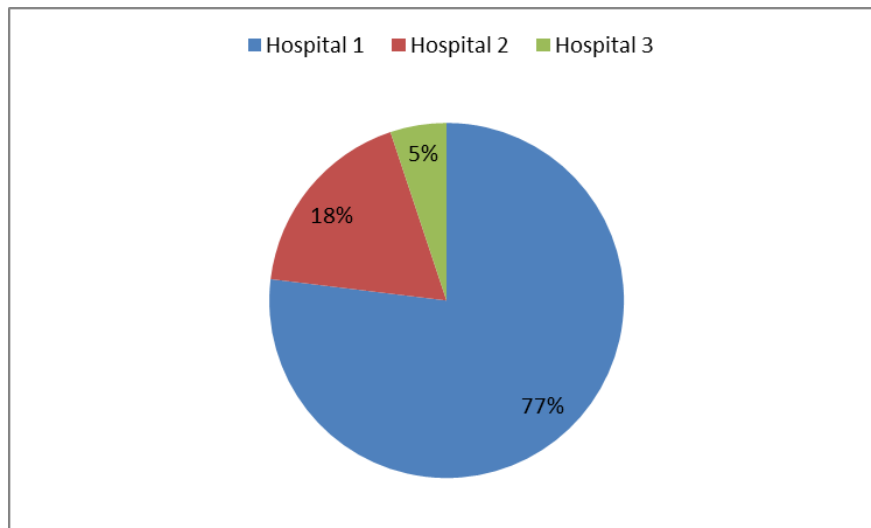
Figure 4.1: Response Rate by Hospital

4.3.2.2.2 Age

Over half of the GRN participants were aged between 21 and 30 years (51%), with the next highest age group between 41 and 50 years (28%). Four of the older participants had previously worked as ENs prior to completing a degree in nursing. Similarly, the age profile of undergraduate nursing students in 2006 determined by university statistics in two states of Australia (Queensland and South Australia) identified 51% ($n = 3763$) as being at or below 25 years of age (Gaynor et al., 2007). The available age statistics on Australian nurses do not reflect the age of the newly qualified graduate nurse. The average age of employed RNs in 2015 was 44.1 years, with 37.2% over 50 years old (AIHW, 2016b). Figure 4.2 summarises the age group distribution of the GRNs.
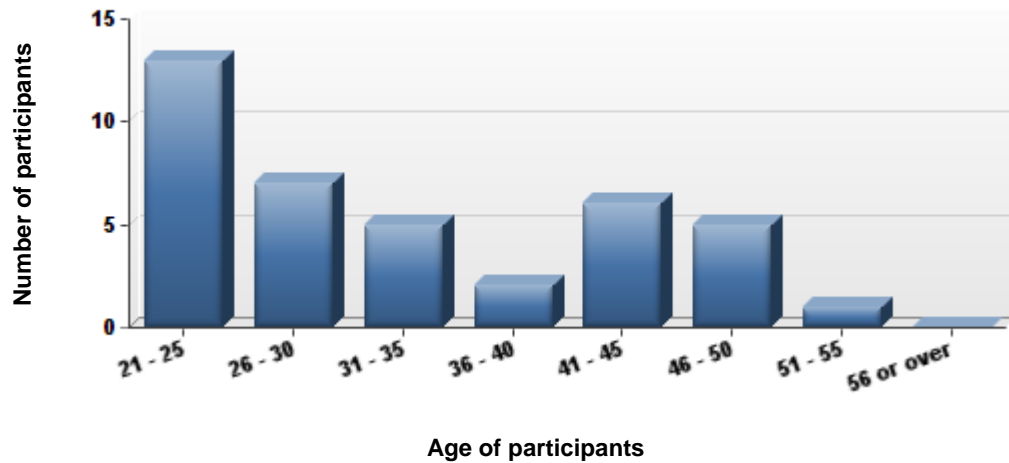
Figure 4.2: Age of GRN Participants

4.3.2.2.3 Gender

All participants were female. Historically, female graduate nurses remain in the majority, accounting for approximately 90% of newly qualified nurses in a graduate programme (HWA, 2014a). In WA, the percentage of female nurses registered with the NMBA (2016c) is 91.38% and Australia wide is 89.38%.

The distribution of the email invitation forwarded by the third-party representative prevented the researcher from determining the gender distribution of the accessible GRN population across all three hospital sites. Therefore, the views expressed were only those of the female GRNs, which could be seen as a limitation of the study.

4.3.2.2.4 Graduate Programme

Of the GRN participants, 72% ($n = 28$) had completed the graduate programme, and 28% ($n = 11$) had completed nine months of the 12-month programme. Of those who had completed their graduate programme, the majority (75%) completed in 2014 and 2015. Table 4.6 summarises the years of completion.

Table 4.6: Participants' Year of Completing the Graduate Programme

Year of Completion	Participant JHC	Participant PHC	Participant HPH	Participant Total	%
2012	1	0	0	1	4%
2013	6	0	0	6	21%
2014	9	2	0	11	39%
2015	7	1	2	10	36%
Total	23	3	2	28	100%

4.3.2.3 Questionnaire Quantitative Data Analysis

This section reviews and analyses the responses to the GRN online questionnaire using descriptive statistics. This summary of GRN responses provides a way to describe, organise and display the data for analysis and interpretation using tables, charts and graphs (Polit & Beck, 2014).

4.3.2.3.1 Frequency of GRN and CNE Meetings on the Ward

This question sought to obtain information on the frequency of meetings between the GRN participants and CNEs on the ward. For example, a meeting may have occurred if the GRN or CNE requested to discuss GRN progress, concerns about patient care, or the graduate programme. The meeting event may have occurred formally in a private area out of patient care hours or informally in the ward outside of the normal ward and patient interaction time.

The GRNs indicated how often they met with their CNE. The majority of GRNs (60%) met with their CNEs sometimes or most of the time, while 40% reported that they met rarely or never. Table 4.7 summarises how often the GRNs meet with their CNE.

Table 4.7: Frequency of GRN and CNE Meetings

Frequency of CNE and GRN Meetings		Number of Participants	%
Never		4	11%
Rarely		11	29%
Sometimes		14	37%
Most of the time		9	24%
Always		0	0%
Total		38	100%

The results also indicated the regularity of the GRN meeting with the CNE during each month. Of those meetings, the highest number of GRNs met with their CNE less than once a month (39%); however, a significant number of GRNs met during the month (34%) and during the week (24%). Table 4.8 details the regularity of GRNs meeting more than once a month.

Table 4.8: Regularity of GRN and CNE Meetings

Regularity of CNE and GRN Meetings		Number of Participants	%
Less than once a month		15	39%
Once a month		7	18%
2–3 times a month		6	16%
Once a week		5	13%
2–3 times a week		4	11%
Daily		0	0%
Other		1	3%
Total		38	100%

Hence, the occurrence of meetings varied between the GRNs and CNEs. For more than half of the GRNs, contact with the CNE was sometimes or most of the time, whereas less than half of the GRNs had minimal to no contact. According to the graduate programme handbook from one of the hospitals in the study, the CNE provides initial orientation to the clinical area, guidance for professional development, education and direction to resources (Jackson & Payne, 2014). This includes time allocated for one-on-one support to discuss patient care issues; provide feedback and debrief; and discuss progress related to performance, goal achievement and improvement areas (Henderson et al., 2015). However, the regularity of meetings with the CNE described by the GRNs

did not always consider the presence of the CNE during the shift, where the GRN may have been working alongside the CNE at the point of care, or may have made contact with the CNE at some point in their working day. This presence of the CNE during the GRNs' shift times highlights the CNEs' availability to the GRNs.

4.3.2.3.2 CNE Availability

CNE availability relates to the normal daily interactions between the GRN and CNE as dictated by the graduate programme and CNE role description. The GRNs were asked to indicate how available the CNE was to assist them when they needed help with patient care during work time. Table 4.9 outlines the number of participants and their responses that specified the availability of the CNE. The majority of GRNs found the CNE available for all or most of the time (43%, $n = 16$), while 34% ($n = 13$) indicated that the CNE was sometimes available, and 23% found that the CNE was rarely ($n = 7$) or never ($n = 2$) available.

Table 4.9: Availability of the CNE

CNE Availability		Number of Participants	%
Never		2	5%
Rarely		7	18%
Sometimes		13	34%
Most of the time		12	32%
Always		4	11%
Total		38	100%

The GRNs reported their experience of working in the ward setting when the CNE was not available to them during their shift. The majority of participants 97% ($n = 35$) had experienced working on the ward when the CNE was not available, compared to only 3% ($n = 1$) who reported that the CNE was available to them. Figure 4.3 highlights the reasons indicated for the CNEs' absence. The majority of participants specified that the CNE was not on duty (76%, $n = 29$) or was on leave (34%, $n = 13$). Other reasons included being busy with education (29%, $n = 11$), working a clinical shift (29%, $n = 11$) or being busy with other staff (26%, $n = 10$).
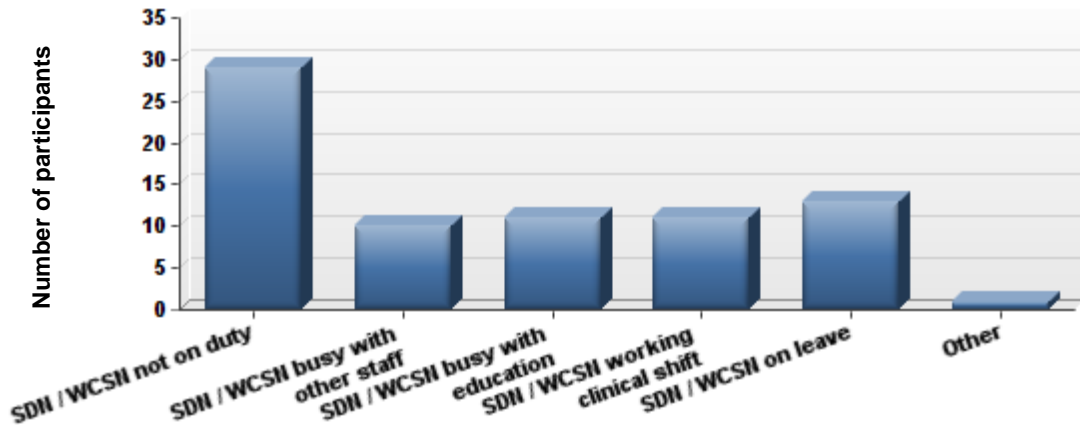
Figure 4.3: GRNs' Perceptions of Why CNE was Unavailable

Thus, the majority of GRNs found the CNE available on request; however, a quarter had a more negative experience. Almost all GRNs had experienced the unavailability of the CNE during their graduate programme, with the view that the CNE was more likely to be inaccessible because they were on a day off or on leave. When the CNE was on duty yet unavailable, the GRNs believed the CNE was otherwise engaged in education duties, working a clinical shift with a patient load, or busy with other staff requests.

4.3.2.3.3 GRN Preferences for Nursing Staff Help with a Patient

To provide an understanding of the CNE role in relation to the GRNs' need for help with a patient, the participants ranked in order of preference the most likely person from whom they would seek assistance. A heat map is employed as a graphical representation of data that uses colour to visualise preferences and rank order (Pleil, Stiegel, Madden, & Sobus, 2011). Figure 4.4 illustrates the GRNs' preferences and rank order of the nursing staff from whom they would seek assistance. In the heat map, green indicates low preference and red indicates high preference.

The results identified that the GRNs' first preference was to seek help from their nursing team member (53%, $n = 19$) and second preference was the coordinator of the shift (42%, $n = 15$). The CNE was rated as the third preference (42%, $n = 15$) and equal fourth preference with the CNM (33%, $n = 12$). The 'other' category included allied health staff, RNs and ENs.

Preference / Staff	1st	2nd	3rd	4th	5th	6th
CNM	6%	6%	8%	33%	47%	0%
Team nursing member	53%	25%	11%	11%	0%	0%
CNE	0%	6%	42%	33%	17%	3%
Preceptor	6%	19%	28%	14%	31%	3%
Shift coordinator	36%	42%	11%	6%	6%	0%
Other	0%	3%	0%	3%	0%	94%
Total	36	36	36	36	36	36

Figure 4.4: GRNs' Staff Preferences for Help with a Patient

Therefore, regardless of the presence or absence of the CNE, when the GRNs needed assistance with their patient care, the CNE was rated as third preference, behind the GRNs' nursing team member and shift coordinator. Support available to the GRN was found within the team nursing model, including the team leader, shift coordinator and other team members. A study by Cioffi and Ferguson (2009) found that nurses were satisfied with team nursing support when assistance was needed to provide patient care.

4.3.2.3.4 GRNs' Perception of the Significance of the CNE Role

Figure 4.5 indicates the GRNs' perceptions of the significance of the CNE role. The majority of GRNs (86%, $n = 31$) agreed or strongly agreed that the CNE role during their first year of nursing was important. Of the remaining participants, 6% ($n = 2$) strongly disagreed and 3% ($n = 8$) neither agreed nor disagreed. Figure 4.5 indicates the participants' responses.
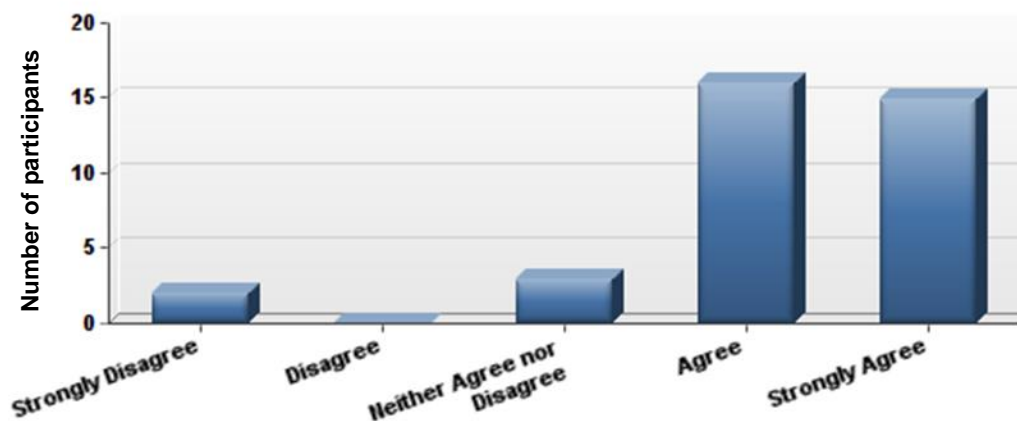
Figure 4.5: Significance of the CNE Role

The GRNs reported their perceptions of the CNE role support (Table 4.10). A greater percentage (89%, $n = 32$) perceived the CNE role as positive, while four participants (11%) did not agree that the CNE role was positive.

Table 4.10: GRNs' Perceptions of CNE Role Support

CNE Role is Positive		Participant	%
Yes		32	89%
No		4	11%
Total		36	100%

When asked to further reflect on the necessity of the CNE support role, 92% of the GRNs agreed the CNE was necessary for support in the first year ($n = 33$). Three of the GRNs (8%) did not agree with this statement, as shown in Table 4.11.

Table 4.11: GRNs' Perceptions of the Necessity of CNE Support

CNE Role is Necessary for GRN Support in the First Year		Participant	%
Yes		33	92%
No		3	8%
Total		36	100%

In summary, the majority of GRN participants perceived the CNE role as favourable to their first year of nursing practice; however, a small number of participants indicated that the CNE was not important or necessary for their graduate programme. The graduate programme handbook also details the support provided by other members of the nursing team, such as ward preceptors, the graduate coordinator, the graduate

facilitator and the CNM (Jackson & Payne, 2014). It is likely that some of the GRNs used all of the available graduate support, with minimal need for the CNE.

4.3.2.3.5 GRN and Patient Errors

The GRNs were asked to indicate whether access to the supernumerary CNE on the ward helped reduce their risk of making a patient error during their graduate year. Of the participants, the majority (79%, $n = 27$) agreed, while 21% ($n = 7$) did not agree. Table 4.12 depicts these results.

Table 4.12: GRNs' Perceptions of CNE Role Support to Reduce Patient Error

Access to the CNE Role Helps Reduce GRN Patient Error		Participant	%
Yes		27	79%
No		7	21%
Total		34	100%

To ascertain who the GRNs would notify if they made a patient error during their graduate year, the GRNs were asked to rank in order of preference who they would most likely inform. The results are illustrated in the heat map in Figure 4.6. The GRNs' first preference was to inform the coordinator of the shift (52%, $n = 17$), while their second preference was equally the coordinator of the shift and the doctor (27%, $n = 9$). The CNE was rated as the sixth preference (33%, $n = 11$) behind the doctor (third preference) and CNM (fourth and fifth preference).

Preference / Staff	1st	2nd	3rd	4th	5th	6th	7th	8th
Doctor	6%	27%	33%	15%	6%	3%	6%	3%
Graduate programme coordinator	0%	3%	3%	12%	12%	21%	21%	27%
CNM	6%	6%	18%	18%	27%	12%	9%	3%
Team nursing member	24%	15%	15%	15%	12%	6%	9%	3%
Shift coordinator	52%	27%	6%	9%	6%	0%	0%	0%
CNE	0%	12%	9%	12%	21%	33%	3%	9%
Patient	6%	3%	12%	12%	6%	12%	27%	21%
Preceptor	6%	6%	3%	6%	9%	12%	24%	33%
Total	33	33	33	33	33	33	33	33

Figure 4.6: GRNs' Preferences for Notification of a Patient Error

In the case of a patient error, the GRNs were asked to rank in order of preference (from most to least likely) the person with whom they felt they could discuss the incident. In this scenario, illustrated in Figure 4.7, the most likely person with whom the GRN would discuss the incident was the team nursing member (33%, $n = 11$). The second preference was the CNM (27%, $n = 9$), while the CNE was equal third preference (27%, $n = 9$) with the shift coordinator. The 'other' category specified by the GRNs was family (while maintaining patient anonymity) and friends who were nurses (being mindful of confidentiality).

Preference / Staff	1st	2nd	3rd	4th	5th	6th	7th	8th	9th
CNM	9%	27%	18%	12%	21%	3%	6%	0%	3%
Team nursing member	33%	12%	6%	18%	18%	9%	0%	0%	3%
Shift coordinator	27%	21%	27%	12%	9%	3%	0%	0%	0%
CNE	12%	24%	27%	18%	6%	6%	0%	3%	0%
Preceptor	9%	12%	12%	24%	15%	21%	0%	6%	0%
Graduate programme coordinator	6%	3%	6%	12%	18%	42%	6%	3%	0%
Counsellor	0%	0%	3%	3%	3%	12%	64%	9%	6%
Pastoral care	0%	0%	0%	0%	0%	3%	15%	52%	21%
HR	0%	0%	0%	0%	3%	0%	6%	24%	58%
Other	3%	0%	0%	0%	6%	0%	3%	3%	9%
Total	33	33	33	33	33	33	33	33	33

Figure 4.7: GRNs' Preference of Person to Debrief after Patient Error

Over three quarters (79%) of the GRN participants identified the supernumerary CNE as a constructive presence to help reduce their risk of making a patient error in their first year of nursing. Less than one quarter did not accept that access to the CNE made a difference to their patient care safety. In the study by Duffield et al. (2007), the authors confirmed that the presence of the CNE on the ward—who provided planned and unplanned education—was a factor that positively affected GRNs' capacity for medication safety.

If a patient error was made by the GRN, the most likely person they would inform was the coordinator, while the CNE was rated as the sixth preference. Similarly, following an error, the GRN chose a nursing team member or the CNM to debrief, while the CNE was their third preference. It is evident that the team nursing model supports newly qualified graduates to work towards independent practice, in addition to providing a

level of comfort in communicating patient care incidents to safeguard patient care (Missen, McKenna, & Beauchamp, 2016).

4.3.2.3.6 CNE Leadership Qualities

In this section, the GRNs were invited to provide data about the role of the CNE in relation to ward clinical leadership. A validated tool was employed to understand the GRNs' perceptions of the qualities and characteristics they associated with the CNEs' clinical leadership. The Perceptions of Clinical Leadership Questionnaire tool, created by Stanley (2014; personal communication, September 24, 2014), contains a list of 54 qualities and characteristics that are ranked in order of preference. This tool has been used in a number of studies over the last decade centred on describing the clinically focused leader (Stanley, 2005, 2006c, 2008, 2014).

The GRN participants were asked to indicate the degree to which they believed the CNE needed to have leadership qualities as part of their role. As outlined in Table 4.13, the majority of GRNs (94%, *n* = 30) agreed or strongly agreed.

Table 4.13: GRNs' Perceptions of CNE Leadership Qualities

Need for CNE to have Leadership Qualities		Participant	%
Strongly disagree		0	0%
Disagree		1	3%
Neither agree nor disagree		1	3%
Agree		9	28%
Strongly agree		21	66%
Total		32	100%

By strongly agreeing with the need for the CNE to have leadership qualities, the GRNs recognised these skills were necessary for the performance of their role in the clinical setting. Stanley (2009) noted that clinical leadership demonstrates values in action, as reflected in nursing staff. As such, the GRNs have an expectation in their first year of nursing for clinical expertise and guidance from a nursing leader, in accordance with the graduate programme outcomes (Tsai et al., 2014).

The GRNs were asked to select the attributes, qualities or characteristics that they *strongly* associated with clinical leadership. The top eight ranked attributes (highlighted) of CNE clinical leadership were as follows: is approachable (72.5%), is

supportive (70%), is clinically competent (65%), sets direction (62.5%), sets goals and targets (62.5%), is a mentor (62.5%), is caring and compassionate (62.5%), and has integrity and honesty (60%). Table 4.14 lists the CNE qualities and characteristics as ranked by the GRNs in order and percentage.

Table 4.14: CNE Qualities and Characteristics Strongly Associated with Clinical Leadership

Rank	Quality or Characteristic	Participant Number	%
1	Is approachable	29	72.5%
2	Is supportive	28	70.0%
3	Is clinically competent	26	65.0%
4	Sets direction	25	62.5%
4	Sets goals and targets	25	62.5%
4	Is a mentor	25	62.5%
4	Is caring/compassionate	25	62.5%
5	Has integrity and honesty	24	60.0%
5	Is an advocate	24	60.0%
6	Is an effective communicator	23	57.5%
7	Copes well with change	22	55.0%
7	Is a role model for others in practice	22	55.0%
7	Inspires confidence	22	55.0%
8	Is a critical thinker	21	52.5%
8	Is a motivator	21	52.5%
8	Directs and helps people	21	52.5%
9	Is a guide	20	50.0%
9	Evaluates the performance of staff	20	50.0%
10	Is flexible	19	47.5%
10	Is consistent	19	47.5%
10	Aligns (supports) people	19	47.5%
11	Is a teacher	18	45.0%
11	Has a healthy sense of humour	18	45.0%
12	Copes well with complexity	17	42.5%
12	Is visible in practice	17	42.5%
13	Considers relationships valuable	16	40.0%
13	Is just/fair	16	40.0%
14	Is inspirational	15	37.5%
14	Can be a decision maker	15	37.5%

14	Resolves conflict	15	37.5%
15	Has management experience	13	32.5%
16	Is creative/innovative	12	30.0%
16	Maintains relationships	12	30.0%
17	Is a regulator/supervisor	11	27.5%
17	Manages staff	11	27.5%
18	Is analytical	10	25.0%
18	Is a coach	10	25.0%
18	Deals with resources allocation	10	25.0%
18	Is articulate	10	25.0%
19	Deals with routine	7	17.5%
19	Deals with reward/punishment	7	17.5%
19	Counts on trust	7	17.5%
20	Is a negotiator	6	15.0%
20	Is responsible for others	6	15.0%
20	Must have relevant postgraduate training	6	15.0%
21	Is courageous	5	12.5%
22	Takes calculated risks	3	7.5%
22	Is a visionary	3	7.5%
22	Is artistic/imaginative	3	7.5%
23	Is controlling	2	5.0%
23	Is a change agent	2	5.0%
23	Works alone	2	5.0%
23	Is an administrator	2	5.0%
23	Is conservative	2	5.0%

The GRNs ranked the eight leadership qualities or characteristics that they strongly associated with CNE leadership in the clinical setting. These attributes of CNE clinical leadership were associated with the CNEs' personal qualities, whereby being approachable, caring and compassionate, and having integrity and honesty were highly valued. Second, the CNE leader ensured that the GRNs had support and provided mentorship underpinned by clinical expertise. Third, the CNE leader guided the GRNs to successful completion of the graduate programme through achieving clinical practice goals and learning outcomes. These qualities and characteristics are identified in the literature as significant to being a role model, mentor and leader in the clinical environment (Adelman-Mullally et al., 2013; Conway & Elwin, 2007; Dattilo, Brewer, & Streit, 2009; Sayers, Lopez, et al., 2015).

The GRNs were also prompted to consider the qualities and characteristics they *least* associated with clinical leadership. The same list of 54 qualities and characteristics were offered and GRNs were asked to select the attributes, qualities or characteristics that they least associated with clinical leadership. The top eight ranked qualities or characteristics least associated with CNE clinical leadership were as follows: being controlling (55%), working alone (47.5%), taking calculated risks (37.5%), being an administrator (30%), being artistic and imaginative (30%), dealing with reward/punishment (30%), having relevant postgraduate training (25%) and being conservative (25%). Table 4.15 ranks the qualities and characteristics least associated with clinical leadership in order and percentage.

Table 4.15: CNE Qualities and Characteristics Least Associated with Clinical Leadership

Rank	Characteristic	Numbers	%
1	Is controlling	22	55.0%
2	Works alone	19	47.5%
3	Takes calculated risks	15	37.5%
4	Is an administrator	12	30.0%
4	Is artistic/imaginative	12	30.0%
4	Deals with reward/punishment	12	30.0%
5	Must have relevant postgraduate training	10	25.0%
5	Is conservative	10	25.0%
6	Is courageous	7	17.5%
6	Deals with resources allocation	7	17.5%
6	Is a negotiator	7	17.5%
6	Has management experience	7	17.5%
7	Is a change agent	6	15.0%
7	Is creative/innovative	6	15.0%
8	Is a regulator/supervisor	5	12.5%
9	Resolves conflict	4	10.0%
9	Manages staff	4	10.0%
9	Is a visionary	4	10.0%
9	Deals with routine	4	10.0%
10	Is articulate	3	7.5%
10	Has a healthy sense of humour	3	7.5%
10	Can be a decision maker	3	7.5%
11	Is a coach	2	5.0%

11	Is analytical	2	5.0%
11	Is visible in practice	2	5.0%
11	Is responsible for others	2	5.0%
12	Is just/fair	1	2.5%
12	Evaluates the performance of staff	1	2.5%
12	Counts on trust	1	2.5%
12	Aligns (supports) people	1	2.5%
12	Is a teacher	1	2.5%
12	Is a critical thinker	1	2.5%
12	Sets goals and targets	1	2.5%
12	Is flexible	1	2.5%
	Is an effective communicator	0	0.0%
	Inspires confidence	0	0.0%
	Maintains relationships	0	0.0%
	Is a role model for others in practice	0	0.0%
	Is caring/compassionate	0	0.0%
	Is approachable	0	0.0%
	Is an advocate	0	0.0%
	Is supportive	0	0.0%
	Is clinically competent	0	0.0%
	Directs and helps people	0	0.0%
	Copes well with complexity	0	0.0%
	Is consistent	0	0.0%
	Is a mentor	0	0.0%
	Is a motivator	0	0.0%
	Is inspirational	0	0.0%
	Has integrity and honesty	0	0.0%
	Is a guide	0	0.0%
	Considers relationships valuable	0	0.0%
	Sets direction	0	0.0%
	Copes well with change	0	0.0%

The GRNs ranked eight of the leadership qualities or characteristics least associated with CNE leadership in the clinical setting. Three of the attributes of clinical leadership not associated with the CNE were controlling behaviour, working alone and dealing with reward and punishment. These behaviours are significant of poor leadership related to conflict management and difficult relationships (Al-Sawai, 2013). The GRNs' perception of CNE leadership as being least associated with being an administrator may

be influenced by the CNM role of ward management and administration (Courtney, Nash, Thornton, & Potgieter, 2015). The attribute of 'conservative' may relate to a leader's desire for traditional methods, which does not align with the clinical environment of increasing complexity, chronicity, social care needs and advancing patient care with new technology and evidence-based practices (Marquis & Huston, 2012). CNE leadership was not defined in this study by artistic and imaginative abilities, which may not be perceived as important in any leadership role (Potempa & Furspan, 2015). Further, by ranking relevant postgraduate training as least associated with clinical leadership, the GRNs may be limited by their own lack of understanding of the role of leadership in the clinical environment, and the benefits of enhancing nursing care provision for the benefit of patients (Barnhill, McKillop, & Aspinall, 2012).

The GRNs were also prompted to consider their views on leadership in relation to the CNE promoting their own role as a leader, the influence of their leadership in the ward and in the hospital, sharing their leadership values and beliefs, and their role as a leader in cultural change. These views are described below.

4.3.2.3.7 CNE Leadership

The GRNs were invited to state their views of and insights to the CNE leadership position on the ward and leadership strengths and weaknesses. The GRNs were asked if the CNE promoted themselves as a leader on the ward. Figure 4.8 depicts the results. The majority of GRNs thought the CNEs promoted themselves as a leader either sometimes (39%, $n = 12$), most of the time (35%, $n = 11$) or always (16%, $n = 5$). Ten per cent ($n = 3$) of the GRNs thought the CNEs rarely promoted themselves as a leader in the ward.
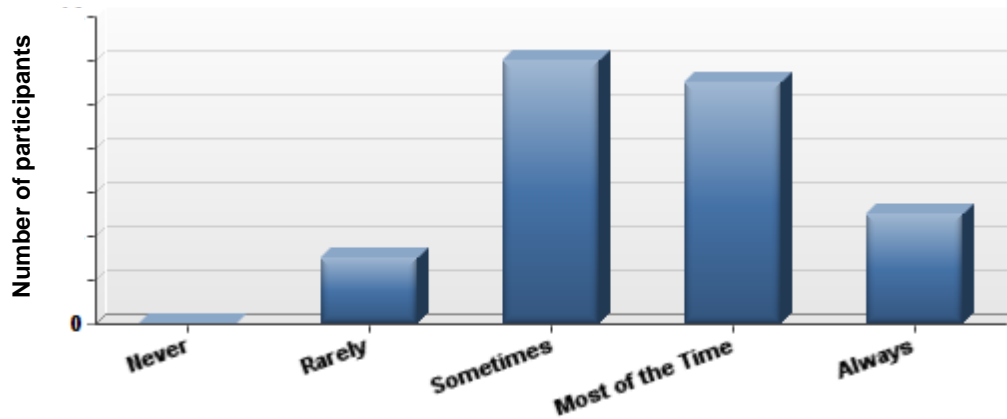
Figure 4.8: CNE Promotion of Self as a Leader

The GRN participants were asked if they viewed the CNE role as an influential leader in the ward. Figure 4.9 presents the following data. The majority of GRNs thought the CNEs had an influential leadership role on the ward sometimes (32%, $n = 10$), most of the time (35%, $n = 11$) or always (19%, $n = 6$). Of the other participants, 13% ($n = 4$) thought CNEs rarely had an influential leadership role on the ward.
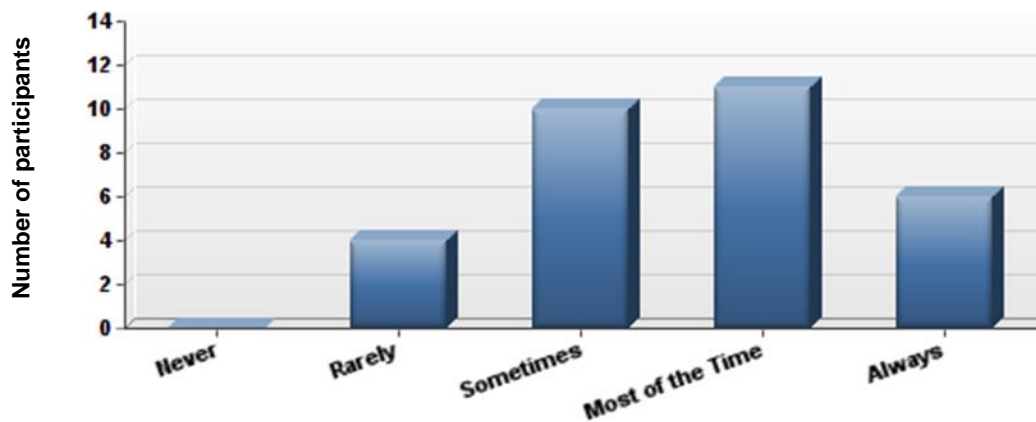
Figure 4.9: CNE Influence as a Leader in the Ward

Expanding on the leadership role of the CNE, the participants were asked if the CNE had an influential leadership role in the hospital. Figure 4.10 illustrates that the majority of GRNs thought the CNEs had an influential leadership role in the hospital most of the time (35%, $n = 11$), sometimes (32%, $n = 10$) or always (6%, $n = 2$). More GRNs (26%, $n = 8$) thought CNEs rarely had an influential leadership role in the hospital.
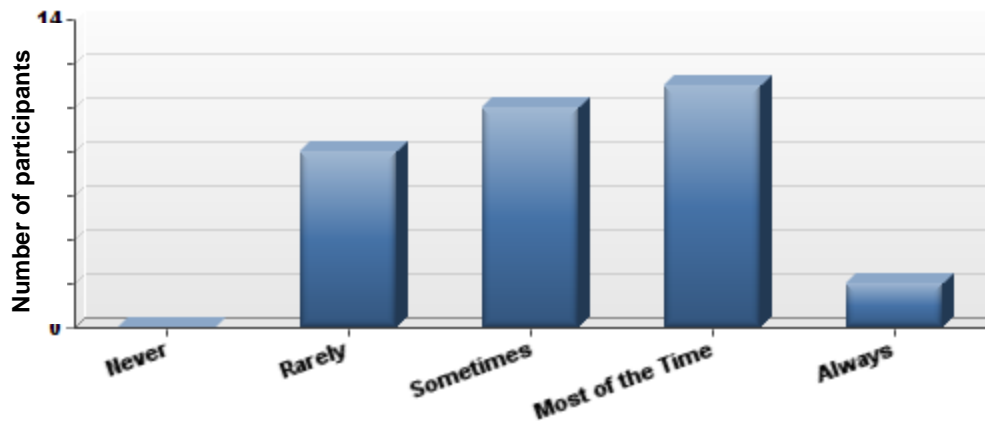
Figure 4.10: CNE Influence as a Leader in the Hospital

The GRN participants were asked about the CNEs' leadership practices in relation to sharing personal values, beliefs and principles; encouraging positive cultural change in the ward environment; and evidence of graduate guidance with attributes of concern and compassion. The GRNs reported how often they perceived the CNE sharing their values, beliefs and principles with them. Table 4.16 outlines the following results. The majority of GRNs reported sometimes (45%, $n = 14$) and most of the time (39%, $n = 12$). The minority thought that the CNEs shared their values, beliefs and principles with them always (6%, $n = 2$), never (6%, $n = 2$) and rarely (3%, $n = 1$).

Table 4.16: CNEs Share Their Values, Beliefs and Principles

CNEs Share Their Values, Beliefs and Principles		Participant	%
Never		2	6%
Rarely		1	3%
Sometimes		14	45%
Most of the time		12	39%
Always		2	6%
Total		31	100%

When answering the question of whether the CNEs encouraged positive cultural change on the ward, the majority of GRNs thought they did this most of the time (42%, $n = 13$) and equally sometimes and always (26%, $n = 8$). Only 6% ($n = 2$) thought the CNEs encouraged positive cultural change never and rarely. Table 4.17 summarises these results.

Table 4.17: CNEs Encourage Positive Cultural Change

CNE Encourages Positive Cultural Change		Participant	%
Never		1	3%
Rarely		1	3%
Sometimes		8	26%
Most of the time		13	42%
Always		8	26%
Total		31	100%

Concern and compassion are attributes associated with nursing (Stanley, 2008). As a leadership quality and in relation to the GRNs' first year of nursing, the participants reported that the CNEs were sometimes and most of the time guided by concern and compassion (42%, *n*=13). Of the remaining participants, 13% (*n* = 4) reported always and 3% (*n* = 1) reported rarely (Table 4.18).

Table 4.18: CNEs are Guided by Concern and Compassion

CNE Guided by Concern and Compassion		Participant	%
Never		0	0%
Rarely		1	3%
Sometimes		13	42%
Most of the time		13	42%
Always		4	13%
Total		31	100%

4.3.2.3.8 Cross-tabulations of Age-related Data

The GRN online questionnaire data were filtered with regard to the age groups of GRN participants in years, which were as follows: 21 to 25 (33%), 26 to 30 (18%), 31 to 35 (13%), 36 to 40 (5%), 41 to 45 (15%), 46 to 50 (13%) and 51 to 55 (3%). All responses were reviewed and analysed specifically related to each age group. There was no significant difference in the findings from Questions 6 to 23. The questions 27 to 32 in the two age groups of 26 to 30 and 31 to 35 (31%) which related to the extent to which the CNEs promoted their role as a leader, their leadership influence in the ward and hospital setting, their encouragement of cultural change and sharing of values and beliefs, and having concern and compassion, indicated a difference. These findings

reported an overall positive agreement in relation to the variable agreement of the other age groups.

In summary, the majority of GRNs viewed the CNE as a clinical leader who promoted their leadership role and had a leadership influence in their ward—for some, most or all of the time. In this manner, the CNEs acknowledged their position as an educational expert, with interpersonal skills that enabled the GRNs to develop as professionals and to deliver quality and safe patient care. Slightly less than the majority of GRNs also viewed that the leadership influence of the CNE role extended to the wider hospital; however, more GRNs thought this influence was uncommon. Stanley (2006c) noted that clinical nurse leaders vary in age, length of time as an RN, and nursing and management experience; thus, leadership influence is not related to seniority.

In relation to the CNEs' leadership practices, the majority of GRNs highlighted the CNEs as sharing their values, beliefs and principles; encouraging positive cultural change; and displaying personal attributes of concern and compassion. These leadership attributes are associated with clinical leaders who are visible, expert and cognisant of contemporary nursing challenges (Stanley, 2008). These attributes provided the foundation for being an exemplary role model and provided the GRNs in their first year of nursing with the confidence, support and encouragement to successfully complete the graduate programme.

4.4 Summary of Quantitative Findings

The quantitative findings consisted of the demographic information of the three subgroup interview participants (GRNs, CNEs and CNMs) and the GRNs' online questionnaire responses. A descriptive statistical approach was used to provide simple summaries and graphics analysis (Polit & Beck, 2014). The purpose of the online questionnaire was to confirm and expand on the interview data in order to explore and generate a deeper understanding of the effect of the CNE role specifically related to the GRNs' safe and quality patient care and transition to competent and confident practitioners. The online questionnaire explored the GRN population demographics in relation to age, gender, hospital site of graduate programme, and current participation or completion date. The reduced response rate created uneven hospital representation and insufficient data from each hospital site, which limited the comparisons.

The quantitative findings demonstrated affirmation of the supportive and resource-rich educator role of the CNE in the newly qualified GRNs' first year of nursing. Overall, the interactions between the GRN and CNE were a positive experience. The GRNs highlighted the accessibility, availability and approachability of the CNEs through periodic meetings and receiving assistance. The majority of GRN participants perceived the CNE role as important, necessary and favourable to their safe and quality patient care. Many identified the supernumerary CNE as a constructive presence to help reduce their risk of making a patient error.

Some of the quantitative findings demonstrated the limitations of the CNE role related to availability. Some GRNs noted minimal interaction with their CNE when assistance was required. Almost all GRNs had experienced the absence of the CNE due to them taking a day off, being on leave or being otherwise engaged. Regardless of the presence or absence of the CNE, when the GRNs needed assistance with their patient care, their preference was for their nursing team and ward members. If a patient error was made by the GRN, the most likely person informed was the coordinator, with the CNE rated as the sixth preference. Similarly, following an error, the GRN chose a nursing team member or the CNM to debrief, before approaching the CNE as their third preference. In this manner, the management of patient errors was not seen by the GRNs as a primary role of the CNE, but that of their nursing team members. These quantitative findings are expressed as an equation in Figure 4.11, where the supernumerary CNEs' availability and positive educational support, in partnership with the point-of-care nursing team members, provide the assistance expected by the GRNs to care for their patients safely.

Figure 4.11: Management of Patient Errors Summary

As a leader in the clinical environment, the CNEs' influence was positive. The GRNs identified the characteristics they most and least associated with clinical leadership, highlighting the CNE as a clinical expert who provided the care and direction needed to support the GRNs through their first year of nursing. The GRNs recognised the CNE as a ward leader through identification of the CNE position; the CNE's influence on the ward staff and wider hospital; and the CNE's shared values, professional concerns and compassion for patients through effective nursing care and as a change champion.

In summary, the quantitative findings indicated that the supernumerary CNE availability, positive support and leadership attributes, in tandem with the nursing team members, provided the assistance required by GRNs to care for their patients safely.

4.5 Chapter Summary

This chapter has presented and analysed the demographic data from the GRN, CNE and CNM subgroup interviews, and the quantitative data obtained from the GRNs' online questionnaire in relation to the role and leadership of the CNE. These findings described the value of the CNE role to the newly qualified graduate nurses in their first year of nursing.

The following Chapter 5 presents the findings from the interview data from the GRN, CNE and CNM subgroup participants, and analyses these findings according to the research design process described in Chapter 3. Chapter 6 will provide further exploration and synthesis of these findings and make comparisons with the literature, while Chapter 7 will continue this discussion, including exploring this study's implications and recommendations.

Chapter 5: Qualitative Data Analysis and Findings

5.1 Introduction

The previous chapter analysed the quantitative data obtained from the GRNs' online questionnaire, and discussed the findings in relation to the role and leadership of the CNE. In addition, it examined the demographic data from the three subgroup interviews. This chapter presents the analysis and discussion of the qualitative data collection phase of this mixed-methods study. The perspectives gathered from the GRNs, CNEs and CNMs about the CNE role are based on each participant's understandings, beliefs, values, attitudes and expectations. The CNEs' articulation of their own understanding, practical experience and aspirations are linked to their role as a professional within the organisation.

5.2 Qualitative Data Collection

The data collection methods for the qualitative data included the open-ended questions from the GRN questionnaire and the semi-structured interviews collected from the GRN, CNE and CNM respondents.

5.3 Qualitative Data Analysis

The qualitative data analysis process was conducted from two sources of data: the GRN online questionnaire text entry responses (dataset 3) and the GRN, CNE and CNM subgroup interview data (datasets 4, 5 and 6). At this point, the GRN questionnaire responses (dataset 3) were combined with the GRN interview transcriptions (dataset 4) and coded together. The rationale for combining the questionnaire responses with the interview transcriptions was to increase the quality and depth of the GRN qualitative data. According to Oei and Zwart (1986), questionnaires provide a wide range of responses of an emotionally detached nature, while Richman, Kiesler, Weisb, and Drasgow (1999) suggested that interviews are affected by the interpersonal relationship between the participant and researcher. The differences between the GRN questionnaire and individual interview method offered strengths and weaknesses that related to sample size, detail, clarification and anonymity (Harris & Brown, 2010). By combining

the qualitative responses into a single dataset for analysis, the depth and breadth of the holistic picture of the GRN viewpoint on the CNE role was augmented.

The thematic analysis of the subsequent three qualitative datasets (3 + 4, 5 and 6) occurred separately to each other. These data sources were analysed according to the principles of thematic analysis by Braun and Clarke (2006), and reported according to the phases of the research process detailed in Chapter 3. For this research, the foundational approach of working with data occurred through the creation of codes, categories and themes (Braun & Clarke, 2006). This iterative thematic analysis process followed the phases suggested by Braun and Clarke (2006, p. 87)—namely:

- becoming familiar with the data
- generating initial codes
- searching for themes
- reviewing themes
- defining and naming themes
- producing the final analysis.

The first phase of the thematic analysis process was familiarisation with the data. Immersion occurred through reading the transcribed text of the questionnaire text entry responses and the subgroup interviews to gain an understanding of the depth and scope of the content (Braun & Clarke, 2006). Active data analysis to assist with initial ideas for coding included reviewing the subgroup interview audio recordings for accuracy in transcription, rereading the transcribed texts to search for meanings and patterns, and considering the field notes for context.

Following familiarisation, the initial codes were produced. Systematic organisation of the data into meaningful groups of interesting features occurred across the datasets using a hierarchical strategy. During this phase, many potential themes were created, while ensuring that the coded extracts remained contextually intact. The researcher highlighted initial extracts of data that identified a feature of the phenomenon under study. This process occurred using the NVivo 10 software to prepare and store texts for analysis using the following steps:

- data were imported from the questionnaire and transcribed interviews from the subgroups
- text was read and organised into a visual hierarchy of parent and child nodes
- search and query functions were used to identify words or segments of text
- the data in the nodes were further examined for detailed coding, interpretation and merging of codes
- thematic maps and charts were generated to present data visually, with summaries exported to Microsoft Word and Excel for further consideration.

From the summaries of potential themes and subthemes, an example of a coded statement made by a GRN participant in the online questionnaire is shown below. The researcher identified the statement with the initial codes of 'new to practice', 'gaining confidence' and 'someone to talk to':

> Your first year can be very daunting and knowing that there is someone that is there to help and support you through that first year is great. They can help you develop your skills with regards to patient care and help to debrief about certain aspects of the job. I think it is important to have someone there that GRNs can talk to because nursing has such a busy working environment you don't always get time to go through things with your other nursing staff (GRNQ).

The codes allocated to the above text were as follows:

- **New to practice:** 'Your first year can be very daunting and knowing that there is someone that is there to help and support you through that first year is great'.
- **Gaining confidence:** 'They can help you develop your skills with regards to patient care'.
- **Someone to talk to:** 'I think it is important to have someone there that GRNs can talk to because nursing has such a busy working environment you don't always get time to go through things with your other nursing staff'.

Once all of the data had been initially comprehensively coded, the researcher searched for possible final themes. According to Braun and Clarke (2006, p. 89), this phase 'refocuses the analysis at the broader level of themes, rather than codes, involves sorting the different codes into potential themes and collating all the relevant coded date extracts within the identified themes' (p. 89) Examples of the initial development of

themes for the GRN datasets 3 and 4 included: 'learning the routine', 'clinical expert', 'learning the right way', 'provides resources' and 'debriefs'.

Braun and Clarke (2006) identified a theme as capturing 'something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set' (p. 82). The identified themes—inclusive of all relevant extracts—were reviewed continually for coherence and fit. Thematic maps were updated to aid the theming process and to consider the relationships between the codes and themes. The checking process included the original dataset and checking between each potential theme.

The reviewing process of rereading and defining the themes, along with continual re-evaluation, resulted in the creation of overarching themes that encompassed the initial themes. The following table identifies the final overarching theme for some of the initial subthemes generated.

Table 5.1: Theme Generation Example from GRN Data Analysis

Overarching Theme	Subtheme
Educator	Learning the routine
Leadership	Clinical expert
Learning by example	Learning the right way
Go-to person	Provides resources
Patient safety advocate	Debriefs

The ongoing analysis led to refining the details of each theme, which contributed to the emerging story. At this point, the themes acquired clear definitions, and specific and relevant names were selected to illustrate the analysis. Individual themes were re-checked for accuracy of meaning, and final overarching themes were decided using an in-depth approach. The researcher continued to be mindful of the research questions during the entire coding process. A final account produced a convincing and balanced commentary of named themes with extracts and examples (Braun & Clarke, 2006). This well-organised interpretation and illustration of ideas captured the essence of the argument in relation to the research questions, and generated pathways to comprehend the CNE role specifically related to the GRNs in their first year of nursing.

The following sections describe the qualitative data collection and subsequent data analysis and findings. The following Chapter 6 will continue the comparison of the findings with the literature, with the implications of the findings discussed in Chapter 7.

5.3.1 GRN

The following extract summarises the general findings of the GRN participants' combined datasets (3 and 4) of questionnaire text entry and interviews:

> But it's nice to have the CNE there to be able to ask … they've got so much more time for you. And they'll go sit down with you and explain why you're doing it and that kind of thing (GRN4).

The themes and subthemes chosen to represent the findings of the GRN are illustrated in a concept map (see Figure 5.1). The collective techniques of thematic analysis produced the first ideas for the initial codes. Examples of some of the GRN initial codes were:

- Is able to provide learning materials.
- Has clinical expertise.
- Is not always available.
- Works closely with the GRN.
- Supports different learning needs.

The following is an example of a highlighted statement that was allocated refined codes:

> The CNE is someone to help broaden and develop your nursing skills, for example, providing SDLPs [self-directed learning packages], completing competencies with you to increase your skill level. Someone there, to provide that extra support when needed in that first year of your nursing career and to help you transition from being a student into a professional in a busy working environment (GRNQ).

The allocated codes included:

- **Provides resources (is able to provide learning materials):** 'The CNE is someone to help broaden and develop your nursing skills, for example, providing SDLPs [self-directed learning packages]'.

- **Provides direction and supervision (has clinical expertise):** 'Completing competencies with you to increase your skill level'.

- **Learning journey support (works closely with the GRN):** 'Someone there, to provide that extra support when needed in that first year of your nursing career and to help you transition from being a student into a professional in a busy working environment'.
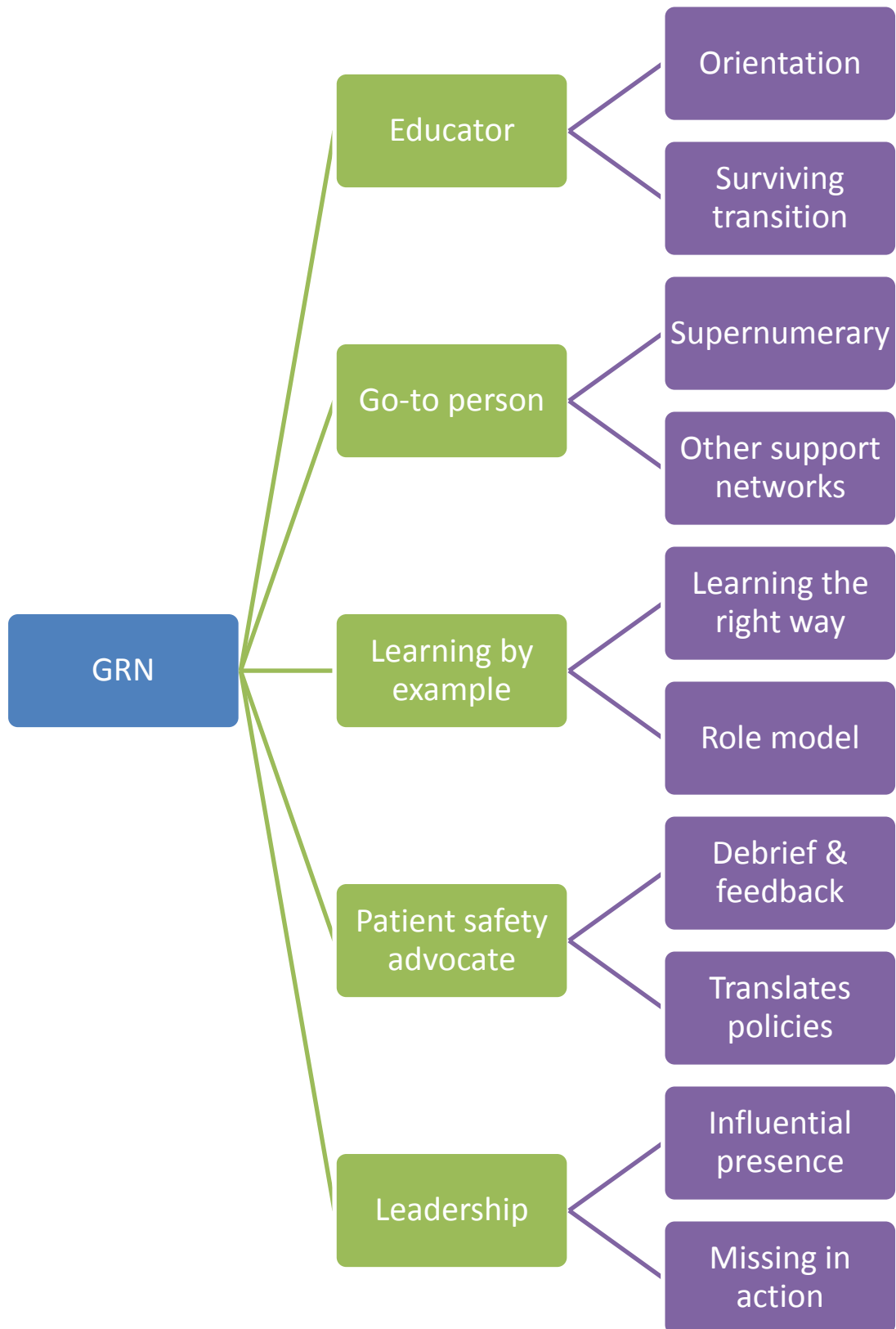
Figure 5.1: Concept Map of the GRN Themes and Subthemes

5.3.1.1 Theme 1: Educator

The overarching theme of educator conveyed the GRNs' feelings towards the CNEs' support of their learning needs to provide safe and effective care of their patients. Specifically, for the newly qualified GRNs, the graduate programme assisted in their transition from novices to competent and confident practitioners in the ward setting. This was highlighted by GRNs who shared concerns about being new: 'Because you come out of uni, you're always with someone and then you get chucked in and you're by yourself and you don't really know what you're doing' (GRNQ).

The supernumerary CNE in their educator role provided the point of contact for the GRNs' first few weeks in the wards. One GRN described the role as fundamental to their transition: 'It is vital to orientate new graduates to the ward their role, scope, competencies and give them support and answers' (GRNQ). The subthemes identified for the overarching theme of 'educator' were 'orientation' and 'surviving transition'.

5.3.1.1.1 Orientation

In this subtheme, the focus of the GRNs' first few weeks on the ward was orientation—the essential process of becoming accustomed to their new situation and surroundings. For the GRNs, this period of change and shift in transition from student to graduate role first required determining the routine of the individual ward and understanding 'how things worked'. The GRNs expressed their thoughts on the CNEs' role in their ward orientation: 'They were really helpful, especially the first few days when you don't know where to start' (GRN9). The GRNs identified the need to become familiar with the routine, processes and equipment as quickly as possible to assist their patients' care. The following comment indicated how significant this support was during the orientation period: 'It would make finding information about procedures and how to operate equipment a lot easier and faster' (GRNQ).

The GRNs recognised that their first concerns were more about the way the ward operated, rather than direct patient care. They emphasised the importance of their need to learn the ward routine and understand how equipment worked:

> It's not really patient care I don't think … it's getting to know how the ward works
> and then working with your team members and getting to know the coordinator … the

routine in which you do things, how things work, how the doctors work … because then you can provide the best care for your patient (GRN8).

The GRNs' supernumerary days as part of orientation were highlighted as necessary to facilitate reduced anxiety levels while working in unfamiliar situations, particularly given that there could be a significant length of time since their last placement as a student and their first days as a graduate: 'University is totally different than working. Although we do prac, that too is also different and from our last prac until we start a job, it can be a few months' (GRNQ). The following comment highlighted the GRNs' feelings about the CNE role in orientation: 'Having the CNE available to me at the start of my programme relieved huge stresses for me and could talk to me about things I was unsure of and show me with education how to manage things' (GRN9).

The respondents included statements about the opportunity to ask questions about specific ward specialty systems and processes: 'Any questions, doubts or concerns can be raised to them' (GRNQ). The following is an example of the type of learning support that was valued by the GRN:

> For me, it was having someone go through the correct way to do all the paperwork, which forms were needed for what and how to use the computer system … and ensured that my basic paperwork was correct right from the beginning, so I could focus on other things, like patient care (GRNQ).

The GRNs identified that the time spent in orientation with the CNE helped them understand their new role as RNs. Participant GRN7 identified the CNEs as: 'The only people that would sort of look at you and say, right, you're a grad, and this is what we do, or this is not what we do'.

The importance of regular contact during the orientation period with the CNE was highlighted by participant GRN4: 'Yeah, the beginning of your grad program, just so you've got her there when you really need her'. For others, this face-to-face contact provided reassurance: 'For the first few days … or first few weeks, she saw me pretty much every day. To make sure I was fitting in well, and everything was going well, so, that was good' (GRN6). CNE support through the first few weeks of orientation was highlighted as necessary for surviving the period of transition. This feeling was expressed by GRNQ as: 'It sets you up for the year ahead'.

The following subtheme related to the GRNs' feelings on surviving this transition period.

5.3.1.1.2 Surviving Transition

The GRNs recognised their graduate year as a significant learning journey that required an increasing level of confidence in their ability to provide safe and quality patient care. This subtheme concentrated on the safeguard provided by the CNEs to support the GRNs through the process of transition. Participant GRN3 expressed this point:

> I believe the role of the CNE is extremely important, as it acts as a supporter, a buffer to new graduate nurses needing the confidence building and trying new tasks and getting the competencies up to the required level.

During this period of learning, the GRNs were concerned about the high expectations of ward staff: 'Graduate nurses are often thrown into the deep end expected to swim when they actually need more support than a non-graduate nurse' (GRNQ). However, the participants believed that the presence of the CNE made a difference. Another participant summarised this provision: 'Someone there to provide that extra support when needed in that first year of your nursing career and to help you transition from being a student into a professional in a busy working environment' (GRNQ).

The GRNs' progress was affected by the pressure of being the 'new' nurse. This observation was expressed by respondent GRNQ: 'It is a learning period and we need as much initial support as possible'. The GRN participants provided examples of approaches used by the CNE to alleviate their stress during the first year. These included regular checks of GRNs' progress: 'She always comes out and asks about what patients I have and what I might need to plan for and might need help with. It ensures that someone is taking the time out to check up on you' (GRNQ). The CNEs also helped clarify the graduate programme contents:

> To provide that direction … but not overpowering or anything. Just enough to say 'Look, this is the way I want to see you go, in your grad programme'. And that gives you a focus and a purpose … what you do and why you're doing it (GRN3).

The CNEs also used teaching strategies that met the GRNs' own learning styles:

For me it was a tactile, touch, do, sort of thing, rather than sit down in a lecture theatre and learn stuff. I'm a hands-on person, and my CNE was that … she was able to incorporate my hands-on learning ability, to perform the task … and straight away you got it (GRN3).

The participants also shared their views on how the CNE role made a difference to their self-confidence at the start of their first year of nursing. GRN9 stated that: 'I did feel more confident. It's just that the first few days you are sort of taken aback a little bit'. One GRN participant expressed this growth of confidence in relation to the CNE role:

For example, if a GRN is a bike then the CNE would be the training wheels. When you first qualify you need them a lot, the GRN needs someone to ask the questions they don't know because they were in a new position and are still trying to find their wheels, they might not want to go to someone else (because they don't know that person, and there is a certain expectation that GRNs should already know what they are doing). Then later on they gain more confidence in asking others for help and require the CNE less (GRNQ).

The GRNs stated that their increase in confidence occurred primarily when they felt the CNE supported their knowledge development and provided opportunities for new experiences:

They help with getting your own personal strengths and confidence, in your own practice, and that it eventually has a flow-on effect to the patients, because you're feeling more confident … understanding why … what you do, and that that CNE will actually facilitate that learning and promoting good patient care (GRN3).

To summarise, a respondent indicated the value of the CNE role for orientation and surviving transition: 'Your first year can be very daunting and knowing that there is someone that is there to help and support you through that first year is great' (GRNQ).

5.3.1.2 Theme 2: Go-to Person

As part of the nursing team, the supernumerary CNE is considered the 'go-to' person—that is, the staff member viewed by the participant GRNs as able to answer questions; obtain resources; and guide, direct or help in the clinical environment when needed or requested. CNEs draw on their clinical expertise, education, experience and investigative skills to advise and corroborate with the GRNs to support safe, timely and

effective patient care. GRN3 described the CNE role: 'They are a "go-to" person for any concerns with your practice'.

This overarching theme highlighted the importance of the CNE being accessible and responsive to the GRNs during their first year and beyond. This was articulated by participant GRN9: 'I believe the CNE plays a very important role for graduate nurses and they have always been there to help guide and direct me, showing me helpful information and always being available and approachable when needed'.

The subthemes for this theme were identified as 'supernumerary' and 'other support networks', as discussed below.

5.3.1.2.1 Supernumerary

The CNEs' supernumerary status—independent of ward and patient management—means they have protected time to support the GRNs, who can request their presence at any time—in person, by telephone or by email. The CNE makes the GRN a priority and is willingly interrupted at any time to provide whatever education or resource is necessary for the GRN to manage the situation. This may include activities such as support by working with the GRN, providing answers to questions, supervising practice, finding policies or procedures, or gathering evidence-based practice information.

In this subtheme, CNE availability is directly related to their supernumerary role. A participant GRN discussed this significance:

> I think it's really important to have someone that you can go to that's able, and has the time, and is not … necessarily the people that you work with … they're busy, they can't always stop to explain things and the coordinator is usually really busy. So it's good to have someone … that's designed for that role so that can basically go, 'Okay, come on, let's go do it'. Because you know … you can always go to them and that's what they're there for (GRN2).

In particular, participant GRN7 regarded the available CNE as being their designated support person: 'I can always ask the other nurses, there are a lot of nurses are very approachable, you can ask them questions, but it's always nice to have that one person to be able to turn to'. The GRN participants noted that their team members were

frequently busy and unable to help, whereas the CNE had the time and capability to assist the GRNs' learning:

> That was the good thing because … you kind of ask the nurse you're working with because they're running around busy but … the CNE was usually available most of the time, just go and ask … get a hand, most of the time (GRN1).

At the point of care when advice was required, the CNE was accessible in the ward setting: 'They are available to discuss and answer any questions at the time they arise' (GRNQ). In challenging situations, participant GRN10 recalled a situation where she requested help from the CNE:

> And they can answer the question of, 'Can I do this?' Whereas, you might be or might not be in a position where you can call the Graduate Coordinator and go, 'Hey, just wondering if I'm allowed to do this right now, I've got a patient dying, I've no one to help'.

The GRNs were proactive in contacting the CNEs to ensure they were able to meet to enable specific skill and competency development. Participant GRN3 outlined her strategy for engaging the CNE: 'And often the case was I would actually email the CNE and say, "I'll be on shift on this morning, will you be as well? We'll run through the such and such to achieve the task"'. Other participant GRNs stated that their plan for learning included contacting the CNE to ensure they continued on the right track: 'I will ring, if I'm unsure about something I will just ring and say, "I haven't done such and such in a while"' (GRN1).

The GRN participants acknowledged that it was useful to have the CNE's help to access, interpret and use material and equipment for patient care in the busy clinical environment: 'It would make finding information about procedures and how to operate equipment a lot easier and faster' (GRNQ). The CNE was also instrumental in guiding the GRNs towards self-directed learning opportunities: 'They seem to have more knowledge about how to get your SDLPs [self-directed learning packages] and, all those other sort of learning' (GRN6).

The next subtheme explores the other support networks that the GRN participants discussed as supporting their learning.

5.3.1.2.2 Other Support Networks

In the presence and absence of the CNE, the team members may fulfil the role of 'go-to' person for the GRNs. However, the GRNs' need for this 'go-to' person does not mean that the nursing team members are active in this role. When available, these support networks exist in the clinical ward setting to ensure the GRNs are actively encouraged to progress in their graduate programme. Positive team support was viewed by the GRNs as necessary for developing a level of comfort and confidence, and reducing their dependence on the CNE over time. Conversely, negative team support was related to lack of clarification, lack of direction, and uncertainty related to problems and the experience of challenging situations.

The GRNs identified the willingness of team members to support their learning in the new environment: 'Fortunately, on each rotation the ward staff have been willing to teach, happy to discuss concerns about patient care and I had great support from the Graduate Nurse Coordinator and on one occasion the Clinical Nurse Manager' (GRNQ). GRNQ indicated the availability of help: 'There was always someone (i.e. senior nurses or shift coordinator) there to guide me'.

While the CNE developed a close relationship with the GRNs in the beginning phase of the ward allocation, the other team members were happy to help the GRNs. The participants shared their level of comfort in making connections with their ward team staff:

> What I did was I always approached the shift coordinator to say, 'Look, this is the task, I haven't yet got my competency, or confidence or skills up to date. Are you able to assist me to learn that role?' And the shift coordinators were always willing to do that. I never felt like I was going to have to say, 'No, I can't do this, someone else will have to do it'. There was always that opportunity to learn in the absence of the CNE (GRN3).

The GRNs noted that the CNEs generally worked business hours and were often part time. Therefore, learning support from their team members was highlighted as essential. During the 'unsocial hours' (such as after 10.00 pm and before 7.00 am), the GRNs sought help from other sources. GRN7 stated: 'If it's afterhours, generally the afterhours CNC [clinical nurse consultant] is very good'. Many of the GRN participants

recognised their ward team members' help as a vital element of their graduate experience: 'There was always somebody else senior enough to give guidance' (GRNQ). Participant GRN5 summarised the collective feeling of many of the GRN participants: 'I actually think it's like a community, everyone actually helps to teach you'.

However, for some GRNs, their team members' workload prevented them from having the time to explain or expand on the care needs of the patients to the new staff members. A GRN respondent stated: 'Unable to clarify questions/problems when other staff members are busy and unable to assist' (GRNQ). Another participant stated:

> But it wasn't always necessarily a good time with your coordinators and you sort of, 'I need to ask you something but I can see you're busy, I'll come back', and you sort of try a couple of times and then you catch them when they're not busy (GRN2).

When asking their team members for help, the participants acknowledged frustration in the inability of some team members to answer their queries:

> I had to source other members of staff to ask questions and ensure I was performing certain tasks correctly. At the same time, not all members of staff can answer the questions I need answers to which makes my learning difficult (GRNQ).

Frustration was also evident in relation to the time taken for the GRN to find a team member to help with learning: 'It can take longer to provide care when the CNE is not available because you need to find someone else who can show you the skill or to find the information yourself' (GRNQ). Reluctance to seek help was exemplified by this statement from GRN8:

> But I think it's more … with patient load, I suppose you're a qualified nurse, so generally speaking you're a professional so you *should* know what to do, but … if there's any issues I suppose you go to your team members.

In summary, the CNE was seen as the staff member who could be depended on to access resources: 'Always has the right answers, or know where to get the right answers' (GRN6). As the go-to person, the CNE delivered the accessibility and capability the GRNs needed to progress through their first year—in comparison to other

team members, whose support was inconsistent. This was summarised by GRN2: 'I think it was just beneficial all 'round to have that person that you could go to'.

5.3.1.3 Theme 3: Learning by Example

Learning by example is the type of learning that occurs by watching others perform a task accurately. For the GRNs' learning, the CNE provided the example of correct nursing practice underpinned by knowledge and experience. Participant GRN1 shared her understanding of this optimal type of learning: 'If I ask my colleague they'll tell me probably the shorter way to do it. If I ask the CNE they'll tell me the right way to do it'.

This overarching theme highlights the importance of having a nursing role dedicated to ensuring the GRNs have opportunities to grow as professional nurses and meet their practice standards and hospital guidelines for patient care. Participant GRN5 described the appeal of the CNE who worked with the GRNs: 'She's like, on the floor with us, getting her hands dirty and, no, she doesn't have a superiority complex at all'.

The subthemes for this theme were identified as 'learning the right way' and 'role model'.

5.3.1.3.1 Learning the Right Way

The GRNs learned the correct way to provide nursing care through engagement with the CNE in practice. In order to provide quality patient care, the GRNs developed skills and competence through specified times of observation with CNE practice and supervision. In this manner, the GRNs had opportunities to discuss and question nursing practice, were able to examine their decision-making pathways, and avoided forming bad habits. In the promotion of evidence-based practice, the CNE ensured the GRNs adhered to policies and their scope of practice, and, when uncertain, were directed to appropriate resources. GRNQ highlighted the importance of learning the right way from the CNE: 'They are available to advise, reducing the risk of the GRN doing something that they might not have done before and/or are unsure of'.

The GRNs recognised that, as newly qualified RNs, they had limited clinical experience in their undergraduate years. Their comfort levels were elevated when the CNE was able to provide the supervision and direction required for the expected standard of professional care. This GRN participant explained her need for supervision:

If you've not done a procedure on a patient before, we've covered it at uni, you've seen it done but you've not actually done it yourself, a couple of times I've said, 'I know the procedure but can you just come and watch me do I think, just to make sure that I'm doing it the right way' (GRN2).

Having someone listen and give advice on patient care protected the GRNs from making mistakes. GRN9 described the patient-focused CNE role:

It does help in my patient care, because they're always there for you, if you don't know what decision to make, you can always turn to them and they always direct you the right way, so it does help patient care. So rather that if I didn't have anyone I will just make my own decision which might not help the patient (GRN9).

The GRNs were vocal about the avoidance of mistakes and did not want to develop a tendency towards bad practice. The GRN participants presented the CNE as the nurse who was most likely to have recent practice knowledge:

I think it's really, really good to have someone that can provide that support, and they're always up-to-date with best practice, which is very, very important, particularly when you're a grad, because it's really hard to try and avoid picking up bad habits (GRN10).

As part of their learning and development as RNs, the GRNs expected to be able to question the CNE to gain confidence in their decision making. GRN3 described her concerns about decision making on her own:

And you're thinking, 'Oh, I'm not sure quite what the next step is, or what I'm meant to be doing here'. Whereas, when the CNE is actually supernumerary as in 'buddy', and working with you, you can question your practice and gain support … and gain the confidence in knowing, why, what you do and then be able to do it safely. Rather than being left in a room by yourself with a patient and, potentially doing something the wrong way, and then having no one to ask, 'Well, what was the right way?'

Participant GRN3 identified the significance of learning the correct way and the CNE role in ensuring their quality patient care: 'If the CNE's available to run through all those factors of safe care that just has a flow on effect to the patient, in ensuring that the patient gets the proper and safe care that's appropriate'.

The next section discusses the subtheme of the CNE as a role model.

5.3.1.3.2 Role Model

As a significant role model for the GRNs, the CNE provided a standard for safe and quality patient care. The participant GRNs had an expectation of learning through patient, interested and caring teachers dedicated to addressing areas of the new nurses' identified needs. By working alongside the GRN, guidance was given through each step of the procedure or process to consolidate practice. Respondent GRNQ expressed the availability of the CNE to provide this one-on-one support: 'My CNE has always been available to assist me with a new procedure I have never done before'.

The GRN participants perceived the CNE as a role model because of their commitment and depth of knowledge and experience. To illustrate, GRNQ commented: 'This role should be given to dedicated people who have vast experience in the area they are leading and to be patient with new graduates as they set a standard for the newly qualified nurses'. GRN7 explained the modelling of the CNE further: '"Follow my lead, this is what we do" … that's the one person you actually watch them doing something, so I think that's pretty important'.

In being a role model, the CNE displayed their understanding of the GRNs' learning needs: 'A bit flexible to some of the grad nurses' means of learning. Everyone learns a different way' (GRN3). The GRN participants also noted a time when the CNE set the example of a pattern for care: 'I find, our CNE was very helpful to explain, especially the medications and certain conditions as well, and what to look for when I'm communicating with patients; what am I looking at when I'm communicating with patients' (GRN9). A constructive and encouraging encounter of the CNE as a role model was a memorable event shared by one GRN respondent: 'The experience I had in public rehab with the CNE was a positive and I still see her as a role model' (GRNQ).

The CNE working alongside the GRNs was a valuable learning experience. They offered assistance to work through procedures, with the opportunity to ask questions in order to consolidate this learning. Participant GRN3 shared her story of encouragement and confirmation when supported through a procedure:

> My experience was we would allocate a time to do a particular task and she would
> stay with us, and just support us through our process, working through the steps and
> … doing the task. I found that beneficial because, if I wanted to stop and pause and

question what I was doing, she was there and available to say, 'No, you're doing the right thing. Keep on doing it'.

In supporting the GRN at the point of care, the GRNs' increasing confidence improved their patients' quality of care. GRN3 continued her story:

> When the CNE is actually supernumerary as in buddy, and working with you, you can question your practice and gain support from the CNE to enhance, and gain the confidence in knowing, why, what you do and then be able to do it safely.

In learning by example, the GRNs were offered the opportunity to be supervised and directed to access, use and understand evidence-based practice, in addition to the CNEs' practical modelling of patient care. GRN4 summarised the feelings of the participants: 'You just need some reassurance that you did the right thing sometimes'.

5.3.1.4 Theme 4: Patient Safety Advocate

The overarching theme of patient safety advocate arose from the description of the CNEs' professional responsibility to support, protect and voice the rights and safety of the patient. Specifically, this occurred through the CNEs' role in supporting the GRNs' nursing practice. In this manner, the CNEs' unique relationship with the GRNs was expressed by a GRNQ respondent: 'Having an advocate for GRNs is a massive benefit for me. I feel very confident knowing that I have someone I can turn to with any troubles, etcetera'.

The participants shared their need for emotional and psychological support in the transition year to facilitate appropriate and responsive patient care. The support of each individual GRN by the supernumerary CNE with well-developed listening and reflecting skills was highlighted as essential: 'I think it is important to have someone there that GRNs can talk to because nursing has such a busy working environment you don't always get time to go through things with your other nursing staff' (GRNQ).

The subthemes identified were 'debrief and feedback' and 'translates policies'.

5.3.1.4.1 Debrief and Feedback

In this subtheme, the CNE devoted confidential time to debrief and provide feedback to the GRNs. The CNE was able to provide the GRNs with a holistic perspective.

Participant GRN8 described this role: 'You can talk to them what's gone on, because they're not actually involved in that situation' (GRN8).

The CNE and GRNs collaborated on practice issues, actions and behaviours. Encouragement was given during difficult times, while reflection was used to understand behaviours and responses to situations, in addition to providing reassurance. A respondent described the CNE as: 'Someone to talk to, share any issues/struggles with, to learn from' (GRNQ). The GRNs' new role as RNs presented occasions that created emotional challenges that required CNE support. A respondent shared that the CNE was able to put her at her ease when she felt nervous. The GRNs recognised that their individual needs varied. Participant GRN8 described herself as a quiet person who made use of time to debrief with the CNE:

> Going through what you did wrong, why you did that. I suppose going through the policies again, understanding all that sort of aspect of things. I suppose for someone that is a lot quieter, it is good to have that extra person just to go to or just to speak to, that's the neutral sort of ground.

Being uncertain of correct practice was a reason for seeking advice from the CNE prior to giving specific care. GRNQ commented: 'They are available to advise, reducing the risk of the GRN doing something that they might not have done before and/or are unsure of … They are an extra check if you aren't sure what to do'.

The CNE was described by the GRNs as perceptive and accepting—a person who provided a comfortable space to allow the GRNs to share. Participant GRN8 commented on her experience of debriefing with the CNE:

> I think it's good, and it's confidentiality as well, and you can talk to them about anything. And trust, I suppose, as well. Because they're involved and they know that patient … the CNE is someone that you can talk to about it later on.

As an advocate for patient care, the CNE was described as non-judgemental when debriefing: 'Not judgemental, understanding, rather than that judgement that you get from some people' (GRN4). Another participant shared her feelings: 'They just take you as you are and develop you and they always give feedback' (GRN9). Participant GRN3 described the CNE advocacy needed for her continued progress:

No question was a dumb question and that's really important for a new nurse coming
through, because, if you haven't done it, you know, and you're not aware of what the
right answer is to something, at least you've got someone … that's approachable and
you can actually say, 'Well, this might sound a dumb question but', dut, de dut, de
dah, 'Is that right, am I on the right track? Am I on the right page?'

Another participant also identified the ease that she felt with the CNE: 'They're always
there, asking us how to help and everything. And it makes you feel more comfortable'
(GRN6).

The following subtheme related to the CNE role in assisting the GRNs to understand
hospital policy.

5.3.1.4.2 Translates Policies

The CNE provided continual support for the GRNs' safe patient practices by promoting
correct interpretation and application of the hospital policies. This included having the
time and capacity to explain the policy and procedure contents and clarify the
legislative, practice standards and evidence-based practice content. The GRN
respondents clearly outlined the CNE's role responsibility in relation to the hospital
policies: 'The CNE is available to discuss application of care to ensure correct
techniques and protocol are being adhered to' (GRNQ).

According to the participants, one of the CNE's role criteria was to promote policy
compliance among all team members: 'They teach the correct procedures and ensure
that all staff are following the policies and procedures of the facility' (GRNQ). The
GRN participants recognised the importance of these guidelines for patient care:

CNEs can reduce the risk for patient errors, as they can encourage you to look up
current policies and procedures applicable to a task that needs performing. They make
GRNs aware of how many of these exist and when/how to use them safely/properly.
This serves as a sound evidence based foundation to care, which prevents nurses
taking short cuts, and thus increasing the risk for error (GRNQ).

One area of difficulty was related to finding the correct policy or procedure for patient
care during work time. The CNE was described as having particular skills in this area:
'We did have a lot of trouble finding the correct policy because our intranet shares with

the other hospitals … whereas she was, like, bam, bam, bam, bam, bam' (GRN10). Understanding the hospital policies and their importance to practice was central to the GRNs' safe patient care. The CNE provided teaching on how to access and use the policies:

> I always found I went to my CNE if I needed the SDLPs [self-directed learning packages], to develop sort of knowledge, and then looking up policies, showing how to do all of that, and understanding the whole system with regards to policies and scope of practice and everything like that, I think it is good, I think they're more there for that than patient care in a way (GRN8).

The participants were also directed back to the policies when they had uncertainties related to practice: 'Definitely, instil in the grads, if you're ever unsure, go back to policy and procedure. Because you can't go wrong, if you're ever in doubt' (GRN2). Participant GRN3 described an example of experiencing another GRN's practice that did not follow the evidence-based guidelines:

> I know of a few experiences of the grad nurses that were on shift with me, through my early part of my programme, that I thought, 'They really should have run that by the CNE'. Not that, it was out of their scope of practice or anything, but, they weren't confident, and the job probably wasn't done as best as it could be, or, as safely as it should have been. One example was, I think it was a dressing on a complex wound, and the grad RN just did what she thought was, was the right thing to do. But, there was actually a wound care plan in place, and she hadn't followed the wound care plan to a T … the CNE can, you know, 'Well, this is how we work through our wound care plans. That's how you should have dressed the patient's wound'. So, unfortunately that patient's wound had to be redone, to get it done properly, so the right dressings were on the right areas. So that just highlights the importance of a CNE being available to give that right direction, rather than a, 'Well, this will do', type approach.

The policies were often difficult for first-year nurses to translate to their own patient care. However, the CNE was able to bridge this gap of inexperience and support the application of knowledge and skills to patient care. Participant GRNQ stated that understanding policy and procedures reduced the potential for errors:

CNEs can reduce the risk for patient errors, as they can encourage you to look up current policies and procedures applicable to a task that needs performing. They make GRNs aware of how many of these exist and when/how to use them safely/properly. This serves as a sound evidence based foundation to care, which prevents nurses taking short cuts, and thus increasing the risk for error.

As a patient safety advocate, the CNE was instrumental in making the GRNs feel comfortable in coming to them to debrief and receive feedback on their patient care capability, in addition to being supported in applying hospital patient care guidelines. In this manner, patient safety and quality of care were safeguarded. The GRNs gained a better perspective of the importance of using evidence-based practice and guidelines to direct patient care. In summary, participant GRNQ stated: 'I feel as if my CNE is an advocate for me, and is someone who I know I can always go to with any issues/concerns etcetera'.

5.3.1.5 Theme 5: Leadership

The overarching theme of leadership indicated how the GRNs perceived the CNE's characteristics and responsibility for overseeing their graduate programme in the ward setting. The GRNs recognised their need for significant support to help them transition from novices to competent and confident practitioners. GRNQ reflected on this role: 'Someone there to provide that extra support when needed in that first year of your nursing career and to help you transition from being a student into a professional in a busy working environment'.

The participants defined the qualities of the CNE leadership: 'They're a leader of good examples and best practice, and role modelling and friendliness, and things like that' (GRN10) and 'It takes a certain person … to be a CNE. They've got to be interactive with people as well as they have to be great at the theory side of it but … patient and all that sort of thing' (GRN2). In the absence of a CNE, the GRN participants felt the lack of expected leadership:

My understanding of the CNE role was that I would be supported and educated in the areas I was unsure about both practically and theoretically. I feel in many respects that I have been alone on my GRN journey through limited availability of the CNE or the ward being busy (GRNQ).

The subthemes identified for the overarching theme of 'leadership' were 'influential presence' and 'missing in action'.

5.3.1.5.1 Influential Presence

The GRN participants identified the CNE as a genuine presence and influence on their career progression, alongside their degree of success in their first year of practice. The CNE was recognised as leader in the ward team—the trusted nurse who provided the tangible sponsorship to advance their practice: 'They provide you direction and guidance in your learning journey … giving the grad RN a direction, and goals to achieve. They need to be a fairly strong person to provide that direction, but not overpowering or anything' (GRN3).

The CNE's genuine offer to help resulted in spontaneous time devoted to the GRNs' progress. To the GRNs, this was identified as a characteristic of the CNE's leadership skillset, where the intent of the CNE was to guide the GRNs to the successful completion of the graduate programme. The GRN participants expressed how the CNE supernumerary status enhanced the ability to guide: 'There is someone who is not managing their own patients that can give their opinion on your patients without compromising their own patients' time' (GRNQ).

The GRNs highlighted the CNE's dedication to their progress, compared with identified constraints on learning from team members:

> They just have the time to spend with you rather than when you have a supernumerary day with another staff member, they kind of do their own thing and you just follow them. Whereas when you're with the CNE they show you how to do things (GRN4).

This factual understanding of the clinical environment and appreciation of the ward nursing roles gave the CNE the insight to know when the GRNs required help. Participant GRN2 commented:

> The people that you work with, they're busy, they can't always stop to explain things, and the coordinator is usually really busy. So it's good to have someone that's designed for that role so that can basically go, 'Okay, come on; let's go do it'.

This resulted in reduced stress for the GRNs:

As a grad it nice to have someone dedicated to your assistance initially, so you don't feel as though you are being a nuisance when asking questions or figuring things out. Once you are able to realise that CNE is there for your help … you can become more relaxed (GRNQ).

Another characteristic of CNE leadership identified by the participants was clinical expertise. GRNQ expressed an opinion on the depth of the CNE's knowledge and skills: 'When the CNE is available, she is a wealth of knowledge'. One participant explained: 'When I was a grad I always thought, well, the most qualified person to ask is the CNE, so even simple questions, I don't want to trouble the other nurses, and you think, I'd better ask my CNE' (GRN7).

The CNEs used their learning and teaching styles to ensure the individual GRNs could use knowledge in practice. Participant GRNQ noted: 'It's essential to have the CNE so you can ask them and at times they can practically show you. A lot of nurses are visual/hands-on learners'. The importance of the CNE's temperament made a difference to the GRNs' acquisition of relevant information needed for their patient care. GRN10 commented: 'Absolutely 110%, because over the years I have met quite a lot of CNEs and personality plays a major part in the role and how much they sort of do'. A supportive and encouraging attitude led to GRN achievement: 'She's got a positive attitude. She's always smiling. She's bubbly, she's got unlimited knowledge and clinical experience. Like, she just knows everything. If you need her for something she's like, "Yep, what do you want me to do?"' (GRN5).

The next subtheme in this section related to the effect of the CNE's absence.

5.3.1.5.2 Missing in Action

Conversely, the participant GRNs observed that the CNEs generally worked during business hours and that the majority of CNEs worked part-time hours. Further, the GRNs commented on how the initial time spent with them during orientation gradually reduced: 'It's really good when you first start off to have a few supernumerary days with her. It would be nice to see more of her' (GRN4).

The GRNs experienced times when they were expected to complete a task or skill without the knowledge or competence required. With the absence of the CNE, the GRNs turned to their team members, yet often found them unable to devote them time

due to their own workload. This lack of opportunity to gain skills and give holistic care was a source of ongoing frustration. Participant GRNQ commented:

> I was unable to perform tasks for example; IDC [indwelling catheter] insertion, NGT [nasogastric tube] insertion as I needed supervision for my first attempt and the ward was too busy for the shift coordinator to supervise me. Instead a colleague had to do it whilst I assisted with her tasks.

The GRN participants acknowledged that it was not possible for the CNE to be present for every shift and that CNEs had their own professional responsibilities:

> Because they are not working on the ward and cannot be with you the whole time you are working on every shift. I think it is up to the GRN to make sure they feel confident to perform within their scope of practice. They are professionals and have studied for three years to get to this point. They should double check things if unsure and should not perform certain things if not within their scope (GRNQ).

The GRN participants discussed how the absence of the CNE affected their nursing care. This included the effect of the lack of supervision:

> I don't think it impacted on my patient care, however I feel at many times GRNs are just put on the ward and left to their own devices and I feel expected to know. There should be more practical guidance and teaching in certain areas (GRNQ).

However, when the CNE was absent, the participants noted they could discover the answers for themselves. Participant GRN7 commented: 'It depends on what it is, if it is a very skilled thing, I would ask the CNE, but if it's something like medication where I can find policies, I can search out myself, I usually do it myself'. The usual approach to gaining an understanding of a task was asking other team members: 'I can always ask the other nurses … a lot of nurses are very approachable, you can ask them questions, but it's always nice to have that one person to be able to turn to' (GRN7). The GRNs were vocal about the lost opportunities to gain competence and experience, and expressed how this affected them: 'Impacted on getting items signed off so I could do my job more effectively' (GRNQ). The participants highlighted their frustration:

> There were those times and usually the shift coordinator, if she wasn't able to do that, you would lose that opportunity to learn at that time, because of that busyness, and therefore an experienced nurse who was competent in the task, ended up doing it. It

was a lost opportunity. And then, by the time you saw the CNE to approach to do that role, it was often a week, sometimes two weeks later (GRN3).

The GRNs had an expectation that the CNE role incorporated leadership through direction and guidance during their first year. Participant GRN10 described the first ward allocation as the time where the CNE was essential: 'They are very needed, because it was very difficult the first six months, not having that sort of support all the time'. GRNQ condensed the disappointment of not having an accessible CNE into one sentence: 'I feel in many respects that I have been alone on my GRN journey through limited availability of the CNE or the ward being busy'.

The GRNs' view of the CNE's authenticity and leadership characteristics was based on their successful progress through the graduate programme, during which the absence of CNE guidance and direction created obstacles for completing the graduate programme educational requirements. GRN5 summarised this view: 'They're a huge influence. What they're teaching you is what you carry on through the rest of your career'.

5.3.2 CNE

The general findings of the CNE interviews can be summarised in this extract:

> I'm clinically active and involved but I'm also helping the new ones to grow and blossom and I'm helping the ones who have been stuck in a rut to go 'Let's do something, Let's learn about this' … I love it. I absolutely love it (CNE8).

The themes and subthemes chosen to represent the findings of the CNE are illustrated in a concept map (see Figure 5.2). The collective techniques of thematic analysis produced the first ideas for the initial codes. Examples of some of the CNE initial codes were:

- Is available through having an 'open-door' policy.
- Supports the GRNs' emotional growth.
- Leads by presenting the GRNs with a good example.
- Patient care comes first.
- Supernumerary position supports relationships.
- Role constraints affect GRN support.

The following is an example of a highlighted statement that was allocated refined codes:

If they're happy with that relationship, and understand what it's all about, then, you know, they'll come and talk to you. They'll come and approach you. They'll be happy for you to go and speak to them; they'll come and ask you for help, it's great. I found that it's given them confidence, as well, I think, and it's not actually the confidence of just having a CNE that will answer questions if you don't know. If I don't know the answer, we'll go out and find it together. We'll go and we'll talk about it … but also, the confidence to actually come and ask me for help (CNE11).

The allocated codes included:

- **Supportive (supernumerary position supports relationships):** 'If they're happy with that relationship, and understand what it's all about, then, you know, they'll come and talk to you. They'll come and approach you. They'll be happy for you to go and speak to them; they'll come and ask you for help, it's great'.

- **Builds confidence (supports the GRNs' emotional growth):** 'I found that it's given them confidence, as well, I think, and it's not actually the confidence of just having a CNE that will answer questions if you don't know. If I don't know the answer, we'll go out and find it together. We'll go and we'll talk about it … but also, the confidence to actually come and ask me for help'.

- **Resource person (is available through having an 'open-door' policy):** 'they'll come and ask you for help … If I don't know the answer, we'll go out and find it together. We'll go and we'll talk about it'.
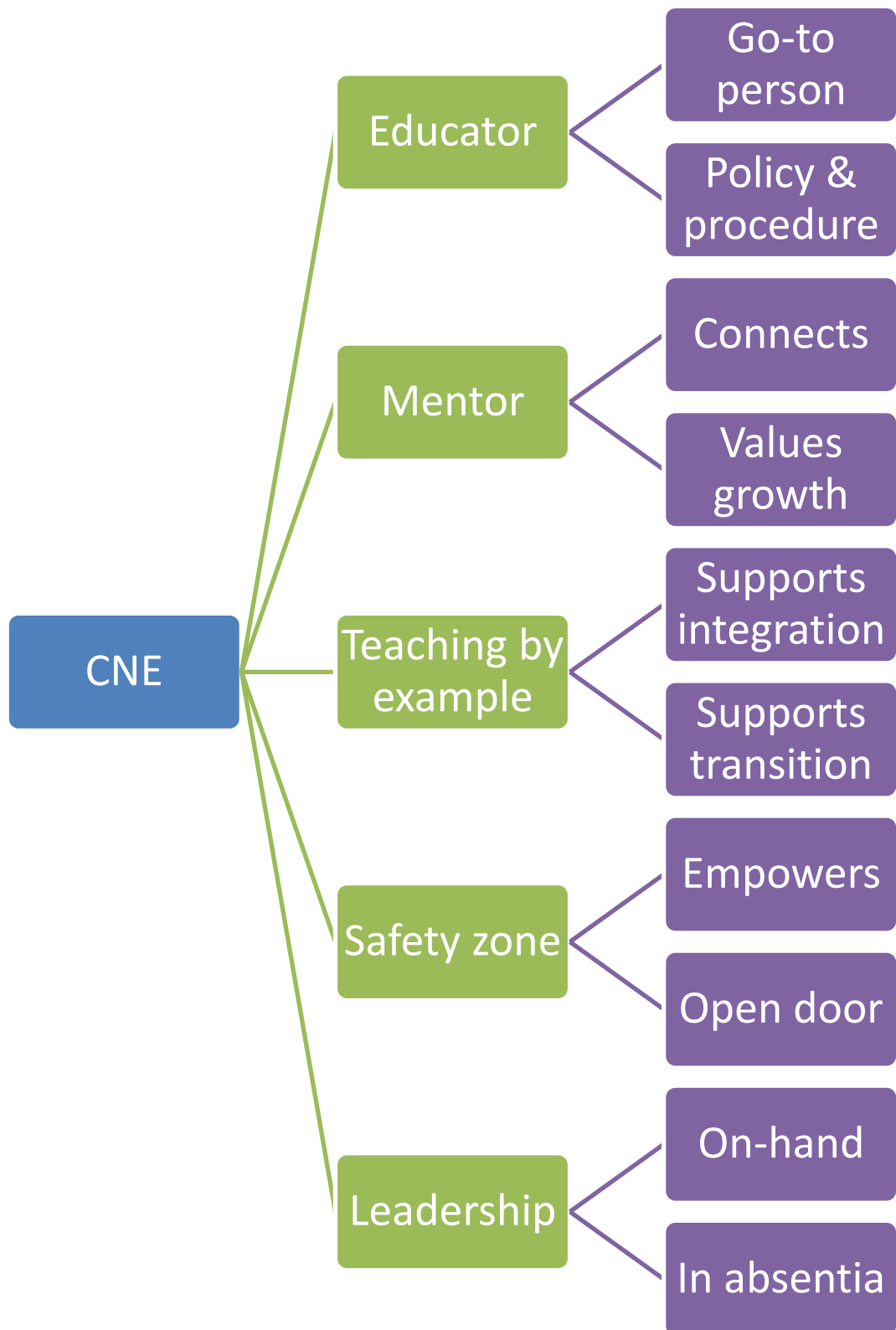
Figure 5.2: Concept Map of the CNE Themes and Subthemes

5.3.2.1 Theme 1: Educator

The overarching theme of educator conveyed the CNEs' expectations of sharing their knowledge and experience of the ward specialty—specifically with the newly qualified GRNs for the benefit of their patients' outcomes. This was succinctly shared by CNE1:

> And you can see with your experience giving them the tips of how to do it, the best way to do it, and how to see the impact on your patients so they can then take the theory, put it into practice with your little ideas and guidance, and once they see the impact on the patient, that's when they start to grow.

The CNEs clearly identified their role as the engagement of teaching and learning with all ward staff. The supernumerary aspect of the CNE role provided opportunities to develop and maintain education that complemented the general educational criterion related to RN professional standards for practice. The CNEs' role was synonymous with the GRNs' spontaneous learning at the point of care:

> On a ward like this, the patient care, it's more clinical things that they come and get us for. Last week there were quite a few things, like removal of the PICC [peripherally inserted central catheter] line that someone hadn't done before (CNE4).

The subthemes identified for this theme were 'go-to person' and 'policy and procedure'.

5.3.2.1.1 Go-to Person

In this subtheme, the CNEs noted that their role as the 'go-to' person on the ward was directly related to their education role. Participant CNE4 explained: 'If there's anything they don't know, they can come to me'. The CNEs estimated their own level of knowledge, experience and skill as benefitting the GRNs: 'They all have that expectation that the CNE will have a certain knowledge base, they would have had certain experience level. I mean, they never asked me once what my experiences were, they just expect, don't they?' (CNE10). Another participant noted that the educator role included supporting the GRNs' clinical reasoning skills: 'Getting them sort of encouraging critical thinking as to how they can problem solve it themselves' (CNE7).

The CNE participants clearly articulated that their supernumerary status meant being able to spend more time with the GRNs to provide opportunities to consolidate learning.

In describing themselves as the go-to person, the CNE indicated that this protected time was significant when the ward was busy:

> So it's taking that time to go through things with them and actually sit there and explain, this is what we do, this is why we do it. Any other questions that they may have of what's going on as well. I'm there, they feel like they can ask me more because I can actually take the time with them, whereas it would be really rushed if they tried to do it with the person they were working with (CNE 8).

Highlighting the importance of this time to spend with the GRNs, participant CNE2 described herself pertinently as the 'long answer person':

> They need a lot of support and they like to have the CNE, because of course I can give them ten minutes of my time quite easily. Whereas, the CN [clinical nurse] or their buddy nurse may not be able to give that ten minutes.

This concept of having time revealed the capacity to expand and consolidate the GRNs' learning in the ward environment. The participants discussed their education strategies:

> I'm there much more about just supporting and instilling confidence and giving them the ability to get out there and know that they can do it. And if they can't then we'll look at strategies, we'll sit down and we'll work out okay, well, what can we do here and how can we go about this differently (CNE9).

A number of CNE participants also described providing suggestions based on their collective understanding of the workload and the ward: 'I give them tips and from my experience, how the ward runs, as every ward runs a bit differently' (CNE8).

The CNEs were cognizant of the GRNs' need to understand patient medical and nursing care requirements, and how to access and use hospital systems and obtain necessary resources. The CNE participants expressed this need as important to holistic care:

> Patients can come in with a number of chronic illnesses as well as an acute episode for some reason of either a new presentation or something that's chronic, acute or chronic. And it's often very difficult for a nurse to find their way through the maze of problems that a patient's got, and it needs someone that's got some experience and got some knowledge, and also understands the information system that's available in the hospital and can access it quickly and find that information (CNE2).

Being the go-to person also meant directing GRNs to the source of a variety of information needed for patient care. Participant CNE7 commented: 'So they can tap into me as a resource at any time', and CNE2 emphasised: 'Having a nurse who's available to help with information, help with complex patient care issues is really important'.

However, the CNEs' recognised that their go-to role was not omnipotent: 'To be an CNE you don't have to know everything about that area, you just have to know how to find things out. That's the key' (CNE2). Participant CNE4 identified the danger to patients if the GRNs did not find answers: 'I say that to my grads "I don't know, I'll go and find out". I said, "There's no shame in not knowing, the shame is not admitting and just doing it anyway"'. For many participants, the fundamental aim was encouraging the GRNs to use the resources effectively. Participant CNE9 expressed the desired result: 'I'm there much more about just supporting and instilling confidence and giving them the ability to get out there and know that … they can do it'.

In the role of go-to person, participant CNE2 commented: 'It's a role that is a resource, both an immediate resource and a source of education and development plans, writing materials that are used in the ward environment'. This also included the GRNs' need to understand and correctly use hospital policy and procedure.

The following subtheme related to the CNE role in ensuring GRNs can access and use hospital policy.

5.3.2.1.2 Policy and Procedure

The CNEs' role as the policy and procedure person was related to their reading, writing and education on evidence-based practice and the responsibility of ensuring the new GRNs followed hospital policy and local, state and national clinical guidelines and standards. One participant recognised the importance of her role: 'I would say that I'm responsible for making sure that things are done properly. Because I know, or I would hope that I know what's out there, best practice, evidence-based practice' (CNE11). CNE8 highlighted that familiarity with the scope of policy and procedure was part of the role: 'The fact that being the CNE you have to know the rationale behind things, you're a lot more familiar with policies and procedures and all that kind of good stuff'.

The CNE participants expressed the benefits of their education role in improving hospital policy compliance:

> You develop in the role and you've brought about changes and updated policies and therefore you have to educate people on that. So you know a lot of background information that nursing staff might … just not have come across it. Or they've been told and they forget, because they don't use it all the time. When you've actually written the policy or researched things to write the policy, it's much easier to remember (CNE3).

The CNEs used policy as a tool for education and to promote best practice for positive patient outcomes. Participant CNE1 commented: 'I've got to practice what I preach. So when I'm physically working on the wards with them, I've got to make sure that they certainly do things to the correct standards, to policies, to time'. The participants shared how this worked in practice:

> So, for example, you have a new bit of machinery, and a sick child needs to be looked after using whatever it is. But the person that's looking after that patient is busy doing all the stuff and they don't have time to go and print off the policy, so you have the CNE around, 'Oh, I'm not sure how to work this?'. 'Okay, no problem, I'll get the policy and I'll come and help you and we'll work through it together' (CNE3).

When policy and procedure was not used correctly, the CNEs were instrumental in dealing with the consequences. Participant CNE10 expressed her stance: 'I'm not a policy Nazi or a policy … but at the end of the day policy is there to protect you. So I would always be sprouting, "Have you looked in the policy?"'. Another participant shared her concerns when GRNs did not follow the policy or ask for help when they did not understand the policy:

> 'Look, that's not the … policy and you can't do it'. And so I think that they don't always come and ask … I think because they're grads and if they ask they feel they'll get a black mark against them that they didn't know. But they actually get a tick rather than doing it wrong (CNE4).

The CNE participants recognised their role in the interpretation of policies for the new GRNs by explaining the content in terms that were understandable. CNE4 expressed the effect of communicating policies:

I think if we didn't have someone … in the middle to translate policies … not that they don't have to read it … but, there never is any leisure. I think having someone there who actually knows what's right and wrong is a great asset. And once you tell someone they'll probably tell another ten people anyway. So 'Oh, you don't do it that way; you can't do that'.

Some policies were identified as very long and difficult for GRNs to download and access when in a hurry. Participant CNE4 described the translation role at the point of care:

If you gave me 28 pages and I had ten patients, and I've got somebody to get ready for theatre, someone that's bleeding, and five discharges, I'm not going to read that 28 pages on the ward. Whereas the CNE has a little bit of knowledge about what's in that policy and can do it without having to go and print it off.

The participants stated that, when policies were accessed, the CNEs ensured that the latest version was correctly retrieved. CNE7 identified that doing the research for the GRNs was not a pathway to better learning: 'I don't want to sort of give everything to hand to them. They need to learn how to look for these things themselves. So it's giving them the tools to be able to do it well rather than spoon-feeding'.

In reviewing their go-to role, the CNEs regarded their knowledge and experience as a resource service to assist the new GRNs and the ward staff. This included the policy interpretation and application necessary to improve patient outcomes. As part of this process, participant CNE7 noted: 'When you write the policy you know the education that you need to give … I think it's a win–win and best practice'.

5.3.2.2 Theme 2: Mentor

The overarching theme of mentor was articulated as the CNEs providing specific guidance and direction for novice nurses to become confident and competent nurses. The participants described how the GRNs presented on their first day as a nurse: 'They're all normally pretty scared. I had one first rotation come in actually heavy breathing down the corridor. She was that petrified' (CNE8).

The need for someone to support them through the first year was highlighted by participant CNE1: 'I think it's just great for them to know that there's somebody

specifically here for them'. Through a relationship based on trust and emotional support, the CNEs enable the GRNs to achieve the requirements of their first year of nursing.

The subthemes identified for this theme were 'connects' and 'values growth'.

5.3.2.2.1 Connects

Making connections between CNE and GRN supported team nursing by providing time to express anxieties, receive feedback and offer error management strategies. This reduced the stress and pressure experienced by the GRNs. The CNE participants commented on the GRNs' need for somebody to be there for them: 'Because, of course, the staff on the ward are really, really busy. They are fantastic at supporting them, but it's not the same as having somebody that they know is there for them' (CNE9).

Participant CNE11 described the pressure felt by the GRNs working in the nursing team:

> Being asked by senior staff and not being able to say, 'I don't know' … or nurses not being willing to explain to them situations, they feel very pressured. They've got a lot of stresses … It's not all about just doing the job either, it's fitting into the team. 'What do they think of me? Damn, I don't know this, I don't know the answer to that. I feel so stupid, like I don't know anything'.

The participants further described the GRNs' raw emotion of learning through experience: 'But then they'll come to me and sit down and often fall apart. But then try and talk through "how on earth I did this? Why I did it and what am I going to do now?"' (CNE1). Participant CNE8 described the secure relationship that allowed the GRNs to reveal their struggles by openly sharing their own vulnerability:

> I think they are more comfortable confessing to me that they don't know something, because I'm open with the fact of saying, 'We still all ask questions, I still ask questions, everyone needs to ask questions'. And so they know that I've got that and I'm not going to go, 'How could you not know that?' And not have that attitude towards it, and just go, 'right, okay, you don't know that, how are we going to get it so that you know that and a little bit more?'

The CNEs spoke of using reflection as a tool to identify and consider the contributing factors to achievement or failure in a variety of situations. CNE9 described the feelings of many of the participants: 'I'm not big on making people feel little in that moment of error'. By reflecting on a situation, the GRNs were gently encouraged to understand the bigger picture:

> If there's been a couple of mistakes and you try and sit down with them, talk to me, what actually happened, how did it lead to an error? Was it that they were distracted or they were in and out of the room or they just didn't look up the drug or not observe the patient taking the medication, just what lead up to it … how they could have avoided that happening (CNE7).

Connecting provided the inexperienced GRNs time to debrief, with the hope of overcoming the challenges in order to move forward:

> While you're feeling absolutely awful right now, it does actually get better. So you will be fine and if you want to be a nurse, we've got to put up with those rotten times and just work your way through (CNE1).

Participant CNE11 expressed the value of such a connection: 'Regular catch up times is really important … I do feel that I've got a really good relationship'.

The CNE participants shared their experiences of mediation between the GRNs and team members. CNE8 commented: 'I've only had a couple of those where I've had, you know, an upset grad and an upset nurse and I've had to kind of mediate between'. Another participant shared an experience:

> At the moment we have a graduate registered nurse—she's probably six weeks in, eight weeks into her grad program—has had lots of difficulty adjusting to the ward. It's perceived by the staff on the ward as lazy, condescending, bad attitude. When I asked the staff can you give me examples, it's difficult for them to give me examples, and I feel that, because I listen to all sides of the story I can paint a different picture, how I see the graduate. So I have to talk to her, about how she sees things and look at it from her point-of-view. So it's in isolation that the staff have just said it (CNE5).

Connecting included times of intervention to support the GRNs' confidence and growth into effective caregivers. Participant CNE7 explained:

I don't allow sort of bullying or just that sort of criticism really. I turn round and do sort of sit down and chat to the people that are being quite vocal and say, 'Look, this is where they're at now, with your input … we can make it a whole lot better'.

The solution-orientated CNEs also played a part in reducing tension between team members and GRNs. Participant CNE7 explained: 'So when I am around I can sort of diffuse that situation and just suggest other ways of managing it as well as taking the burden off assisting with that sort of grad's role as well'. In this manner, the CNEs identified the value of supporting GRNs' development, as discussed in the next subtheme.

5.3.2.2.2 Values Growth

In this subtheme, the CNEs, in their relationship with the GRNs, recognised the importance of constant growth in practice skills and competency for quality patient care. In valuing the progress of the GRNs, the CNEs shared their reputation of being all eyes and ears: 'I'm on the ward three days a week, so I'm always looking and I often get comments like, "How did you know that?" I said, "Because I hear and see things all the time"' (CNE4). The importance of each GRN's rate of progress was identified. The CNEs were able to gather information on the GRNs' performance through feedback from staff. Participant CNE8 observed:

When I'm not on the floor those people that have helped the grads out do tend, knowing that I'm the support person, to come back and say, 'I work with so-and-so, and we did this and this is how she performed'.

The CNE's presence also increased the GRNs' confidence in their practice. CNE8 remarked: 'So even just popping in and saying, "How are you going?" is a big thing for them and their confidence, just to know that someone's there watching out for them'. By working closely with the ward staff and advocating for teamwork and safe patient care the CNE values GRN growth. CNE11 shared her staff interactions on behalf of the GRN:

The staff are saying to her 'You need to do this, and you need to do that'. Well, my role is also to advocate for her and say, 'Look, she's only been here three months. She's on a busy surgical ward, and she's only just learning, how to prioritise, how to

do her time management'. And I have to say to the staff sometimes, 'you've got to take that into consideration'.

The participants shared how the GRNs had difficulty understanding their new role and that having the CNE around provided reassurance: 'They need a support person there to give them that confidence and say, "It's okay", whatever they're going through on that day or whatever they have to deal with' (CNE6). The CNE further described their support role as the optimistic and confident voice necessary to counteract negative perceptions by the team members. Participant CNE6 reflected on a scenario that occurred when the GRN was a member of the team:

> It's when more senior staff say, 'You're not around'. Or I've got all junior staff on today and really they haven't, but that's how they see it … and I have pulled those certain people up for saying things like that in front of everybody because it's really demoralising, you know? Everyone's doing the best they can with what they have, but at different stages. They need to hear positive.

The participants described their support and advocacy as evident in the GRNs' decision-making ability. CNE8 described a situation where she supported her GRN to stand firm on patient assessment:

> It comes down to … picking up patients from theatre, even though the theatre nurse who's done it a kazillion times has assessed them, it's still up to you taking their patient on, that you've got to be happy to bring them back to the ward. And it's being able to say to them, 'I'm not happy to take them back. I'm going to ring my coordinator' … and that's just communicating that to them that they are able to make those decisions and they're not going to get punished for that.

The participants also provided comments on how the GRNs' confidence in their support was a satisfying feeling: 'They know they can come to you with any question, and they can come to you if they think they've done something wrong or they can come to you if they think they've done really well' (CNE3).

However, the CNEs were resolute about encouraging the GRNs to actively pursue opportunities for growth: 'I don't want to follow you around all day because that doesn't give you an opportunity to learn to do things your own way, because it's

embarrassing when somebody's watching you all the time' (CNE3). Participant CNE2 described creating a distance as beneficial to the GRNs in the longer term:

> I'm sure they would absolutely love it if we were there for every single shift, and worked alongside them. But that wouldn't actually allow them to take on their own role that they have to achieve, you know as part of their job.

A cause for celebration occurred when the CNEs identified that their presence was no longer required:

> You instil that confidence … that you can do it … I say to them, look, how awesome you are … you are doing this … you just see that smile, it's just all the clichéd stuff but it is awesome (CNE9).

In summary, the CNEs' connection with the GRNs and support of the GRNs' growth led to greater confidence in patient care. CNE1 reflected on this pathway: 'They can then take the theory put it into practice with your little ideas and guidance, and once they see the impact on the patient, that's when they start to grow. That's the best bit'.

5.3.2.3 Theme 3: Teaching by Example

The GRNs' experience of the graduate year varied between individuals. The CNE participants identified their role in teaching by example as a way to promote quality and safe patient care. This supported the GRNs' transition to competent and confident practitioners, and integration into the nursing team: 'I feel that it's an opportunity to pass on the knowledge that, and experience that I have to the graduates and hopefully we can iron out any difficulties in early stages with their learning' (CNE 5).

In assisting the GRNs to reach their fullest potential, the CNEs acted as a guide, directed patient care and promoted excellence through a consistent partnership with the ward nursing team. Participant CNE5 expressed the importance of the constant CNE role in the ward setting: 'I think there would be a lot of miscommunication between, the graduate and the ward staff insomuch that the same person is not able to follow them through for the six months'

The subthemes identified for this theme were 'supports transition' and 'supports integration'.

5.3.2.3.1 Supports Transition

In this subtheme, the CNEs supported the transition of the GRNs by providing a realistic and comprehensive orientation to the ward specialty, with the consistent information necessary to meet the expected level of nursing care. From their first step onto the ward, orientation facilitated the GRNs' return to the ward for each allocated shift. The participants commented on their reactions to the GRNs' new career:

> She was a bit shell shocked to start with and you find they're overloaded with everything that they have in that first week. By the time they get to you to do the run of the ward, they've already had hospital orientation, they've already had all this other stuff going on and they are so overloaded. It's not even funny. They're just in a daze (CNE8).

Many CNEs commented on their need to be proactive to ensure the GRNs were not alone: 'I can see from the time they start on the ward, they're very nervous, I reassure them, buddy them up to begin with … between myself and the staff on the ward' (CNE5). Participant CNE8 described those first few weeks:

> I try to spend at least four hours per week with each of them. So I try to go down and be on the floor with them for as much as I possibly can and the three weeks that follow. So if they're on and I'm on, or if I do and come in later so I can stay with them on the start of their afternoon shift just to see how they're coping.

These early days highlighted the participant CNEs' pleasure of participating in the learning of the new nurses: 'So we can actually teach them when they're raw and they're very teachable at that stage' (CNE2). In addition, the desire to see the GRNs become relaxed during this period was important to CNE6: 'Help them settle on to the ward, orientate them to the ward and helping them become comfortable in their new role as a registered nurse'.

The CNE participants shared the content of their orientation process that was integral to the GRNs' transition:

> The initial days, the support is really given focusing on how we do things in our ward area. So from the admission process through the routine of the day, bed making, medications, obs, wound care, all of these things that we do during our shift in our area, and all of the special things like complex discharges and transfers to other areas,

taking handovers from ED [Emergency Department]. That's what we focus on during those first few weeks (CNE2).

The CNEs identified how time spent in orientation weeks was necessary for retaining the GRNs as a valuable member of the team. One participant shared her own experience of support that influenced her interactions with the GRNs:

I had a rough experience where I was overwhelmed coming from a different country, different paperwork, different people, different machinery. Thrown into an acute ward, it was really quite overwhelming. And despite the fact I had 30 years under my belt I was still ready to leave, until one of the nurses turned around to me and said, 'Right, I'm going to help you through and just guide you'. And that helped me, and I was determined I was not going to ever let anyone else go through the same thing. There's no ways I'll let that happen … because we can't afford to let the youngsters implode (CNE1).

During orientation and beyond, the CNE participants identified the necessity of ensuring that the information conveyed to the GRNs was consistent. Participant CNE3 shared how the GRNs felt at the beginning of the rotation: 'It's good to have one person that you can rely on for information, and that you feel confident is going to give you the correct information'. CNE3 further elaborated on the GRNs receiving incorrect information:

They get told something completely wrong and they're none the wiser, because they don't know any different … they don't have enough knowledge yet to work out their own decision as to whether this way is right or the other way is right. It's useful to be taught the same thing and then once they work alongside somebody else, and they do it differently they might be able to work through that process a little easier or, you know, ask questions.

In teaching by example, the CNE participants viewed their role as the best source of reliable information and the role that provided the big picture view for the GRNs:

I follow them through for the six months in conjunction with the other staff … I give the staff on the ward the guidelines, how the grads should follow procedures and practices … There needs to be a person there to monitor the whole situation, to have an overview of it all (CNE5).

Many of the CNE participants recognised their instrumental role in providing orientation and dissemination of correct information in the GRNs' first year. This comment by CNE11 echoed the participants' views: 'I can say to them, "I'm your CNE, I'm here for anything, you've got me. I know all about you. I know what you're expected to know"'. This promotion of a comprehensive orientation and provision of information for transition supported the following subtheme of GRN integration into the clinical environment.

5.3.2.3.2 Supports Integration

In teaching by example, the participant CNEs provided the same care to patients that the GRNs were expected to deliver. The CNEs supported the GRNs' integration into nursing as a profession by modelling the attitudes and behaviours expected of RNs as part of the ward team. The participants commented on how professionalism supported integration: 'But I think sometimes … going back to the professional manner, treating them as adults and being that role model' (CNE10).

The CNE participants noted the influence of the team members and ward culture on the GRNs in their formative year. The mix of generations was noted to be an influence on professional practice: 'I'd probably say the younger ones certainly would be very influenced by some of the other already qualified younger nurses. "I don't do it like that, do it like this, this is a quicker way of doing it"' (CNE10). The pressure to conform affected the professionalism of new staff and was highlighted by CNE9's experiences:

> And all these staff, some of them are troublesome. And over the years they try and drag you down, they want you to be as unprofessional as they are, but I've never ever ever faulted in that ever with any of them. And they all know, I can joke with the best of them … I'll get down and get in there and get it all done, but when push comes to shove the professionalism, it has got to be there.

Professionalism was noted as necessary to safeguard the RN pathway and career progression. Participant CNE11 expressed the importance of directing the GRNs on the right learning path as future role models:

> Trying to organise training and things has become more difficult because the wards have become very, very busy … because you want to make their learning experience

in those first couple of years … make it really important for them, so that they stay, so that they feel they've been nurtured, and give them a good start.

The participants shared how they supported integration through working alongside the GRNs:

Teaching by example is better than giving them something to read. So, teaching them how to actually approach a patient, how to get a hip or a knee out of bed, how to roll somebody, how to use the hoist (CNE4).

CNE7 elaborated further on the benefits of working alongside the GRNs:

Acting as a role model for them. Not only are you sort of helping them identify some of their objectives, some of their areas they've identified that they need to work on, to be able to be safe and work ready.

The CNEs used these opportunities to make assessments on the GRNs' progress: 'I find that fantastic, because that's a time that I can be working with my grads … seeing where we're at' (CNE8). Teaching by example provided evidence of the improvement and growth required for progression to the next stage of the graduate programme:

So I can see how they're working and see their learning in general, because you get sort of third-party reports, but they're never particularly precise, and if you're needing to extend a grad's probationary period, you need to sort of see evidence of that or evidence of improvement (CNE7).

The GRNs' successful transition to practice and integration into professional nursing practice was the goal of the CNE participants. Their role in nurturing the newly qualified RNs through modelling was emphasised by CNE9: 'For me being out on the ward with my new grads and being able to make that difference at a very different level … is awesome'.

5.3.2.4 Theme 4: Safety Zone

The phrase 'safe zone' denoted a familiar place where the GRNs could feel safe and were able to exert some control over what occurred. The theme 'safety zone' extrapolated on this concept to signify the CNE role and incumbent as the designated support nurse. This role incorporated a relationship with the GRNs and providing a safe

outlet to explore feelings, attitudes and behaviours during the graduate programme. This overarching theme was succinctly expressed by CNE4: 'With the CNE, they've got little safety zone, a little link between ignorance and knowledge'.

In providing a safe place and person for the GRNs in their first year of nursing, the GRNs' challenges and difficulties were managed to promote successful completion of the graduate programme. Participant CNE7 described this provision: 'They feel sort of safe and they know that if there's any emergencies, any issues they're going to get that support. They're going to have somebody there on tap to help manage it'.

The subthemes identified for this theme were 'empowers' and 'open door'.

5.3.2.4.1 Empowers

The GRNs developed their decision-making and critical reasoning skills through their own experiences. The CNEs identified the GRNs' specific learning needs and the provision of the necessary opportunities and encouragement to develop and increase autonomy in the clinical environment. The CNE participants shared their experiences of being with the GRNs to encourage and assess their progress: 'When I do assist them or work with them for a couple of hours on the ward, it's initially usually with medications and things … so I know that they're travelling okay, that they still maintaining safety' (CNE7).

The CNE participants described their role as an investment in the GRNs' work and patient safety: 'Because there's nothing more I want than to keep our staff safe because if they're safe within their practice then the patient is going to get good care and they're going to be safe' (CNE2). To ensure the GRNs maintained a patient safety focus, the CNEs described a method of providing point-of-care support:

> I'm not encroaching on what they're doing, but I'm there as a supportive role observing and discussing what they're doing as well, and giving them the opportunity to at least, sort of critically analyse what they're doing, evaluating the care and sort of rationalising what they're doing (CNE7).

Being able to ask questions was important to the GRNs and their patients' safety. The CNEs' visibility provided a point of contact for the GRNs:

'I really don't know how to do this', 'I'm really not sure about this' … Yes, they should I suppose primarily go to their buddy or their team leader or to the coordinator. But if you're visible and on the ward and they know that you are approachable and … you haven't got a hundred other things, you're focusing really on them and their patient, then they will come to you and ask you. So I suppose that is a big element of protecting the patient (CNE10).

To further develop the GRNs' decision-making and clinical reasoning skills, participant CNE1 explained the approach to encourage the GRNs to 'figure it out': 'But I try not to give them the answer. I try to say to them, well, what do you think is likely to happen? I'd rather them, sort of reach that conclusion themselves'. Another participant related how she supported the GRNs' reasoning skills: 'And often I've found they can figure it out for themselves, so the other side of that is me sort of pushing them out and saying, "Well no, you go and figure it out"' (CNE5).

The CNE participants also recognised that their absence on the ward provided an opportunity for the GRNs to use their own cognition. Participant CNE6 commented: 'I've got to walk out the door at 3:30 and know that they're sort of left to their own devices. Which in a way is sometimes is good, to let them sort of stop and think for themselves'. The GRNs were always encouraged to seek help with patient care from other team members, as the CNE participants were aware of their limited availability: 'There's probably a time when it might be good for them as well, in some ways, because it makes them step up and go and seek help elsewhere because they can't always rely on that person' (CNE3).

Participant CNE4 commented on the team members' ability to deal with the constancy of the GRNs' learning: 'So, they do ask a lot of questions and probably with me because I'm less threatening than the angry person that they might be working with'. The participants detailed how the GRNs preferred directing their questions to the CNEs:

I think I often get a comment that, 'Oh, I was looking for you on Tuesday and you weren't here'. In some ways it takes them away from asking those questions to someone else, because they know they've got that safety umbrella and they can ask us anything and we're not going to make them feel stupid. If you're working with someone who's really busy and in a busy section, and you ask them a stupid question, their body language tells them that it's a stupid question. And they feel it. And when

that happens, they don't ask again. And when they don't ask, they make mistakes (CNE4).

When the GRNs made mistakes and their confidence was shattered, the CNE—as the safe person—accepted responsibility to deal with the consequences. Participant CNE5 noted: 'I will always find that they will come to me because I guess they know that I'm responsible for what's happening to them in the events after that'. Participant CNE3 commented on her role in the GRNs' success by working towards overcoming problems and recovering from errors:

> Because they need … somebody to look after them when they've made a mistake as well. So, by informing the CNE, that person should actually be looking out for them and not looking for the worst, but looking for what can we do to prevent this happening again and how can I … build the person's confidence again and sort out what the issue was. So it doesn't happen again.

The CNEs responded differently to the team members: 'Because I'm not going to scream and shout, or not usually. Try and talk them through it versus crucifying them' (CNE1). CNE9 elaborated further:

> Errors are errors and we're all human and we all make errors, and I certainly wouldn't … make them feel that it's so huge that then it impacts on their ability to continue on, because that's how we learn in life … I'm not big on making people feel little in that moment of error.

The CNEs inspired the GRNs to become more autonomous and safe in their clinical practice. Participant CNE9 expressed her feelings about her role investing in the GRNs: 'I get so excited all the time about little things because I love to watch people be empowered … and that self-belief that they can now do it'. The notion of continuing to encourage the GRNs to provide excellent care via continuity of support from the CNEs led to the 'open-door' subtheme.

5.3.2.4.2 Open Door

A pivotal aspect of the CNE role in the ward setting was centred on GRNs' unrestricted access to their educator. The GRNs' needs were prioritised, with spontaneous face-to-face interactions promoting safe patient care. 'I always say, "I'll stop anything that I'm

doing, so it doesn't matter what I'm doing, it's more whatever you're doing. The patient is much more important than what I'm doing at my desk"' (CNE3).

The CNE accessibility afforded GRNs compassionate and emotional support in their transition from novices to advanced beginners. The CNE participants expressed that their availability provided opportunities for the GRNs: 'Yes, they do generally seek their CNEs' opinion more and advice on things' (CNE3). On the topic of the GRNs feeling more comfortable accessing the CNEs, CNE1 noted: 'They feel that I'm more approachable and that there's no judgement'.

In highlighting their availability, the CNE participants commented on how the GRNs viewed the fast-paced clinical environment: 'They feel that some of the other nurses are racing around like a mad thing, too busy to ask. And they feel like they can ask me anything and pull me away at any stage to do it' (CNE1). One participant expressed how she felt about supporting the GRNs in light of the activity of the team members: 'They're so busy and they're often teaching and supporting other staff as well so they don't have that time, whereas I have that time to dedicate to them and I also want to' (CNE9).

The initiation and continuation of the GRN/CNE relationship was predicated on the CNEs' availability, accessibility and approachability. CNE8 stated:

> We have an understanding of where they're at and what they can do and what they can't do, and I feel that we're approachable … we're the first ones they meet and so they know that they can come to us with anything. And I personally, really reiterate that, that you know, this is my email, this is how you contact me, any problems you just give me a call. So it's all about open communication and making sure there's a reciprocal relationship there.

Another participant shared how this worked on a daily basis: 'I keep a quite flexible calendar, so I'm usually there for an eight-hour shift. So if any issues come up … unless I'm at various meetings, I'm usually accessible on the ward there and then anyway' (CNE7).

For the CNEs, understanding the GRNs' new role provided the stimulus to be available: 'Every time I get out on the floor, most of the time it's a learning opportunity for someone … I feel that if somebody needs me out on the ward, that's more important'

(CNE11). The CNE participants were reactive and responsive to the GRNs' needs: 'It sort of enhances my role because they can see that I'm not just sort of sitting in an office, not knowing what happens on the floor' (CNE7).

The CNE's presence provided relief to the new GRNs when stressful situations were encountered. CNE3 stated:

> Or there's something new … something unusual happening on the ward, particularly busy or a very sick child and they would have liked to be able to come and talk to someone or call you and say, 'Can you come and help me with this?' because you're team member is busy … So to have that supernumerary person that you can go to, knowing that they can stop what they're doing and specifically come and help you, I think is a massive help to them. So if you're not there, and their team member happens to be busy with another sick child and they are then left to sort of look after the rest, it is very, very stressful for them (CNE3).

In addition, the CNE participants understood the need to demonstrate empathy and friendship towards the GRNs to reduce their anxiety:

> That's what the CNE does. And that's awesome for me that I can be that for her, and her not feel judged or less because I know how that feels, because I have felt like that over the years as well (CNE9).

> Building up that relationship, so that they know that they've got a friend. Because sometimes they don't feel like they've got friends up here. They think everybody's just going to be at them all the time (CNE11).

The CNE participants discussed their approachability as related to the caring aspect of their role. CNE1 compared her role to the CNM role: 'My manager is approachable, but I think it's the authority that is a bit of a barrier from that aspect. I don't think they perceive me having the authority that they do her. And that's the difference'.

In summary, the CNEs' approachability and investment in developing the GRNs' clinical reasoning ability created a safety zone for the GRNs to work through challenges and complete rotations successfully. Participant CNE6 commented on her experience: 'Come and tell me, because I try and make myself really approachable, and nothing's shocking. I'd rather they come and tell me and the coordinator … and we'd try and work it out from there'. The participants also commented on how this active support

protected patients: 'If you're supernumerary and you're visible in the ward, you are always a point of contact. So that would be protection for the patient' (CNE10).

5.3.2.5 Theme 5: Leadership

The overarching theme of leadership described the participant CNEs' ability to direct ward staff through their education role. The participants perceived their CNE role as a position of responsibility: 'All of our function is leadership and actions. You have to lead by example and show the way and develop, educate, be an advocate for the patients and the staff' (CNE2). In particular, the CNEs demonstrated their attributes of clinical leadership through supervising the new GRNs' practice. The CNEs' wisdom and experience contributed to the GRNs' capability for good patient care. This was clearly expressed by the participants: 'We're leaders of education, we're leaders of change, to make the patient's experience better, we're here for patient outcomes' (CNE11).

The subthemes identified for this theme were 'on-hand' and 'in absentia'.

5.3.2.5.1 On-hand

The CNEs influenced the GRNs' practice though their role characteristics. These characteristics included educator, role model, clinical expert and advisor. CNE1 articulated how her role was instrumental in the development of the new GRN: 'I think the leadership is what pulls the grads along, because they feel that's what they want to aspire to versus having a colleague of the same level or inexperience'. The CNEs used their capacity to communicate, collaborate and influence. To be a successful CNE, participant CNE11 noted that visibility in leadership was paramount: 'And I think that's important … provide a good role, or to fulfil your role, you need to be seen, to do that'.

In their educator role, the CNEs provided the GRNs with educational resources as a basis for nurturing complex nursing practice in the ward specialty area:

> Being the CNE you have to know the rationale behind things, you're a lot more familiar with policies and procedures and all that kind of good stuff. It's just part of our role. And I think that it gives us a good base on which to explain the justification of what we're doing with them (CNE8).

The participants discussed the type of nurses who become successful CNEs. They stated that 'diligence' and 'work ethic' were significant parts of the leadership role. Participant CNE4 described these key criteria and their effect on others:

> I think education has chosen well to choose that person that doesn't go, 'Oh well, 15 minutes and I'm on overtime', or something like that, you know. You do your job and you get it done, because you believe in what you're doing. And when you do that, it rubs off on other people.

The CNE participants noted that their education role with the GRNs included being a positive example. Participant CNE1 stated: 'I have to lead in that way as well, so really by example'. Another participant elaborated on how she provided an example of responsible care:

> I would like them to think that I lead by example. Like, I don't walk past a bell. I don't leave someone on the toilet … If someone needs help on the other side, I would go over and see what needs doing (CNE4).

The CNE describes their role as an exemplar for the newly qualified graduates. CNE9 described why she desired to influence practice:

> And I always said, way back at the beginning of my training, if I could ever in some way impact on somebody's nursing care and their practice and have them reflect in 20 years' time in their nursing and think wow, you know, that person really made a difference to me as a nurse. And so when the opportunity as clinical nurse educator came up, that was when I started then looking and reflecting on that mindset that I had from back then and thinking wow, this is my opportunity to do that. And for me being out on the ward with my new grads and being able to make that difference at a very different level is awesome.

The CNE leadership encompassed a degree of expert clinical knowledge and skill. The participants described how they used their expertise to guide their GRNs' practice. In this example, the CNE's understanding and communication of evidence-based practice was evident:

> The other day there was one of our grads with a student who was going to take out a drain. And I heard some incorrect procedure, so I just pulled her aside and said, 'You know, our policy is changing all the time, so before you give anything to a student …

to do, always read the policy yourself. So go and print it off and have a read and, you know, we clamp our drains now, we don't disconnect them' (CNE4).

The participants also shared their concerns about individual nurse accountability and how they communicated the nurses' responsibility:

You really just need to be double checking the policy … I can guide you with my knowledge, but at the end of the day, you're accountable for what you do so you really need to make sure that, you're investigating what you're meant to be doing (CNE7).

The role of advisor was identified as a leadership quality. The CNEs described how their role on the ward informed the staff opinion of the CNE as a leader: 'They see people coming to me asking me questions all the time. They can see information that's been put out by me or perhaps seeing the role that the CNE takes in ward meetings' (CNE3). Participant CNE3 further elaborated on the respect gained from this advisory role: 'Like allied health and the manager, the doctors, slowly they start to look to you for things, and that again builds up that respect and other people notice and then see you as a leader and you feel it'. Respect was identified by other participants as a distinguishing leadership trait. Participant CNE9 expressed her opinion of the definition of a leader:

And to me a leader is not always somebody that just is a manager or whatever, a leader is somebody that people want to do things just because of who you are and what you stand for. And that comes from them respecting who you are as a person.

The CNE participants saw themselves as impartial when dealing with GRN issues on the ward. Conflict resolution was a significant part of the role: 'You've got to be able to deal with conflict … you've got to be fair … you need to know how to deal with people who are going through external issues that may affect their work' (CNE11). Interaction was the key to anticipating any GRN concerns, as expressed by CNE8: 'Because a lot of it is communication and a lot of it is seeing something at the time and dealing with it or helping them out … and it's not something that you're going to put in your calendar'. Other participants expressed how communication was necessary for their assessment of the GRNs' practice: 'You've got to be able to interpret what you're getting back, non-verbal … communication signals, and all that sort of stuff' (CNE11).

Collaboration with the CNM provided the foundation of support for the CNEs' leadership role. The CNE participants noted the ward hierarchical leadership structure. CNE10 explained:

> There was definitely manager, CNE … up there with the clinical nurses. You were definitely in that decision making … not confidantes but the manager would come to speak and say, 'Right, this is going on, what are we going to do?'

The participants provided examples of how they collaborated with the CNM for the benefit of the staff and patients. CNE4 shared how collaboration increased autonomy in her role:

> I usually meet with my manager, and have done, like, once a month. We'll have a little half an hour meeting, and I'll say, 'What do you want?' And we get a list and we put it up and I start crossing off the things that I'm doing. So that I have the autonomy to do that in my way and in my time.

The CNE role as an influencer was depicted by having 'eyes and ears' on the GRNs' performance:

> I'm a person who likes my fingers in all the pies. I like to know what's going on. I tend to be a leader in having an understanding of what's happening, and being that person that people can come to (CNE8).

Participant CNE2 identified the role as significant: 'I think it's the most important leadership role that you've got. I think it's more important than the manager's role in terms of what really happens on the ward. I really do. Because you're the most influential person there'.

Supporting patient care through influencing the GRNs and team members resonated with the CNE participants: 'That's how me, as a CNE can still make a difference with my patients because I'm doing it through my staff, you know, at a much, much higher level' (CNE9). Participant CNE7 endorsed this opinion: 'When you're looking at patient feedback and things that we do have a big role to play there. So I'm hoping and thinking that our leadership on the role of CNEs is contributing to that'.

In terms of the CNE role's leadership effect on GRNs, nursing and staff members, the CNEs identified the safety and quality of patient care as the most important point. This was clearly expressed by participant CNE2:

> Because there's nothing more I want than to keep our staff safe because if they're safe within their practice then the patient is going to get good care and they're going to be safe. So that's how I see it. I'm not directly responsible for patient care but I am indirectly.

The following subtheme details the participant CNEs' feelings and reflections on the implications of their absence from the ward.

5.3.2.5.2 In Absentia

When the CNEs were not present, there were support gaps evident for the GRNs. Participant CNE8 shared an experience with GRNs and team members after an absence:

> When I wasn't on the ward for a period of time, it was definitely noticed and mentioned by all my grads on my return. Mainly not only for support for them … as well as my staff members, but also the support that I give to the grads, which in turn helps their teamwork.

In the early weeks of the graduate programme ward allocation, the GRNs relied on CNE support. One participant experienced an intense reaction from the GRNs after taking leave:

> I know that sort of when I first started on the ward, I was there for the first two weeks and I was away for the second two weeks. Oh my God, were they so glad to see me when I came back from annual leave. And yes, I do get comments that I'm sort of well missed and they feel that they haven't got a designated person to go to when there was issues (CNE7).

The frustration felt by the GRNs regarding the CNEs' absence was also noted by the participants when their role was directed to working a clinical shift. This occurred frequently and left the GRNs without support. An example of this was shared by CNE2, whose experience occurred during the orientation of new graduates to the ward setting:

> There was one time which was particularly stressful for me, was I was supposed to be orientating … I don't know if it was two graduates or three graduates … it was their

very, very first day on the wards, so nobody had even shown them where anything was or fire exits … I was told as I walked through the door that actually I wasn't CNE that day, I was needed on the ward. And obviously it was an emergency and had to do that, but then I also had to work out what I was going to do with three nurses that were supernumerary and knew nothing, so even though I was supposed to be taking handover and had a patient load, I also had to work out what to do with three brand-new people into the company who had nobody to look after them. So … that was really difficult.

The participants described the new GRNs' need for assistance in working through and understanding what could sometimes be perceived as 'the overwhelming amount documentation' required for each patient care episode. Participant CNE1 shared her experience:

I had a recent bereavement and I was away for three weeks, and when I got back all three of the grads said, 'I'm so glad you're here'. And I think it was partially some skills honing or it was also, 'oh my gosh, I've got so much paperwork, I don't know what I'm doing'.

Working on competencies also required extra time and patience. These practice moments were difficult for ward staff to include in their busy shift times. Participant CNE3 highlighted this lack of practice: 'When you only do part time work or you've had a day off sick … the poor girl didn't end up doing any medication practice because nobody wants to take the time to then have a third person checking'.

The CNE participants understood the graduate programme and had a working knowledge of the scope of practice of the newly qualified nurse. The participants described the GRNs' practice when they perceived they were without support and under pressure to complete care. One participant shared her story on this genuine concern:

If she didn't have me for that … she's going to feel completely inadequate going to one of her other colleagues to say, 'I'm not quite sure about that'. So, instead, she would then just fumble her way through, probably work a little bit outside of her scope, maybe make an error and then … it's at the detriment of the patient, and she feels less of a person. Whereas, she's been able to come to me today, completely anonymous to anybody else, and we'll just do a bit of work in here.

Being available to the GRNs was important to the CNE participants. However, when they were confronted with the results of their absence, it created frustration:

> Because I was doing set days … I could go without seeing one of my grads for a week. It was awful. I hated it, and I felt like I wasn't achieving my goal, and my role, by not supporting him (CNE11).

Conversely, the CNEs' absence created added stress for the GRNs: 'So if you're not there, and their team member happens to be busy with another sick child and they are then left to sort of look after the rest, it is very, very stressful for them' (CNE3).

In summary, the effect of CNE absence meant the GRNs experienced difficulties in completing their graduate programme requirements. The participants relayed comments by their GRNs: 'Oh, I was looking for you on Tuesday and you weren't here' (CNE4) and their staff members: 'I think we're missed by our staff, because they go, "Oh, thank God, you're here because you can help", you know. "Can you do this?"' (CNE3). Further, other participants highlighted that their absence affected the CNM and the running of the ward: 'I mean, she does heavily rely on me … when I am there. She does notice the difference when I'm not there' (CNE7).

The effect of CNE leadership on the GRNs' patient outcomes was integral to this theme. In the absence of the CNE, support gaps were evident and affected the GRNs' progress. In summary, participant CNE8 provided an insightful comment on the outcomes of CNE leadership: 'That's what we do because at the end of the day I would like to be in the hospital bed and know that they're well trained'.

5.3.3 CNM

The general findings of the CNM interviews articulated the importance of the CNE role, and can be summarised in this extract from participant CNM4:

> I certainly couldn't do without the CNE! I don't know who would be able to take on that job if we didn't have one and I think a lot of things would certainly decline very, very quickly if we didn't have one.

The themes and subthemes chosen to represent the findings of the CNM are illustrated in a concept map (see Figure 5.3). The collective techniques of thematic analysis

produced the first ideas for the initial codes. Examples of some of the CNM initial codes were:

- Supports the GRNs through core education focus.
- Supernumerary status has benefits for the GRNs.
- Takes pastoral care of the GRNs.
- Is responsive to the GRNs' needs.
- Is the 'go-to' person.
- Has a patient safety role.
- Displays leadership abilities.
- Has role limitations related to time and financial constraints.

The following is an example of a highlighted statement that was allocated refined codes:

> I wouldn't say the quality of the care's questionable, because I don't think that they provide poor quality of care, but there's probably more that they could be providing. And, when the CNE's there, they can help prompt them. If they do have a lot of complex things going on, it does help them a lot if the CNE can lend their time and assistance to the grad to support them. So we try and maintain that continuity, make sure that there is somebody here, all the time. But I would imagine that if we didn't, they would … they would really notice it (CNM9).

The allocated codes included:

- **Patient safety support (has a patient safety role):** 'I wouldn't say the quality of the care's questionable, because I don't think that they provide poor quality of care, but there's probably more that they could be providing. And, when the CNE's there, they can help prompt them'.
- **Extra supervision (is responsive to the GRNs' needs):** 'If they do have a lot of complex things going on, it does help them a lot if the CNE can lend their time and assistance to the grad to support them'.
- **Working alongside (supernumerary status has benefits for GRNs):** 'So we try and maintain that continuity, make sure that there is somebody here, all the time. But I would imagine that if we didn't, they would … they would really notice it'.
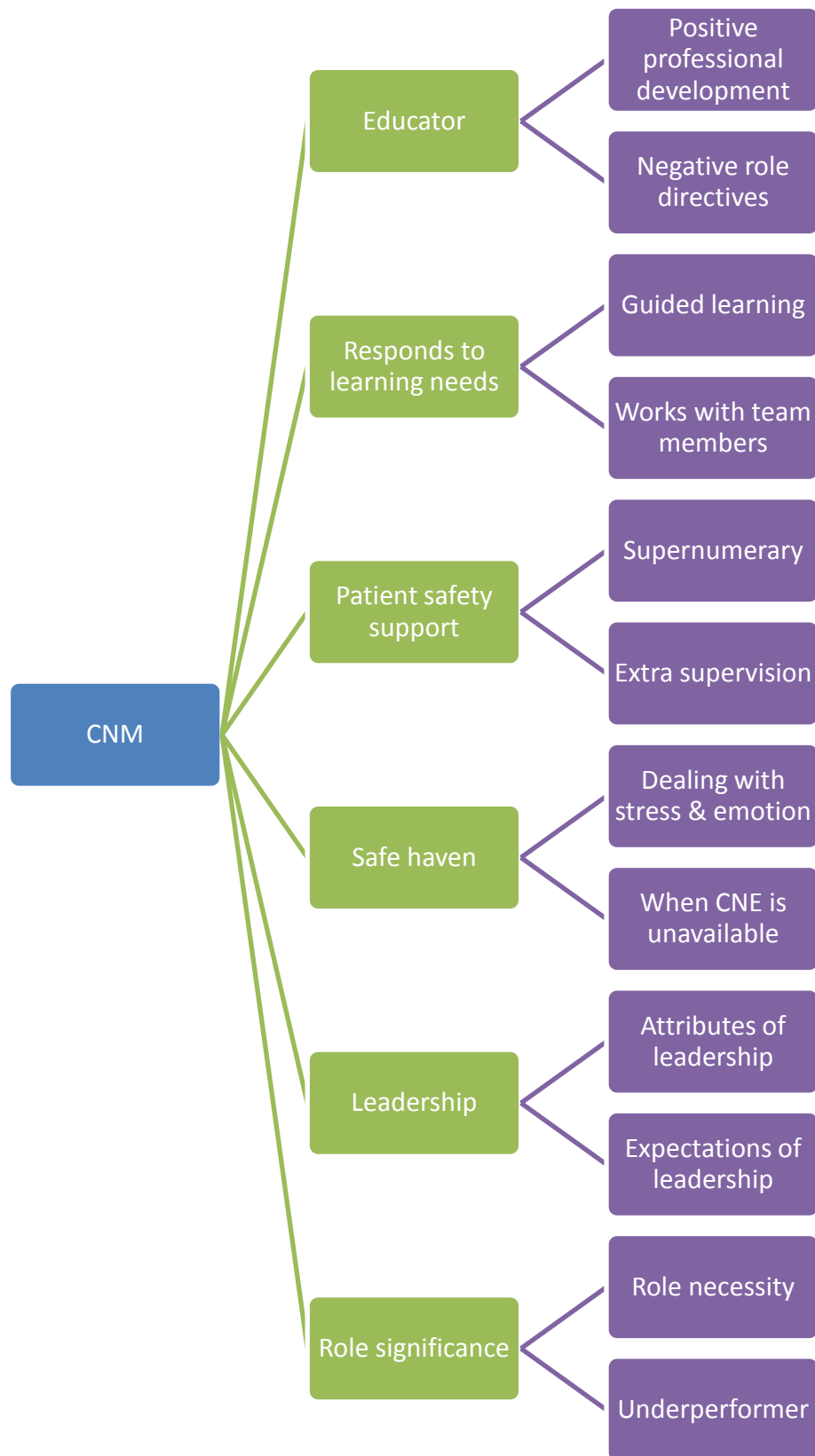
Figure 5.3: Concept Map of the CNM Themes and Subthemes

5.3.3.1 Theme 1: Educator

The overarching theme of educator expressed the CNMs' viewpoint of the significant CNE role in the ward setting. This role expectation included sponsoring the newly qualified GRNs' progress from novices to capable practitioners through 'on the job' training. The CNM participants described the CNE role as: 'More education focused and … more aware of the needs of the grad nurses and what level they're at' (CNM8).

The diverse and changing clinical environment in the current healthcare climate requires nurses to be flexible and skilled professionals who are cognisant of and responsible for quality practice standards. Participant CNM5 highlighted the CNE role as preparing GRNs for existing and future patient care needs: 'Because … they're teaching and guiding the nurses, well, of tomorrow really'.

The subthemes identified were 'positive professional development' and 'negative role directives'.

5.3.3.1.1 Positive Professional Development

The CNMs perceived the CNE role as critical in providing positive professional development opportunities for ward staff and specifically for GRNs. The participants described the CNEs as understanding the graduate programme's clinical content requirements and the challenges that the GRNs would face in their first ward allocation. Participant CNM9 gave a concise illustration of the outcome of the CNEs' provision of quality educational experiences: 'They put all the pieces of the puzzle together'.

The participants highlighted the CNEs' contribution to developing the GRNs' patient care specific to the ward specialty. In particular, the CNEs augmented critical thinking skills at the point of care: 'To work alongside and to make sure that they are able to identify the relationship between medications and for example, your observations and why people fall … it's basically driving and extending them from a book to think laterally' (CNM1). The participants detailed the way the supernumerary CNEs worked with the GRNs and team members to provide necessary and individually tailored educational opportunities. The learning support of the GRNs started with building rapport:

And I think that starts from day one, they're the first point of contact for the grad nurse … and we try and make sure that they touch base with CNE before the start as well, so they have that familiar face from day one. And the CNE is then responsible for taking them through the orientation … we have a lot of different processes and policies and procedures … that anybody that's working has to understand it as well. So having that dedicated time to take the grads through that is incredibly important (CNM2).

The responses highlighted the supernumerary role advantages in relation to specific skills: 'They can point them in the right direction … because they really need to get the basics of the time management … you've got somebody who's supernumerary, they're able to support them to do that' (CNM5).

The participants described the availability of the CNE as creating a responsive learning climate for the GRNs. Participant CNM7 commented: 'I think it gives them the extra supervision. It gives them a go-to person. Gives them someone they can go and check things with, or just to reassure them that they're doing things correctly'. Participant CNM3 described the importance of the GRNs' comfort in accessing correct information:

Because the last thing you want is for somebody to feel … that they can do something but they don't have the skills and knowledge. So … you create an environment that allows them to ask those questions upfront rather than … just plod along.

The CNM participants included statements about how the CNEs worked with the GRNs. One aspect of the CNE role was to respond to the feedback from team members on how the GRNs were progressing:

If there's any areas they're particularly struggling with, like medication rounds that are particularly slow or they're asking a lot of questions that at that point they should know the answers to, so that feedback goes through to the CNE, who can then go and work alongside the grad to do that, hands-on sort of assessment type of thing, and then put in any extra support or education that's needed (CNM2).

Another aspect was to keep an eye on each GRN. According to participant CNM1, the role of CNE was: 'An observant role'. Further elaboration by CNM7 outlined this observing role in practice:

She sort of hovers at times when she needs to … she's very good at standing back and letting people do the work and watching and then helping as and when it's needed. And then she's really good at reinforcing what people have done well and any gaps that they have as well.

When working alongside the GRNs, the CNMs explained how the CNEs found opportunities for learning new skills:

Sometimes in the morning round the CNE will work with them to be able to be part of that team and to try and … keep the ball rolling. And then in those first couple of weeks there's a lot of skills that they're picking up that they need to be able to do the job. And you can't expect them to come with those skills. They may not have been exposed to surgery in their clinical practice so you want to make sure that they're safe when they're doing that (CNM3).

Spontaneous clinical teaching sessions by the CNE occurred in response to knowledge and skill deficits identified by team members and the CNM: 'She knows the answer or knows where to get stuff from … and she can give us like a mini teaching on, "Right, this is what we need to be doing" … and supporting them' (CNM5). In addition, the CNEs responded to the consolidation of clinical skills by supporting the GRNs' theoretical understanding: 'Also then building on that with those self-directed learning packs and keeping them on track' (CNM3).

The participants also commented on the amount of collaboration that occurred between the CNM and CNE to ensure the GRNs' educational focus and safety needs of the patient were met:

I like having my supernumerary CNE it's very helpful to me and when … we focus on various things, so if we're finding that we've got an issue with, I don't know, pressure injuries on the ward, or wound deterioration we'll focus on it. If it's to do with falls … and that's when RiskMan [software] comes into it, because you see incidents coming through that might not necessarily get verbalised to you. And you recognise a pattern or a trend (CNM9).

This recognition of issues related to the new GRNs meant the CNMs were able to direct the CNEs to support the acquisition of new knowledge and skills: 'And if we get in a run of … adverse events … we can sort of act on it, more or less, straight away as it happens. And put that education and training in place' (CNM5).

The participants expressed how the CNE was necessary to challenge the GRNs to actively develop their clinical skills beyond the basics:

> Certainly I'd expect a graduate to be able to do the basic ADL [activities of daily living] sort of stuff … however, they might be able to wash people but are they looking for skin assessment, are they looking for the other things that you can do in a shower? (CNE1).

By their presence, the CNEs drove the GRNs' capacity to nurse patients under increasingly complex conditions: 'If they do have a lot of complex things going on, it does help them a lot if the CNE can lend their time and assistance to the grad to … support them' (CNM9).

The CNM participants highlighted the CNE role in supporting the GRNs to understand their responsibility to provide holistic, patient-centred care. Participant CNM9 emphasised the importance of this point: 'I think they help the grad nurse take a step back and think about the patient as a whole, instead of thinking about the tasks that they've got to perform'. Another participant elaborated further:

> She can then bring it back in and make sure that any grads … have that bigger picture stuff, they're not just focused on I'm coming in, patient care, I'm going home, it's about understanding that whole service and how we work here (CNM2).

The CNM participants discussed the constructive role of the CNE in providing positive professional development for the GRNs, with the focus and outcome of this role highlighted by participant CNM9: 'I think that it's pivotal having the CNE work closely with the grads when they're … fresh out, to help them piece everything that they've learned together'.

In contrast, the next subtheme highlights the absence of the CNE in their educator role, and the effect of this absence on the GRNs.

5.3.3.1.2 Negative Role Directives

The CNM participants described their CNE as being frequently directed away from their core educational duty. Clinical patient needs were identified as being more important, and the CNM was often directed to use the CNE role in direct patient care. This included replacing staff shortfalls due to absence or during times of financial constraints

centred on staffing: 'If the KPIs [key performance indicators] are blown out, we're usually asked to try and reduce KPIs, which means the CNE goes on the floor' (CNM1).

The CNEs' substantive role was often part time, which was identified as a factor affecting the GRNs' and nursing staff's professional development. The CNM participants expressed their opinions on the hospital's senior leadership, whose actions were indicative of the CNE having a less significant role when they directed the CNM to allocate the CNE hours to direct patient care: 'When we're trying to cut back on hours, they're the first ones to go, so it's like, are they really … seen as important?' (CNM5).

In discussing the clinical need requirements and the need to balance patient care and executive decisions on financial restraint, the CNM participants highlighted the vulnerable role of the CNE: 'I hate to say it, but the CNEs are the first people that they pick on' (CNM4). The reasons for the CNE being moved to a clinical role included financial issues, nurse supply and workload. Participant CNM7 noted: 'Being called away from their job, being made to work on the floor due to budget issues or just lack of staff and I think the main reason would probably be budgetary or general busyness'. Team member sickness was also a common theme: 'Clinical hands-on … if there is staff that have gone off sick and there is no replacements, the CNE is utilised on the wards' (CNM1). Another reason stated by the CNMs included being used as a patient chaperone: 'Quite often they're called upon to escort and that might be even outside of hospital, so they're gone for, more or less all day' (CNM5).

However, the CNM participants also noted the willingness of the CNEs to spontaneously help on the ward: 'But it's also when it's extremely heavy and busy there is a component where they do help out on the ward' (CNM1). This CNE hands-on support for team members was identified as helpful, but needing balance: 'I say to her, she's always helping out on the ward but you've still got that office work that sits there. So, you've got those limitations … because the office work still needs to be done' (CNM6).

The CNM participants supported the CNEs' supernumerary role status in order for the CNEs to achieve their own schedule of education and training activities. This was made evident to the CNMs when the CNEs were directed to clinical work:

I don't think they could have their own patient load because there's so much for them to do that, and they're sometimes pulled off of their role in staffing shortfalls and then they've got to work on the floor. And then a lot of what they're trying to achieve goes out the window (CNM8).

The lack of understanding of the CNE role criteria and education knowledge and experience was persuasively stated by participant CNM4:

Just because they're not out there, wiping bottoms or giving out meds all the time, doesn't mean that they're not working. I know they do have an enormous amount of work … especially with the bigger units. So … our CNE might have up to 110, 120 staff to look after on top of with the grads and students as well. And that's just sort of making sure that things get done, the competencies are done, the push, push, push. Organising education, whatever they can do … on top of being a reference type person, assisting on the ward when there's emergencies and all that type of thing. So you could be sitting at your desk and there's some work there and only you can do it, but you keep getting dragged away from other things and all of a sudden you find the CNE … in the catch up mode.

This highlighted the CNMs' concerns about the lack of CNE time for GRNs when the role was directed elsewhere: 'When you've got new grads or grads that need support, you're not really doing them any favours by putting them out on the floor, because they're not getting supported' (CNM5). Lack of time also equated directly to the amount of education offered during work hours:

It's hard for staff as well to have to do things in their own time, when they're completely shattered at the end of the shift, they don't necessarily want to stay on, or come in on a day off to learn something new. So you have to try and fit into their work time, which … is often too hard (CNM7).

However, when the CNEs were directed to work on the floor, they often used that time to continue to provide education and support: 'I know that even if I say help for two or three hours, she'll use that time as her development stuff as well' (CNM2) and 'It isn't a bad thing, because they could be working with the grad and having that input' (CNM1). The participants recognised that, while the CNEs supported the GRNs as much as possible, the additional roles created conflict: 'The CNEs often end up taking on coordinator shifts … they probably do multi task, but there's a limit to what … they can

provide, because, obviously they've got other responsibilities, during that shift' (CNM9).

The participants provided insight to their CNE role expectations and response to directives to use the CNE role in direct patient care. The CNMs highlighted the necessity of the educational guidance and direction required by the GRNs and provided by the CNEs, and noted the effect of the inconsistency of the CNEs' core role function. There was a lack of standardisation of CNE hours allocated to each ward, as reflected by participant CNM6:

> My CNE just works three days a week. Sometimes it would be nice if they were there
> five days a week. But you think about budgets and how … you have to meet those
> requirements, so I understand that … is not possible.

5.3.3.2 Theme 2: Responds to Graduates' Learning Needs

This overarching theme identified the CNMs' understanding of the CNE role response to individual GRNs' learning needs. The GRNs in the clinical environment applied theory to practice and worked closely with the CNE and team members to achieve professional and personal goals. This period of transition for the GRNs was the continuation of their capability for learning. CNM1 noted: 'It is no good coming straight out of uni and think you know everything from the book, because that's just the beginning, really. It's being able to take what you've learned and apply it'.

The commitment of the CNE to facilitating the individual GRN's development in each ward specialty occurred with the CNMs' support and guidance. The collective goal for all ward staff is quality and safe patient care. The benefits of the supernumerary CNE role were expressed by the participants: 'So that's how I think it helps patient care, because they can give them that guidance' (CNM3).

The subthemes identified were 'guided learning' and 'works with team members'.

5.3.3.2.1 Guided Learning

The CNEs responded to the GRNs' learning needs in their first year by guiding their learning throughout the ward rotation, from novices to advanced beginners. The

expectations of the graduate programme and the associated ward specialty were detailed by participant CNM8:

> They're working one on one with them … from day one they're telling them, 'These are the expectations of you, what we expect from you. These are the differences on our ward. These are new forms'. They go through everything with them in the first week … so I think the fact that you set those ground rules is improving the patients' safety.

The learning gaps were identified and support was directed to these areas to ensure the GRNs were developing at an acceptable pace. Each GRN is unique, and building a rapport and relationship ensures any learning gaps are satisfied. The participants highlighted the role of the CNE in providing holistic education support:

> The ability of the CNE … somebody might shout loudest, she spends a lot of time. Okay, there might be somebody that's in the background and they're trotting along, nobody to really picking up much, but also that checking in constantly as well and making sure. Some people are too scared to come and ask (CNM2).

The CNM participants detailed the CNEs' role in guiding the GRNs' learning. This required understanding the individual GRN's personality, work ethic, communication skills and advancement of competency skills. The CNM participants shared the need to deal with individual GRN's personalities. Busy team members may not be sensitive to the learning needs or gaps of quiet and unassuming GRNs:

> Personalities, and I'm just thinking about one particular grad that we've got at the moment, quietly gets on, not particularly doing anything wrong but not setting the world on fire a little bit, so the CNEs are going in, is everything okay? Is there anything I need to help you with and trying to sort of pull out some of that extra stuff that we can offer (CNM2).

Conversely, team members could be vocal in their support of the GRNs by highlighting their observed learning needs and communicating these to the CNE. Participant CNM2 continued:

> The opportunity when the CNE is here the whole time is they receive feedback from our RNs and clinical nurses around how the grads are doing. If there's any areas they're particularly struggling with, like medication rounds that are particularly slow

or they're asking a lot of questions that at that point they should know the answers to, so that feedback goes through to the CNE who can then go and work alongside the grad to do that, hands-on sort of assessment type of thing, and then put in any extra support or education that's needed.

Practical and repeated assessment occurred to ensure the GRNs were competent. Participant CNM4 described the CNE role to ensure that medication knowledge and skills were developed and safe:

Especially with the first year ones where they actually have to do the medication competencies … and my CNE … is very hands-on, to the point where she wants to see it. And once she feels comfortable with them that they can do it then she will let them go with other staff to therefore get other assessments done.

Participant CNM3 identified how GRNs needed the supervision time and the calm offered by the CNEs to support learning:

They can also be there and readily available if for the first time taking out a drain they can do that with their team member … but often the pace of the ward doesn't allow the length of time that you need to explain it fully and not feel that you're rushed.

In the provision of learning, tailored to the individual GRNs, the CNM participants identified the need for the CNE role to have stability: 'So we try and maintain that continuity, make sure that there is somebody here, all the time … but I would imagine that if we didn't they would really notice it' (CNM9).

The next subtheme provided detail on the collaboration between the CNEs and team members for the benefit of GRNs' success.

5.3.3.2.2 Works with Team Members

The CNEs responded to the GRNs' learning needs in their first year by working closely with the wards' nursing team members to ensure the GRNs' continual growth. Participant CNM4 highlighted the importance of the CNE role to the nursing team:

Not only are they … from an education perspective, a go-to type person, they're almost there as a … a CNC [clinical nurse consultant] type person as well. So if anything goes down, as in say, MET [Medical Emergency Team] calls … the majority of the time the educator will be there. I think we get great value out of them.

The team members—including senior and junior staff—were keen to offer support to the GRNs; however, lack of time and concern over patient safety required an available, comfortable and consistent presence to support learning, as provided by the CNEs: 'Being supernumerary she can certainly make time and spend with them. She'll look at their rosters, she'll say, "Right, I'm going to come and spend some time with you". And it also takes the pressure off senior nurses' (CNM4).

Participant CNM4 reflected on the progress of the GRNs after their initial orientation period, and the role of the CNEs in providing team members support when necessary:

> And initially graduates especially can be … slow. And when they are no longer supernumerary and they are part of the working environment, slow isn't necessarily a good way to be. To be efficient is better and to be safe, but slow doesn't mean either one of them. Okay, to be slow doesn't mean you're efficient or safe. So having the staff, the CNE there with them certainly allows other staff members to get on with their work, rather than having to supervise a not so efficient grad at the time. But their efficiencies certainly do improve and they improve quickly. And that comes with confidence and that's what they need. And depending on the type of CNE that you've got and their attitude, confidence can be built up quickly or sometimes confidence can be lost because people can sometimes get frustrated.

The CNM participants commented on the GRNs' need for immediate assistance with patient care, and the ability of the CNEs to respond:

> If a grad or any of the members of staff needs some assistance with something, [the CNE] will drop stuff to go and assist at that point in time. She does promote them using the staff that are around on working alongside and the clinical nurse or the RN but, obviously … there's times where that's impossible because the ward is totally chaotic (CNM2)

Busy team members' lack of ability to respond to or meet the learning needs of the GRNs was highlighted as adding stress to the team members:

> I think it would put a massive onus on the staff, and I don't think that the grads would get the same level of training and support that they do get through the CNE. Because the … RNs have their workload as well. Whereas, the CNE is supernumerary on the floor to assist them, so she's not counted in the actual numbers of the shift (CNM7).

The CNM participants also commented on the way the GRNs found it difficult to talk with their team members when they struggled to provide the type of care expected. The CNE role acted as a mediator between GRNs and team members, and prevented misunderstanding:

> A lot of the grads, especially the first rotation grads feel like, 'You're holding people back'. They don't know anything. And I've been in the position before; a lot of them feel like they're useless. But they don't want to speak … because then they don't want to be talked about behind their back or anything like that. So having that CNE to actually discuss this with and if there are any issues and the grad does not feel comfortable to bring that up, which I don't blame them either, then they can come through the CNE through to the manager, or the CNE can certainly speak to the other nurses because they utilise them as well and the CNs (CNM4).

Participant CNM3 described the process of ensuring the GRNs were provided with a ward environment conducive to guided learning:

> So you want to make sure that they do know that we're accessible, you can approach anybody … so it's good. And most of the times it's the CNE that they'll be looking for to do that. I think everyone needs to be approachable, if they need some guidance and that's what we've tried to promote, but they realise that the CNE will have a lot more time to be able to spend with them.

The CNE was described by the CNM participants as being able to make the difference through providing supernumerary, planned and prompted support to the whole team to ensure continuity and consistency of GRN learning. This encompassed difficulties, challenges and celebrating successes:

> If they're having any troubles with the grads, they can always go to the CNE and say, 'Look, there's some issues here, I've discussed it with them but I just don't have the time, because I've got all this other stuff going on'. So therefore, the CNE can certainly step in and try and help out there. Make time, performance manage, etc. … very helpful (CNM4).

The CNM participants acknowledged that the CNEs supported the GRNs' success during their graduate year through guided learning, in collaboration with team members. Participant CNM9 summarised the importance of this support to the GRNs: 'the focus is

very much on learning the tasks that are involved in nursing care, and … sometimes the empathy, the piecing together, the time management is not necessarily there'.

5.3.3.3 Theme 3: Patient Safety Support

The umbrella term 'patient safety support' was used to denote the CNE role commitment to the GRNs' delivery of safe, quality patient care during their first year of nursing. This overarching theme focused on the desired patient care outcomes from the CPD of novice nurses throughout the graduate programme. The CNM participants commented on the newly qualified GRNs' assimilation into the nursing team and the importance of the CNEs in promoting care to an expected standard:

> The CNE helps them observe and identify … risks … and I think that … sometimes, I wouldn't say the quality of the care's questionable, because I don't think that they provide poor quality of care, but … there's probably more that they could be providing. And, when the CNE's there, they can help prompt them (CNM9).

The CNE support role provided a safeguard for patients through being available and accessible on the ward to reinforce the GRNs' learning and practical patient care skills. Participant CNM2 stated: 'I think the value of that role really sits within that ability to respond'.

The subthemes identified for the overarching theme of 'patient safety support' were 'supernumerary' and 'extra supervision'.

5.3.3.3.1 Supernumerary

In this subtheme, the supernumerary aspect of the CNE role significantly benefitted the nursing team. Each CNM participant described how the addition of a non-direct patient care position operated in their own area to support the GRNs. Participant CNM7 described how the extra labour force advantaged the GRNs:

> The CNE is supernumerary on the floor to assist them, so she's not counted in the actual numbers of the shift. So it means that the grads get their full attention; that they're not rushing off to do other things.

The CNE participants described a common viewpoint of the availability of the CNE for the new nurses: 'The CNEs … they're around, so they're quite easily accessible … and

obviously they would then be able to give them that time, just to support them, whereas the other team member, you know, perhaps wouldn't' (CNM5). CNM2 made a statement about the role value: 'I actually believe it's integral and important'.

The amount of supernumerary support required varied with each individual GRN and the type of ward specialty. The CNM participants recognised that the CNEs made regular assessments on the GRNs' need and apportioned time as required:

> Some grads fly and they don't need it there all of the time, others need that there constantly. So, I think as a baseline it would need to be there, and that's when you can then use the CNE in different areas if the grads are functioning more independently, away from that (CNM2).

Considerations of the GRNs' life experience, knowledge and skills also indicated the level of support required:

> I think that they … prompt them a lot … because … with some of them being new to employment … they don't necessarily have all the developed life skills that some of the more mature grads coming through have. So the considerations are slightly different. They … can't necessarily identify all of the risks that are associated with patients (CNM9).

In alleviating a substantial portion of the GRNs' time-intensive learning needs from the team members, the CNEs contributed to the smooth administration of patient care. Participant CNM8 commented: 'With the amount of grad nurses you've got to have somebody who's there for them … especially if they're working the one on one sessions and they're talking through it and doing the med rounds'. The fast pace of the work day was also a factor that improved with CNE support to reduce work interruptions:

> Because the mornings are busy for us. We've got to get patients out; we got to get patients in. And it's a fast pace and if you say I need to do this dressing, I've never done this type of thing, or I need to take a drain out, I've never done it, then that stops the pace, so that's great that that person's just readily available to do that (CNM3).

During the busy shifts, the supernumerary CNE was able to respond to a variety of ward needs to maintain safe and quality patient care:

She can assist on the ward as needed, and particularly when the acuity's really high, so it's about being an extra pair of clinical hands very quickly. I think, again, in this specialty, because we have so many different facets of what we do that role has to be able to respond to what's needed in that particular time (CNM2).

When necessary, the CNE works alongside the GRNs to provide direction, reassurance and reinforcement of safe patient care principles, and to extend GRNs' ability to use critical thinking. Specific situations, such as resuscitation, provide the opportunity for the CNEs to facilitate new learning experiences:

Because they're supernumerary … if we do have MET [Medical Emergency Team] calls, which is obviously quite frequently on here, they've that added extra person, so they can let the grads go in and let them take an active role in it, whereas when there isn't that support there, I think they maybe tend to pushed to the side because it's an emergency situation, you haven't got time them to start teaching or showing somebody else what needs to be done (CNM5).

The CNM participants also noted that the CNEs provided the GRNs and team members with access to resources for continued GRN support and learning, and to manage challenges in their absence. Participant CNM4 explained: 'They do give the grads … I know my staff do … gives them coping mechanisms for when they're not there' (CNM4).

The following subtheme highlighted the need for 'extra supervision' to encourage GRNs' safe patient care.

5.3.3.3.2 Extra Supervision

The subtheme of extra supervision highlighted the way the CNEs encouraged the GRNs' patient safety through empowering their practice. This occurred by supporting decision-making processes: 'She's very good at hovering, so she allows them to make the decisions or to talk through the decisions that they're going to do' (CNM7). The participants expected the CNEs—with their knowledge and experience—to be vigilant and promote GRN comprehension. CNM1 commented: 'Certainly, I expect the CNE to reinforce things' (CNM1).

The extra supervision provided by the CNEs was explained by the CNM participants as occurring in a variety of ways: 'There's the support, whether that be on the floor, physical help and helping them in the right direction without actually taking them there by the hand … and assessing them on the job on the role' (CNM1). CNM7 also commented on her experience: 'My CNE works alongside the grads for a lot of the time. She's fully available, so even if she's not working the whole shift with them, she's available to pop in and out of the shift time'. Other participants highlighted the availability of the CNEs to respond to questions:

> For them to then be able to sort of have somebody always there for them is really important because there might be times where they've got a burning question, they really don't know how to do something, they're really unsure about something, the CN's [clinical nurse] perhaps in a two-hour ward round then they've always got that person to come back to as well (CNM2).

The CNEs provided a sounding board for the GRNs when making decisions, provided alternative choices and gave direction to support their growing autonomy. Participant CNM7 explained:

> She sort of hovers at times when she needs to. She's very good at standing back and letting people do the work and watching and then helping as and when it's needed. And then she's really good at reinforcing what people have done well and any gaps that they have … and also empowers them to make choices as well, because otherwise … she can't do everything for them. Or tell them all the time because they'll never get going to move on … so it's important empowerment as well. And it's to give them some autonomy.

The GRNs required the CNEs to help broaden their thinking in relation to decision-making options. CNM6 explained: 'It takes new thoughts and attitudes to come in. So I think shared decisions is probably a better word'.

In providing additional supervision of the GRNs' practice with their patients, the CNEs shared their own significant knowledge and experience to guide new experiences, while broadening the GRNs' competence in the ward specialty. Participant CNM4 commented on their CNEs' knowledge and experience for the benefit of all staff and the GRNs:

So, staff will come to me, I'll give them whatever advice I can I'll say and then I'll say, 'Go see the CNE just to clarify a few things'. But if they can't then they will come to us, but I'll get in touch with my CNE and say, 'Well, this is going on, can you just check up on them?' (CNM4).

New GRNs did not always have the ability to recognise risks to patients in the clinical setting. Participant CNM9 provided an example of a problem that required CNE intervention:

> You know, simple things like beds being left too high, which is not an issue for a young person that can jump … hop on and off it. But, for somebody who's just had a knee replacement or a hip replacement done, or, who's just frail and old, and not very well … the CNE helps them to … observe and identify these … risks.

In the discussion on GRN mistakes with patient care, the CNM participants reflected on the CNEs' role: 'If it's … a grad the CNE has a role in other errors that sometimes are made … and we try and learn from that and share that information' (CNM3). Direction and consolidation of knowledge were pivotal to GRNs' development and capability in patient assessment. Participant CNM5 commented succinctly on the CNE role: 'They can point them in the right direction', while other participants highlighted the necessity of the extra supervision: 'And that's where that supernumerary side of it comes in to it' (CNM2).

Participant CNM7 summarised the magnitude of the supernumerary position in empowering GRNs' decision making and application of theory to practice through availability and supervision: 'I think it gives them the extra supervision. It gives them a go-to person. Gives them someone they can go and check things with, or just to reassure them that they're doing things correctly'.

5.3.3.4 Theme 4: Safe Haven

The overarching theme of 'safe haven' was the noun used to describe the CNE role as a position that represented shelter and security/protection of the GRNs' practice in their first year of nursing. The participants characterised the key components of the CNE role as availability and approachability to provide direction and guidance for patient safety. Participant CNM8 provided a definition: 'Yes their little safe haven. You know, they

might not need them all the time but generally they're popping their heads in at least once a shift. And they might have questions or queries about something or issues'.

The participant CNMs identified the need for a confidential and neutral, yet informed, person to invest time in the GRNs, who could listen, counsel and provide coping strategies. Participants commented on the characteristics required:

> It does take a special type of person to be a CNE and I think you do need to lend a kind ear now and then, and sometimes some of the grads just need to get stuff off their chest but they don't want to speak to the staff that they're actually working with, their fellow staff members. Where they know they've got that go-to person they can actually come and debrief with (CNM4).

The subthemes identified for the overarching theme of 'safe haven' were 'dealing with stress and emotion' and 'when CNEs are unavailable'.

5.3.3.4.1 Dealing with Stress and Emotion

The CNM participants described the specific role of the CNE in dealing with the issues of increased stress and emotions in the GRNs' first year of nursing. In particular, the first few weeks were a challenge for GRNs and staff:

> They do have a strong support role with our graduate nurses, but I think in the first couple of weeks the CNE role is vital for them to be able to manage and cope. And for the staff to be able to manage and cope.

There was recognition of the GRNs' natural preference for support from an accessible, time-rich nurse:

> I think everyone needs to be approachable, if they need some guidance, and that's what we've tried to promote, but they realise that the CNE will have a lot more time to be able to spend with them … so that's why they tend to more go towards or gravitate and ask them (CNM3).

In the beginning of the graduate programme, the CNEs identified and managed the new GRNs' difficulties: 'They're the eyes and ears of what's going on and if they see issues arising, they come up with ideas of how maybe to do things better' (CNM3). The participants further described the process of feedback from team members to the CNEs,

specifically regarding the GRNs' advancement related to the ward specialty: 'Most of the time if any of the grads are struggling with the clinical environment, we see it very quickly and that gets feedback very quickly from the staff that work alongside them on the floor' (CNM2).

In addition, the new GRNs sometimes had to deal with emotional stress related to inexperience, lack of confidence and responsibility. This could affect their patient care and required frequent intervention by the CNEs. Participant CNM1 described the process when difficulties arose:

> Emotional, it's everything. It's the way people work as well as their emotions, and how they interact with team members and whether they actually are progressing, and if there's a hindrance pull them aside, you know and try and assess what's going on.

The participants provided further insight to how time spent with the GRNs identified concerns and future career directions:

> Some people she can sit and she can talk through, explain a lot more, do a lot more sort of counselling type stuff with them, and they start to fly, and it's wonderful to see, others, you just know it's not going to be for them (CNM2).

One CNM participant shared her experience of new GRNs in terms of the effect on the ward, CNEs and CNMs, and the disappointing outcomes:

> I do think a lot of CNE time is taken up with high maintenance young ladies … on the grad program that don't take things seriously enough. Have issues constantly to deal with family or emotional stresses, and I feel that we're, both CNM and CNE are constantly having to intervene with talking to HR constantly about these people. And when you've got, which I had, or we have, three out of the five that have got issues at the moment and that is when it detracts from what you're trying to achieve … you are trying and investing in these people to make them the best nurses possible and then it all is almost a waste because they haven't completed (CNM8).

The CNM participants expressed their satisfaction with the CNE educational role in ensuring the GRNs were able to work through the stress and emotion in their new role: 'Certainly with this particular person, you meet on a weekly basis quickly and see … what the issues were' (CNM1) and 'If we get in a run of … adverse events, and we can

sort of act on it more or less, straight away as it happens. And put that education and training in place' (CNM5).

The role of the CNE in supporting the GRNs' journey through stress and emotion was evident in the responses of the CNM participants. CNM1noted:

One of the skills that the CNE needs here as well, is to be able to do not just that practical side of stuff … how are they travelling emotionally? Yes, that's it, it's almost like a pastoral care role for them.

Conversely, the next subtheme detailed the results of patient care described by the CNM participants when the CNE was not available to provide GRN support.

5.3.3.4.2 When CNEs are Unavailable

It was clear that the CNM participants knew there would be times the CNE would be unavailable: 'You want to create an environment that they can ask anybody. If the CNE isn't there then they have to be able to ask somebody. So you want the whole ward on the same page with that' (CNM3). Participant CNM4 commented on who the GRNs would approach in the absence of the CNE: 'Who to go to, and over a period of time the grads do work out who … not being picky here, but who are the better staff to talk to if they require any assistance' (CNM4).

When the CNE was not available on the ward and a GRN was experiencing difficulties, it was clearly noted by the CNM participants: 'When she's not there, you notice it. You really do. Particularly if you've got somebody, really poorly that you're struggling with … supporting them' (CNM5). In addition, in the absence of the CNE, there were other issues identified that affected the GRNs. The ward specialty was highlighted as significant: 'I think it would be difficult given the nature of the patients, and the range of conditions that we look after. And I think, because we're so used to now going, "Oh, can you?"' (CNM5). Another participant identified the use of casual staff as affecting the GRNs' development:

So they're always going to work with an RN or an EN. But then you've got sickness and things like that, that come into account, so that's when you rely on your casual pool. So if there wasn't a supernumerary CNE on the ward, and they were with a

casual nurse their learning would be dependent on that casual pool nurse … their learning would suffer, I think (CNM6).

The CNE role provided mediation between GRNs and team members when there were issues. In the absence of the CNE, these issues affected team nursing and needed to be escalated to the CNM. Participant CNM4 shared how this occurred:

But they don't want to speak to the staff that they're actually working with, their fellow staff members. Now, obviously if they don't have a good relationship with them, then they're going to have to escalate and, go to the coordinator or something like that. But they don't want to speak to their [team member] because then they don't want to be talked about behind their back or anything like that.

A number of CNM participants expressed their opinions on the GRNs' learning journey and the support offered by the CNE and team members. The participants suggested that the GRNs should not always be provided with too much help, so they will use their own critical thinking abilities. For some, the absence of the CNE was a learning opportunity:

There is many … different drivers for … a CNE, being clinical governance, students, own ward staff and, of course, the graduate nurses … and from my understanding and where my thoughts are coming from, is that I think for a long time … certainly in … in the first five years … I've worked here, I had seen a lot of spoon feeding. I don't believe that's the way to go forward … in that role. It should be more as to guiding people as to where do you think you might find the information, or how do you think you might go about this. Let the grads think about it for themselves, so rather than just giving them the answer, because there … there is actually no benefit in spoon feeding people (CNM1).

In summary, the safety of the patient was a priority to the CNM participants. The compassion and care of the CNE was vital to GRN success during challenging times. Participant CNM2 identified the interruptions to the CNEs' education and reflection schedules that created times where the safety zone benefits were absent:

Probably sometimes there's too much to do and not enough time. I know in some other areas when they're particularly short on the ward of nurses, they pull the CNE hours. It's not to mean on an odd day there might be three or four hours where it's like, 'Can you help, please, we're absolutely desperate'.

5.3.3.5 Theme 5: Leadership

The overarching theme of leadership identified the CNE role as having the capability to guide staff in the clinical ward setting. The CNM participants recognised the CNE as the educational and clinical expert, aligned with a position of influence: 'She has a lot of influence and I think that's partly what you can do … she's the role model' (CNM3).

The CNE role was identified as significant and essential to collaborative leadership in the clinical setting. The participants articulated their understanding of this leadership role: 'I expect them to own that role … we work side-to-side and collaborate as to where we are going' (CNM1). Specifically, the guidance and direction of the GRNs in the graduate programme was distinguished as a leadership role: 'Leading by example as well … raising the bar … and showing the grads what the expected level is' (CNM7).

The subthemes identified were 'attributes of leadership' and 'expectations of leadership'.

5.3.3.5.1 Attributes of Leadership

The subtheme of CNE attributes of leadership centred on clear communication and mutual respect. The CNM participants emphasised the importance of communication as a two-way process of imparting and exchanging information, ideas and feelings to reach a shared understanding: 'Very communicative, which certainly helps in that position' (CNM4). Participant CNM2 highlighted the depth of the expectation of communication between CNEs and CNMs: 'I practice very open communication style, and she does the same … so the majority of time we discuss everything openly, whether that's around grad nurses' performance through to policy development'. Respect for the CNE role and person was highlighted as necessary to fulfil role criteria. Participant CNM3 emphasised: 'I really respect that role'. Participant CNM2 commented: 'She has that respect of the people out there as well, so that's been a real bonus for me. And you can't set … somebody's CNE as the messenger without actually having that respect'.

From the CNM perspective, the CNE role required both social and psychological skills to be effective in the clinical environment. The participants identified their key criteria: 'I think they really have to be a … forth-fronted type of person, a special type of

personality that can be assertive and be approachable and get the job done' (CNM3). Participant CNM1 further elaborated on the types of people skills essential for the role:

Someone that's adaptable to different personalities and able to cope with them … that's a particular skill for anyone to be able to do, adapt across age groups, across cultures, and people that have different behaviours. You speak to them differently, you look at them differently, you modulate your voice and … you almost think … the way they're thinking and adapt to that. So, generally, someone who's been in nursing for a while certainly a minimum of five years I would think, and possibly has had a bit of life experience, at the same time have a bit of compassion and grace and understanding that no-one's perfect.

Cooperation and collaboration in teamwork were identified as essential to the success of the CNMs' team relationships and patient care directives: 'So we both kind of know, we're always on the same page, and we both know what's going on' (CNM5). Participant CNM7 shared how important the perception of team unity was:

It's important that they [the nursing team] see us as a cohesive group … because otherwise, that sends out the wrong signals. So I think it's vital that we have a really good relationship and understand each other's roles completely.

The CNM participants discussed the skill set required for the role. The expectation was for clinical expertise: 'A certain level of knowledge as well, and they're not just educators as in the formal sense as well, they have a lot to offer still clinically as well' (CNM2). Being the person with analytical skill who provided creative solutions to difficult situations was vital to good management:

So coming up with ideas of how to manage and … keep the ward flowing, keep everyone safe, to me is part of that leader, and they're part of that team. So when we have … ward meetings, which is once a month … they've got their education hat, but they're there also to pick up if there's issues, ideas, that we can try and problem solve together (CNM3).

In contemporary nursing, acting as a change agent was also a highly prized skill: 'If I want something changed or implemented, then I'm going to liaise with the CNE on the best way to do it, best way to bring it in … regardless if it's a clinical change or anything else' (CNM7).

The CNM participants identified the CNEs as a positive influence on the GRNs through leading by example:

> They're seen as a role model for those grads … and they've got to display the certain set of behaviours and skills that are expected of somebody of that level … it's raising the bar … and showing the grads what the expected level is. And, leadership is part of that isn't it? Even though, obviously, they're not the manager (CNM5).

In role modelling professional standards, the CNEs exemplified the values, attitudes and expected clinical behaviours of a leadership role. Evidence of this was described by the CNM participants in relation to their own management role:

> Not that we see it as a dual role, or anything like that … that's just the way we work. So everybody knows that … when I'm not here … they're the next line, that they will actually go to (CNM5).

Some of the CNM participants described their CNEs as having a different style of leadership. For CNM1, this difference was considered to provide a balance:

> Sort of complements me probably, with a bit more direct and assertive, whereas I like to talk things through, have a think about things, and see if this is actually fit or if this is actually the right way forward. She's probably a bit more direct and is a bit more amenable, which … both have the pros and cons, there's no right or wrong, just work differently (CNM1).

However, for one participant, CNM8, there was no leadership feature of the CNE role, as her experience of the executive team was that they did not recognise or treat the CNEs as leaders: 'They're not … a senior member but they're not actually leading a team of people. There's leadership summits, but the CNEs aren't invited to leadership summits'. However, CNM8 considered her CNE as complementary to the CNM role: 'They're almost supplementary … to the CNM role. You rely on them a great deal, because they're not there to lead the grads, they're there to, sort of, support them and monitor them really'.

The CNM participants indicated that willingness to take direction was an important criterion of the CNE role. The CNMs understood the requirement to give clear directions to the CNE, who needed to be able to interpret this direction clearly. CNM3 highlighted her experience:

I think you have to be clear about what it is you want. Like with the person that didn't work out, still very clear about what it was I didn't want, and what became evident was I didn't get what I wanted. So, obviously, either I'm not giving the clear direction, which I knew I had … then obviously that person isn't the right person … for that role (CNM3).

The CNM participants discussed negative aspects of leadership that affected the CNE role. Lack of self-confidence proved an issue: 'And you really need to have that … assertiveness, that personality to look past that and say okay, what are the needs for this person regardless of what level they are' (CNM3). Being able to step in and out of the clinical area and also connect with staff on education were necessary skills. The CNE who could not proactively manage this shift between role criteria was not considered a leader: 'My CNE, I have to lead her quite a lot. Some others don't need to be lead at all. So, it depends very much on me as a person, as a CNM, and also on your CNE as well' (CNM6). This also related to the ability to be organised and prioritise work:

I specifically say to my CNE, 'Focus'. So she's a sort of person that's almost grasps at all the apples, rather than grasping one and working with that. So when you're like that, to me it creates a very disorganised professional. So I always have to ensure that my CNE focuses on specific things at hand (CNM6).

To have the CNE actively work as a change agent, the CNM participants recognised the need to share their authority: 'If they're not invested in, or had that leadership ability invested in in the empowerment, then they don't come particularly credible when they're trying to deliver change' (CNM2). However, not all CNEs had the ability to be comfortable working with other senior roles out with the ward setting. Participant CNE3 described her CNE: 'Great with dealing one-on-one with students and … junior staff, but certainly reflected that they felt intimidated by people that were above them'.

The CNM participants acknowledged the attributes of leadership. Participant CNM3 summarised the CNE qualities necessary for a favourable team outcome: 'The big thing for CNE is passion in what they do. And when that comes across I was happy' (CNM3).

The following subtheme details the expectations of CNE leadership.

5.3.3.5.2 Expectations of Leadership

The CNM viewpoint of the CNE role incorporated an expectation of leadership. The CNE role was promoted by the CNM participants as a position of influence in the nursing team. Participant CNM1 acknowledged: 'You have a healthy respect for them as leaders. To what level I couldn't tell you. I think the expectation probably is there to an extent'. Further, CNM5 stated: 'Leadership is … important … because we're team nursing, so, you need some leadership skills' (CNM5).

The expectation also included a professional relationship built on having similar values and goals: 'I think it's vital that you have a really good relationship, I think it's really vital that you … understand each other's expectations, and what's important to both of you' (CNM7). However, the suitable pairing between CNM and CNE was noted: 'It depends who their … CNM is, and whether they are empowered to feel like they can take some leadership' (CNM5).

Finding the right fit required a determination of all the factors related to the CNE role. Each ward speciality and CNM specified a variety of prerequisites. A CNM participant shared their process for finding the right nurse for the CNE role:

> If we do our interviews and our jobs well enough that we've picked the right type of person for that job. Because I think … it needs to be a particular type of person. We're the ones who have to work with them and we need to know them and know their work ethic and know the type of people that they are and how they're going to get along (CNM4).

Participant CNM7 elaborated further on the criteria of a suitable candidate: 'I think that the CNE has to have an understanding of all the roles. I know they're not necessarily CNs [clinical nurses] when they became CNEs, so I think that they have an understanding of the role'. The CNM participants also highlighted the increased responsibility and leadership expectations related to the role of CNE over that of a level one RN: 'I think it doesn't change when you come to be a CNE. I think that there's some who regard themselves as leaders, and there's some who don't appreciate the additional level of responsibility' (CNM9).

A combination of clinical and education aptitudes were considered a good balance: 'You can get somebody who's purely based in an office, and teaches like that, or you

can get hands-on. And a combination of the two I think is the best' (CNM6). Another CNM participant emphasised the role expectations differed between the CNM and CNE: 'She needs … to educate everybody else on the ward … my role's entirely different to a CNE' (CNM6).

Being an inspiration to the GRNs and team members was important for patient care. A CNE who had compassion made a difference: 'And then we found a good fit … because you have to have the ideas, you have to be driving it, you have to have the motivation and the passion, I think' (CNM3). In addition, participant CNM3 commented on praising the CNE for meeting the CNM expectations:

> I think we've tried to give the significance of what they do, you know, make sure that they understand. And I realised the other day, because she hasn't been that long in that role, but after the last ward meeting gave her some positive feedback to say, you know, like she's done a brilliant job because I don't think that, you know, like they hear that enough. And … I might think it but didn't say it, so, you know, like you just want to make sure that they are recognised for what they do.

Participant CNM2 described the expectation of leadership and authority devolved to her CNE:

> I've promoted that role … it's an active part of our leadership group here as well. Passed authority to her to actually be able to do that. It's about empowerment for her as well … it's not just the nice-to-have, it's an essential.

Other participants described the CNE role expectation as providing leadership support through decision making for other senior roles: 'Often the coordinator will go to the … CNE for verification, just to debrief, discuss issues, come up with plans' (CNM8).

The participants shared their expectations of the CNEs' role of leadership in the ward setting. CNM1 was candid about the current CNE role incumbent:

> I think she steps up as a leader … sometimes that's confidence in itself. I expect them to be a leader … it's certainly a position of influence … whether you look at this as leadership or management … more a bit of both because there is a workload to manage and there's also leadership people as well … you have a healthy respect for them as leaders.

Another CNM participant noted that the CNE and CNM roles were not always compatible with certain personalities: 'Some people can jump between those roles, and some people can't' (CNM6).

The CNM participants highlighted the positive and negative attributes and expectations of the CNEs in their present clinical, educational and professional role. To summarise, CNM7 was emphatic: 'I think it's vital that they are very good at being the CNE, to be honest, firstly and foremost'.

5.3.3.6 Theme 6: CNE Role Significance

The CNE role was emphasised by the CNMs as vital, essential and necessary for safe and quality patient care. Specifically, the role of the CNE in caring for the newly qualified GRNs was considered vital: 'I don't know how we would cope without it … and I don't think our grads would cope without it' (CNM3). In relation to their own role, the CNM participants highlighted the significance of the CNE role: 'My job would be ten times harder without it, most definitely' (CNM5).

An understanding of the CNE role within the team was necessary. This included the ability to develop and maintain relationships, and the flexibility to work with a changing and challenging workforce. The role required confidence to drive education within set boundaries. The CNM participants indicated the importance of their choice of educator for the role: 'Not to say this is what you've got to do, but just you've got to have some say in it' (CNM8).

The subthemes identified were 'role necessity' and 'underperformer'.

5.3.3.6.1 Role Necessity

In this subtheme, the CNM participants compared their own role with the CNE role to highlight the importance and necessity of the educator in the clinical setting: 'I think it's important that they understand my role and they understand what I do, but I don't think they have to be any good at it. Because it's a totally different thing to what they do' (CNM7). Despite the differences, the CNM participants also described times when they were able to use the CNE role as a substitute manager in their absence: 'Because obviously when I'm not here, they will pick up aspects of my role' (CNM5).

In recognition of their own time limitations, the CNM participants noted their own need for CNE support: 'Because as a manager you can't drive everything' (CNM3). Participant CNM4 stated: 'I know a lot of other managers that's their first go-to person'. CNM9 discussed the CNEs' contribution to the plan for professional development and the provision of feedback on GRN and team member progress:

> We do meet collaboratively … my CNE and I meet every couple of weeks and we go through areas of focus, what we want to focus on. We kind of look at strategic planning … we have a strategic planning session twice a year. And then we meet every couple of weeks thereafter. And she provides me feedback on staff on the ward, any issues.

In relation to the GRNs' progress through the graduate programme, participant CNM4 presented a pathway followed by the CNEs to ensure any problems with team members were dealt with promptly:

> If there are any issues and the grad does not feel comfortable to bring that up, which I don't blame them either, then they can come through the CNE through to the manager, or the CNE can certainly speak to the other nurses and the clinical nurses.

Participant CNM8 listed the importance of the CNE role in the following way: 'These are the issues, these are our priorities, I would like you to be doing this many in-services or this with the grads or being on the floor this much'. In expressing these priorities, the CNM participants understood the knowledge and experience base of the CNEs. CNM5 stated: 'I can only speak for the ones that we've got, but they're so knowledgeable'.

In recognition of the necessary and essential role, the CNM participants discussed the ways used to protect the CNE role from financial constraints. When tightening of budgets occurred, senior management instructed the CNMs to remove the CNEs from their substantive role and employ them in direct patient care. The CNM participants responded to this directive variously. Participant CNM2 was emphatic: 'I actually protect those hours to make sure they're always available'. Participant CNM3 commented: 'We try not to … there is an odd occasion that they've had to work on the floor but it's not a regular thing, and we try and quarantine that time because I think that's important'. Another participant stated:

I would prefer to get an agency or casual pool person in if possible … but if it does come down to KPIs [key performance indicators] and there's budget constraints and they need to put them on the ward, then if we have to do it, we have to do it (CNM4).

During times of team member absence, the CNM participants also shared their inability to protect the role of the CNE: 'Sometimes, although we don't tend to do it very often, but with sickness, if we can't get staff, so then the CNEs are picked on' (CNM5).

CNM5 discussed the relationship between the safety and quality of patient care and the ward staff support by the CNE:

If you've got really sick patients, then you know, you need to look at the safety aspect as well, so I have done it, but I try to keep it to a minimum. I suppose it depends on the manager as well though, to say they're needed on the floor, despite the KPIs [key performance indicators] going through the roof. It's going to affect the safety of patients. It's going to affect patient care, so we did try and keep the CNE.

In relation to role significance, the following subtheme highlighted the outcomes of underperforming CNEs.

5.3.3.6.2 Underperformer

In this subtheme, the term 'underperformer' was used to denote CNEs who performed below the CNMs' expectations, or failed to meet the requirements of the CNE job description. The CNM participants described the temperament required for a successful CNE: 'I think that's a personality thing as to whether they're good at everything, or not' (CNM7). The CNEs' ways of thinking and behaviour affected their education role. The CNM participants commented: 'It does depend on the CNE really, it depends on their personality' (CNM6) and 'It does depend on the type of personalities that we have when it comes to CNE' (CNM4).

The participants described their concerns:

I gave direction of what it was that I wanted and tried to be quite clear they didn't have that personality to support that. So I didn't say they did a bad job but they just weren't right for that role (CNM3).

Another participant indicated the need for more than just personality: 'I think on here, because it's so busy as well and … having a passion for medicine … I think that makes a huge difference' (CNM5).

The education focus required characteristics that some CNM participants identified as absent in their CNEs. Participant CNM3 stated: 'That then caused a lack of confidence in driving that role forward' (CNM3). In discussing their teaching role, CNM6 highlighted: 'So everybody's different at the end of the day and everybody learns and teaches differently'. The ability to provide flexible education was a component of the CNE role. Participant CNM7 highlighted what gave CNEs the edge:

> Sometimes the general busyness with a ward is hard to actually pin people down, to receive any education, and I think as a CNE you have to be quite inventive as to how you get the education across. Most people don't want to just sit and listen, so you're better off, you know, doing it in different ways. You definitely have to have an imagination.

With underperforming CNEs, the CNM participants identified characteristics that prevented role success. Participant CNM3 commented: 'They felt intimidated by people that were above them … so that was really obvious. And that then that caused a lack of confidence in driving that role forward'. Unwillingness to take direction from the CNM was another significant issue expressed by CNM6: 'With my CNE, I have to give her a lot of direction. "This is what I want you to do". And sometimes it depends; this is where you're talking about different personalities'. Participant CNM9 described her CNE's limited understanding of the education role: 'They just see themselves as equal, of equal standing, and they're just there to help, and it's just that they've got some knowledge and expertise that they're happy to share with their colleagues'.

The CNM participants described their concerns about the flexibility and focus of the CNE role incumbent. CNM6 shared an experience:

> It depends on personalities again, and individuals. To me the CNE is a CNE role, now can you pull the CNE into a coordinating a shift role? … And I think being open and honest about things as well? Like, I want you to concentrate on that education role, and she really struggles, because she doesn't do it all the time. She struggles with coordinating a ward. Because it's something that's unfamiliar to her. Some people can jump between those roles, and some people can't.

Another participant CNM4 related a different incident that provided information about the CNEs' performance:

> There's plenty of people out there that have the knowledge, that can do CNE that may even have the skills, but their demeanour … and it only takes you to have one bad day and you'll scare the grads especially. You know, they'll feel uncomfortable coming to you etcetera. If your CNE does have an issue with the grads, and we've had that before, then it's got to the point where, well … who is the problem here? Is it CNE or is it the grad?

After having worked with a number of CNEs, participant CNM3 could identify when a CNE was working in the role successfully or not meeting expectations: 'It became really obvious, and it wasn't just me dissatisfied with that but everybody else dissatisfied with that. So you can see when it doesn't work and you can see when it works, so you've got that comparison'. Participant CNM8 was also familiar with the CNE role criteria and expectations, and shared her experience of CNEs:

> I'm speaking to you now about my experience of CNEs now, I'm probably thinking about the CNE I've had who I would see as quite passive. I come from an area where the CNE was absolutely top bunny, outstanding and yes, I probably would say a definite leader. But, then … my expectation of an CNE is that they would happily and willingly get up and present to a group of people. I think it's part of the role. But, to have an CNE that has never done that or will not do it, is not willing to do it, that's tough.

In summary, the CNM participants expressed issues surrounding underperforming CNEs. However, when difficulties arose in the ward environment, the CNM participants expressed their support of their CNEs, in view of their active involvement and collaborative practice in ensuring staff and GRNs have access to the professional development and education requirements. Participant CNM4 commented on their relationship with the CNE: 'Now generally if you've worked with your CNE for a long time, you know all their idiosyncrasies or their little quirks'.

This completes the qualitative analysis process of the two sources of data: the GRN online questionnaire text entry responses (dataset 3) and the GRN, CNE and CNM subgroup interview data (datasets 4, 5 and 6). These responses provided the researcher

with a rich description of the CNE role from the diverse viewpoints of the GRNs, CNEs and CNMs. The findings will now be synthesised.

5.4 Qualitative Findings

The success of the newly qualified GRNs' first year of nursing is focused on their transition and integration to the clinical environment, capability to provide safe and quality patient care, and subsequent retention to permanent organisation employees. The perspectives of the three subgroups (GRNs, CNEs and CNMs) provided a focused overview of the influence of the CNE role on the newly qualified GRNs' transition to practice. These findings identified that the influence of the CNE role and clinical leadership are essential to the GRNs' transition and integration to the clinical environment and are significant to the safe and quality care of GRNs' patients.

The qualitative findings of the study were analysed according to each subgroup represented. The GRN and CNE subgroup data analysis produced five themes, while the CNM subgroup data analysis produced six themes, as depicted in Figure 5.4.
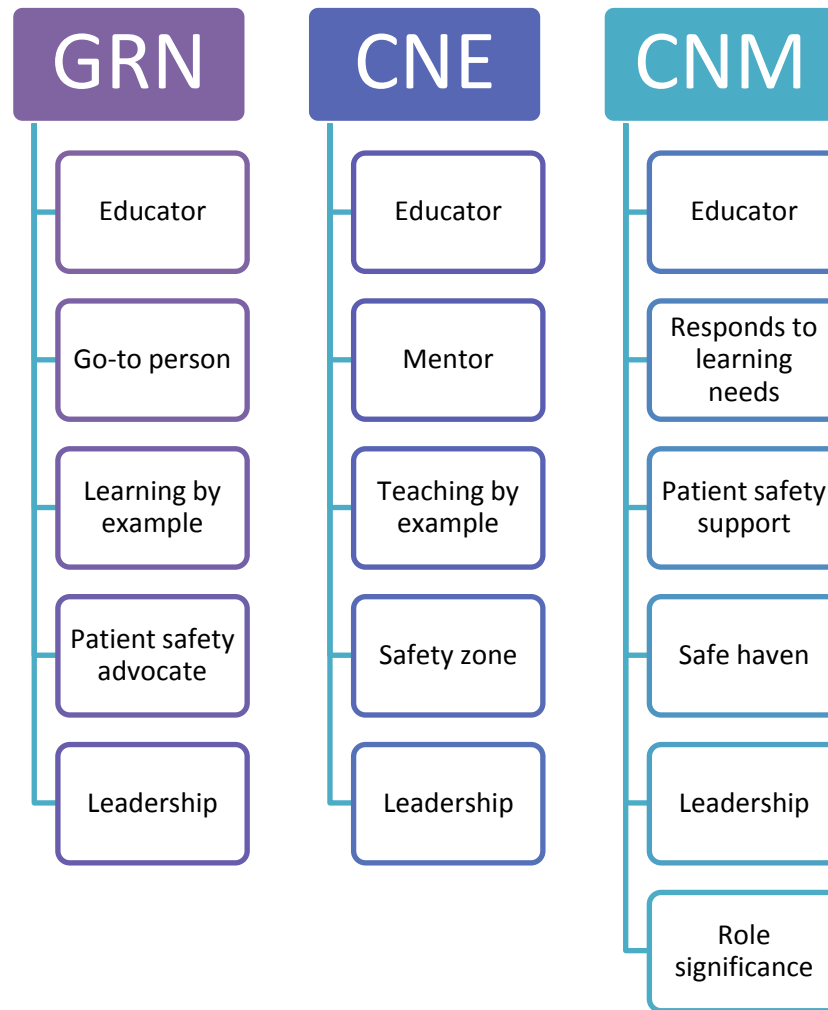
Figure 5.4: Subgroup Themes

These themes identified commonalities between the CNE role and clinical leadership in each of the subgroup perspectives. Two of the themes—educator and leadership—were described similarly by all subgroups. Three themes identified used different terms to define the same practice. For example, the GRNs identified the CNE as their 'patient safety advocate', the CNEs themselves noted that their role provided the GRNs with a 'safety zone', and the CNMs indicated that the CNE was a 'safe haven'. The CNM subgroup included an additional theme related to collaborative practice and the consequences of underperforming CNEs in the ward environment. The qualitative findings are summarised in the following section.

5.5 Summary of Qualitative Findings

The qualitative data collection included the open-ended question responses from the GRN questionnaire and the semi-structured interviews collected from the GRN, CNE and CNM respondents. A thematic approach was used to analyse the qualitative data and identify the themes connecting the CNE role to the newly qualified GRNs in the clinical environment. The overarching theme of the qualitative data was designated as 'CNE advancing GRN quality and safe patient care'. Figure 5.5 presents a summary of the findings.
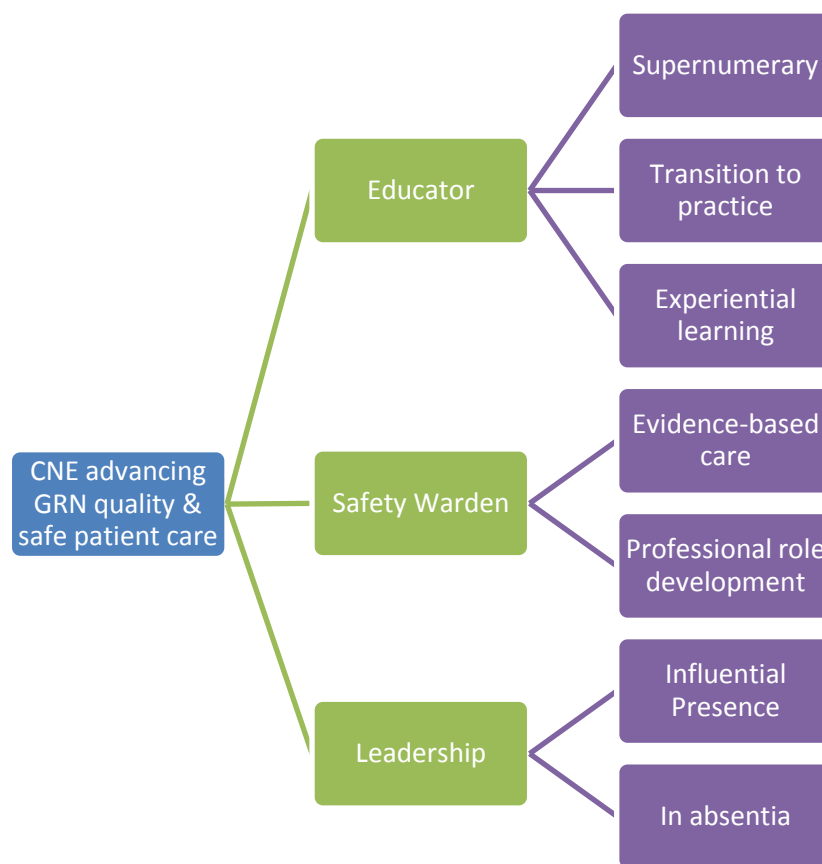
Figure 5.5: Qualitative Theme Summary

5.5.1 CNE Advancing GRN Quality and Safe Patient Care

The overarching theme of 'CNE advancing GRN quality and safe patient care' signified the effect of CNE support during the GRNs' first year of nursing, and influence on the GRNs' patient care outcomes. This is further portrayed in Figure 5.6 as a conduit

towards positive patient outcomes, where the CNEs' support for the ongoing advancement of the GRNs' continuing professional education and clinical practice in the acute care setting is linked to their role as educator, their leadership influence and their investment in quality and safe patient care.
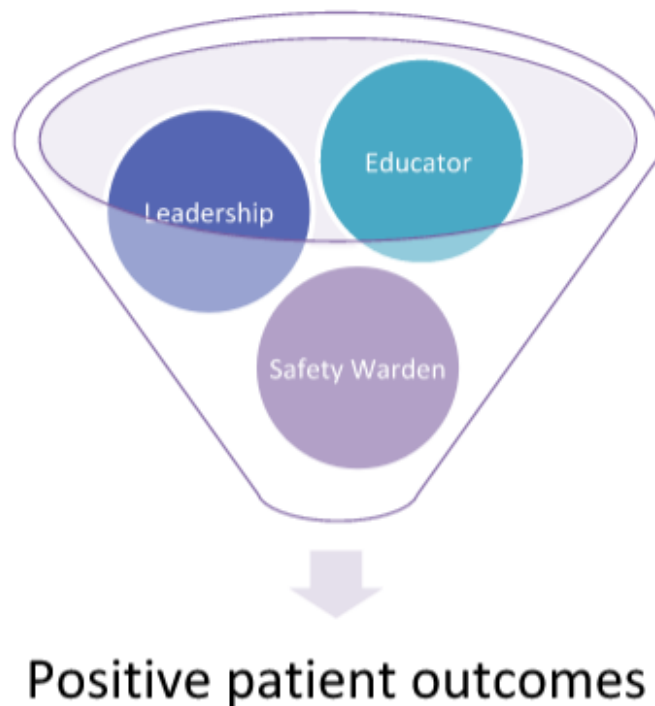
Figure 5.6: Overarching Theme

Each of the three main themes—educator, leadership and safety warden—and their subthemes are summarised in further detail below.

5.5.1.1 Educator

The value of the CNE as an educator to the newly qualified GRNs correlates to the CNEs' support of continuing professional education in the GRNs' first year of nursing. From the first day of orientation to the completion of the graduate year, the novice GRN acquires knowledge, skills and competence to progress to a level of proficiency. This occurs through the CNE being available, accessible and approachable. The CNE is able to deliver resources and guided learning, provide direction and opportunities to

supervise practice, and promote collaboration with team members in order to advance GRNs' clinical practice. The CNE connects with the GRN to nurture confidence in patient care and successful transition and integration into professional nursing practice.

5.5.1.1.1 Supernumerary

The CNEs—with their supernumerary status, independent of ward and patient management—have protected time to prioritise the GRNs' continuing education. This occurs at the behest of the GRN themselves, the team members, the CNM and through CNE assessment of individual GRN's knowledge and skill—as directed by the graduate programme requirements. As the GRNs' designated support nurse, the CNEs build rapport, recognise individual needs, and provide opportunities to consolidate learning and clinical reasoning at the point of care. The supernumerary role is beneficial to the nursing team during times of high patient acuity and increased workload by providing extra attention and assistance to the GRNs to develop skills and competence to meet complex patient care needs.

5.5.1.1.2 Transition to Practice

For the GRNs to transition from novice to proficient, the CNE focuses on a comprehensive orientation to ward and specialty routines, processes and equipment to provide a foundation for confidence and growth. Consistent information ensures the GRNs understand the expected level of nursing care required. The CNEs support the GRNs during their significant learning journey and clinical pressures to meet the requirements of the professional role of RN, with a matching level of confidence. The presence of the CNE assists the GRNs to process anxieties, receive feedback and provide error management strategies. In valuing the transition to competent practice, the CNE provides nursing team support to actively progress the GRNs through positive reinforcement to a level of comfort and self-assurance in their knowledge and practical skills.

5.5.1.1.3 Experiential Learning

Kolb (1984) defined experiential learning as 'the process whereby knowledge is created through the transformation of experience' (p. 38). Thus, the GRNs—through their engagement with the CNE and the process of practical hands-on experience, combined

with observation and supervision—are able to grasp the correct way to provide complex nursing care. The GRNs have the opportunity to examine evidence-based practice, comprehend their scope of practice and scrutinise decision-making pathways. To influence integrated professional practice, the CNEs model expected behaviours and attitudes and demonstrate a standard for quality and safe patient care. Guided learning with holistic education support includes a familiarity of individual GRN's requirements, personality, work ethic and communication skills. The CNE champions the continual development of the GRNs at an acceptable pace through a close working relationship with the nursing team to identify learning gaps and address nursing care concerns.

5.5.1.2 Leadership

The leadership of the CNE is viewed in relation to the GRNs' progression from newly qualified GRNs to successful transition and integration to the clinical setting in the first year of nursing, culminating in completion of the graduate programme and subsequent retention in the workforce. The affirmative characteristics of the influential CNE presence demonstrate their significant clinical, educational and professional role. The CNE as a leader promotes the importance of GRNs' positive patient outcomes through CNE access and active involvement in continuing education and in supporting collaborative practice in the nursing team. When the CNE is unavailable, the absence of educational leadership is evidenced by GRN support gaps and lack of progress in competency and skill. In addition, the underperforming CNE creates further challenges for GRN growth and affects the nursing team leadership and efficient operation of the ward.

5.5.1.2.1 Influential Presence

The CNE was identified as a genuine 'presence' and tangible influence on the GRNs' career progression and successful transition in their graduate year. The CNE educational leadership skillset supported the GRNs' completion of graduate programme criteria, with particular emphasis on supernumerary status and visibility as integral to the GRNs' understanding of safe and quality nursing practice. The findings indicated that the CNEs' leadership was evident in the fulfilment of the role criteria of educator, role model, clinical expert and advisor, and in the motivation of the GRNs and nursing team to communicate, collaborate and cultivate professional development. Role essentials for

effective practice included respect, social and psychological skills, compatible personality traits and the ability to work harmoniously with the nursing team to meet patient care directives. Conversely, unity in the nursing team was affected by a CNE who did not feel empowered for leadership or who found their role challenging. Finding a right fit was important for consistent and successful progress of the GRNs and was necessary for succession planning. Overall flexibility in CNE leadership was essential in order to contribute to all facets of the ward and patient management.

5.5.1.2.2 In Absentia

The work hours of the CNE role were generally business hours, were often part time and were at times assigned to a clinical patient care role, which created conflict for GRN engagement. The CNE absence experienced by the GRNs led to difficulty in completing the graduate programme criteria and the requirement to use team members to complete skills or competencies. Other team members' workloads often presented time and opportunity challenges that prevented them from supervising GRNs. These support gaps were particularly felt during the orientation, and resulted in a lack of clarification and direction, and generated uncertainty in relation to patient care issues and complex situations.

When the CNE was directed away from their core educational role as a replacement patient care nurse due to shortfalls or issues with nurse supply, workload or financial deficits, the CNE role was seen as vulnerable and their leadership as less significant. Observations by the nursing team highlighted the GRNs' struggle without the input and support of the supernumerary CNE. In addition, underperforming CNEs inhibited the GRNs' progress and undermined the nursing team unity, resulting in reduced benefits of the educational leadership expected by the nursing team.

5.5.1.3 Safety Warden

A 'warden' is defined as a person who is charged with the care of others and with enforcing specified guidelines (Merriam-Webster Dictionary, 2017). Thus, the CNE safeguards the GRNs and their patients' quality and safe care in the acute clinical setting. The delivery of theoretical, practical and emotional support is evident, as the CNE assists the GRNs to develop clinical reasoning, confront challenging situations, engage in debrief and feedback, and offer reassurance and compassion to complete

rotations successfully. In acting as the safety warden, the CNE invests in the GRNs' evidence-based patient care capability and highlights the importance of policy compliance to reduce error whilst supporting professional role resilience and accountability.

5.5.1.3.1 Evidence-based Care

The CNE provides continual support for the GRNs to achieve safe and positive patient care outcomes by promoting correct interpretation and application of hospital policy and best practice. This includes having the time, familiarity and capacity to educate on the policy and procedure contents and clarify legislative and clinical practice standards and evidence-based practice content. The CNE encourages the GRNs' evidence-based practical care through continuous assessment, empowering sound decision-making processes, fostering autonomy, and responding and guiding challenging patient care allocations.

5.5.1.3.2 Professional Role Development

To provide the holistic perspective necessary to advance the novice GRNs in their professional role, the accessible and available CNE provides confidential debrief and feedback and reflective practice opportunities to examine actions, attitudes and behaviours. The GRNs' new role and experiences present varied levels of stress with emotional challenges that require the CNE to collaborate with the nursing team to identify, manage and employ strategies to develop the GRNs' resilience. Through awareness of the GRNs' inexperience and lack of confidence, the CNE promotes professional accountability and directs interactions and interventions to protect safe and quality patient care.

5.6 Chapter Summary

The CNE role in the clinical environment was described by all participants as vital to the professional development and ultimate survival of the GRNs in their first year of nursing. The role positively influenced GRNs' safe and quality patient care through advocacy, availability to support decision making, and providing a safe place for learning, with the correction and compassion needed to navigate new and challenging situations. Leadership was highlighted as necessary for GRN success. The CNEs'

clinical, educational and professional role was realistic and influential, with their absence noted as affecting GRNs' progress through the graduate programme.

In this chapter, the findings have substantiated the importance of the supernumerary CNE role and clinical leadership in the clinical environment for newly qualified GRNs in their first year of nursing. However, the findings also indicated the importance of the CNEs' capability to fulfil the role attributes and expectations that complement the team, the CNM and the ward clinical environment.

Chapter 6 will provide further exploration and synthesis of these findings and make comparisons with the literature, while Chapter 7 will continue the discussion and present the study implications and recommendations.

Chapter 6: Comparison of Findings

6.1 Introduction

The previous chapter analysed the qualitative data obtained from the GRNs, CNEs and CNMs, and discussed the findings in relation to the role and leadership of the CNE. This chapter will explore and generate a richer, deeper understanding of the CNE role and clinical leadership specifically related to the GRNs' quality patient care and clinical confidence in their transition to practice year. The use of the newly qualified first-year nurse as the lens to evaluate the effect of the CNE role involved a variety of nurses' perspectives on the GRNs' confidence and competence in patient care as a result of the CNEs' support. The findings from this study will be compared to the relevant literature, and the limitations of the study will be discussed.

Chapter 3 described the quantitative and qualitative data collection and analysis that occurred separately in Chapters 4 and 5, respectively, before the comparison of quantitative and qualitative data in this chapter of the thesis. The integration and interpretation of the combined findings has provided a comprehensive and emergent picture of the supernumerary CNE role. Figure 6.1 articulates the synthesis of the quantitative and qualitative findings.
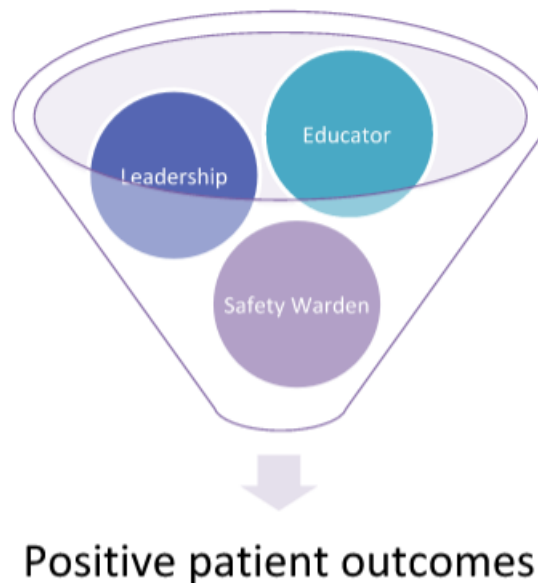
Figure 6.1: CNE Role Study Findings

6.2 Comparison of Findings to the Literature

The following sections compare the study findings to the literature in relation to each of the three themes—educator, leadership and safety warden—and incorporate role theory and leadership theory.

6.2.1 Educator

The findings presented in this thesis indicated the value of the supernumerary CNE to the newly qualified GRNs was in their continuing support of their professional education. The novice nurse—through the available and accessible CNE with designated time to orientate to ward and patient, to consolidate theory in practice and guide practical experiences—progressed from novice to confident, competent practitioner providing quality patient care.

Role theory has provided a framework to evaluate the educator role of the CNE in respect to the effect on the GRNs' clinical confidence and quality of patient care in their first year of nursing (Schuler et al., 1977). The key concepts of role theory explored in

this section include role occupancy, performance, negotiation, identity and evolution, as depicted in Figure 6.2 (Fellows & Kahn, 2013). The study participants described the role performance and behaviours of the CNE through their own perceptions and understanding of the role expectations, responsibilities and expected educational strategies (Conway, 1988).
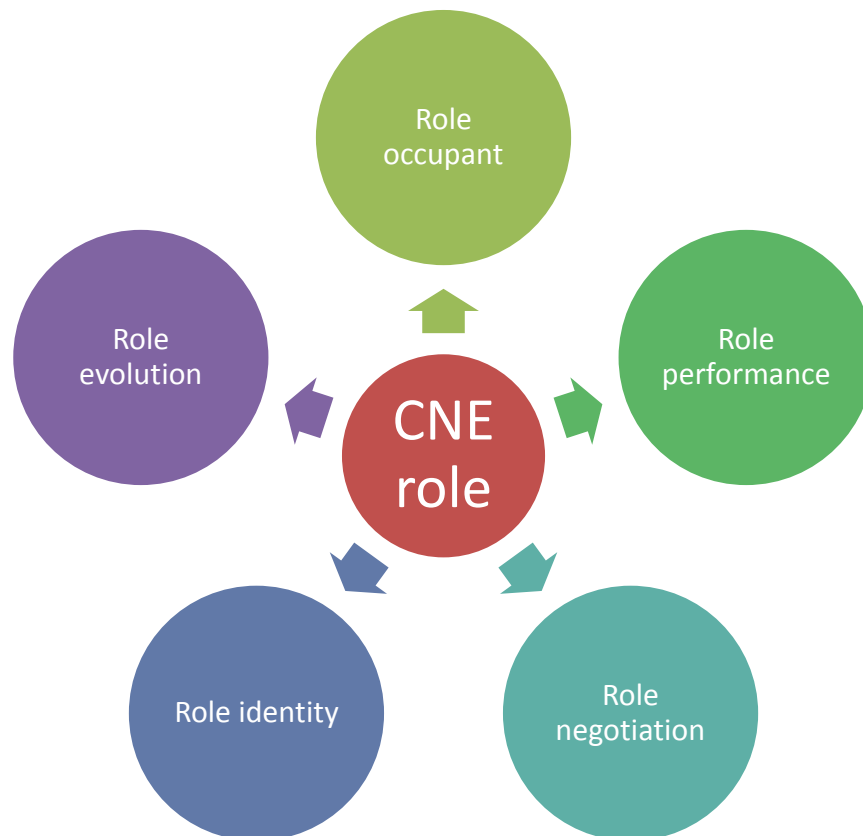
Figure 6.2: The CNE Role

6.2.1.1 Role Occupant

The demographic findings of this study are compared with the findings from a study by Sayers (2013), who investigated the role and scope of practice of CNEs across Australia. Known as the NEACH study, the survey respondents were from acute care hospitals in city, metropolitan and rural centres in all states and territories in Australia. The respondents were primarily female (88%) and the highest percentage were aged between 46 and 50 years (21%). A precise comparison between the current study and the NEACH survey was not possible because of differing categories. However, the CNE participants in this study were all female and 54.5% had been nursing for over 20 years, which is similar to the Australian nursing population average age of 44.6 years and

89.8% female (AIHW, 2013), and the NEACH survey results, in which educators were in the majority female (88%) and aged between 46 and 50 years (Sayers, 2013). The CNE participants' average length of time in nursing reflects the seniority of nurses working in the hospital clinical educator role (Sayers, 2013).

According to the AIHW (2013), the full-time equivalent rate of Australian nurses in clinical education was 21.8. Of the NEACH respondents, 64% ($n = 272$) were full time, compared with the current study, in which only 18.2% ($n = 2$) were full time. Sayers (2013) noted the increasing trend of reducing hours to maintain budgetary requirements. This trend continues to be significant, with the CNE role dictated by financial constraints, rather than the nurses' choice of hours in the current healthcare climate (Conway & Elwin, 2007). The CNE participants in this study reflected the trend, with 63.7% ($n = 7$) working part time. In addition, the CNEs worked additional rostered clinical patient care shifts. The reason for these supplemental clinical shifts was not identified; however, this may be a mutual agreement in the workplace that suggests insufficient personal financial work hour requirements or a preference for additional hours to maintain clinical currency.

The NEACH respondents also stated that their nurse educator activities included direct clinical care and role relief. The percentages engaged in direct clinical care (34%) and role relief (22%) were highlighted as being directed by patient workload, nurse supply, or ward or nursing management, as opposed to nurse education role responsibilities (Sayers, 2013). In this study, the CNEs were also directed from their rostered educator days to patient care and role relief when requested by the CNM or hospital senior leadership. This removal of the CNE from their substantive position or expectation to carry a patient load during an education shift was identified by the participants as reducing the value of the CNE role. This correlates directly with the NEACH study findings (Sayers, 2010; Sayers et al., 2011).

With reference to the postgraduate qualifications of the CNE, the NEACH study indicated that 86.8% ($n = 369$) had completed a specialist clinical qualification, with 21.8% ($n = 88$) having a master's degree or above (Sayers, 2013). In comparison, only five CNE participants had completed clinical postgraduate qualifications (45.5%), while two CNEs had a Master of Nursing degree (18.2%). Of the NEACH respondents, 74.1% ($n = 315$) indicated they had completed a specialist education qualification, with 21.9%

($n = 93$) completing a master's degree or above, whereas only one CNE participant had a qualification in education (9.1%). The number of participant CNEs with postgraduate educational qualifications was less than identified in the NEACH survey. However, the CNE job description requirement for the participating healthcare organisations was a VET qualification (Certificate IV in Training and Assessment) (JHC, 2014), which 54.5% ($n = 6$) CNE participants had completed. The VET qualification was not a category of the NEACH survey, so cannot be compared. Sayers (2013) and Brookes et al. (2007) suggested that the CNE is an advanced professional RN role in the nurse education specialty area, and should have a postgraduate degree to a master's level in education.

The *Australian Qualifications Framework* (AQF)—the national policy for regulated qualifications in the Australian education and training system—uses a system of levels from 1 to 10 to indicate qualifications' relative complexity and depth of achievement (AQF Council, 2013). There is a significant difference between the autonomy, authority and expertise between the Certificate IV (AQF level 4) and master's degree (AQF level 9). The difference lies in the depth of understanding and application to practice of knowledge, theories and concepts; capability to demonstrate critical analysis; and reflection and integration of research and evidence-based practice as a professional practitioner. CNEs who engage in higher AQF level study offer enhanced benefits to patient care through helping GRNs comprehend and practice critical thinking and reasoning skills and apply evidence-based practice principles (Girot & Rickaby, 2008; Moore, 2008; Sayers et al., 2011). A CNE at master's level will use advanced knowledge and expert clinical reasoning with critical analysis, reflection and evidence-based practice to facilitate, support and ensure professional development in the contemporary clinical environment (Barnhill et al., 2012; Dickinson, Scollan-Koliopoulos, Vergili, & O'Connell, 2013; Levett-Jones et al., 2010; Sayers et al., 2011). The nursing literature highlights the significance to patient care when nurses engage in postgraduate study (Barnhill et al., 2012; Clark, Casey, & Morris, 2015; McKillop, Doughty, Atherfold, & Shaw, 2016).

6.2.1.2 Role Performance

Role performance is governed by regulations, demands and social norms (Brookes et al., 2007). The examination of the success or otherwise of the CNE role encompasses

the current state of healthcare and the complexities of the ward clinical environment. The Shape of Caring Review in the UK (HEE, 2015) and HWA (2014a, 2014b) reports indicated the need to plan for an uncertain future, and evolve and respond through new and innovative programmes designed around patient-focused care. As such, significant drivers of CNE performance include national and state legislation, policy and standards—such as national standards and accreditation (ACSQHC, 2015b) and RN standards for practice (NMBA, 2016b)—and local organisational policies, risk management and ward specialty guidelines and procedures.

In this study, the CNE role of educator offered the GRNs the opportunities to apply theory to practice. This occurred through access to and appraisal of evidence-based practice, and the provision of practical interpretation and translation of policies to ensure adherence to hospital protocols. Moore (2008) outlined the importance of supporting new nurses to understand the ward policies and procedures as a significant strategy to meet patient needs and promote effective patient care. Further, a study by Duffield et al. (2007) on the hospital working environment at ward level emphasised the importance of policy and standard criteria, processes and initiatives when converted to educational actions as influencing positive patient care outcomes.

The existing frameworks for CNE practice, as described in Chapter 1, also guided individual role performance in the demanding, unpredictable and complex care setting of this study. The CNE role was found to be a positive influence. The participants largely indicated that the CNE met the job description criteria of the organisation by providing CPD through knowledge, skill and competence to progress the GRNs from novice to a level of proficiency (Benner, 1984). Hence, the CNE focus on national and state standards of practice and organisational healthcare directives met the approval of the participants associated with their own actual and anticipated clinical needs.

The specialised standards and competencies for nurse educators are an important prerequisite for the continuing success of the CNEs' performance. As with all RNs, the CNE is mandated to participate in CPD and to provide evidence when requested by the nursing regulation authority (National Council of State Boards of Nursing, 2017; NMBA, 2017; NMC, 2017). In contrast, the standards and competencies developed specifically for Australian nurse teacher practice (the ANTS professional practice standards) and the competencies developed for global adoption (the WHO Nurse

Educator Core Competencies) remain recommendations only for the preparation and guidance of CNEs (ANTS, 2010; WHO, 2016). In comparison to the mandatory drivers of CNE performance, these frameworks (emphasising quality, accountability and the improvement of patient care outcomes) were not as clearly expressed by the participants of the study; however, the CNEs' performance was generally consistent with the elements presented in these frameworks.

The CNE role performance was rated by the study participants based on the successful transition of the GRNs through the theoretical and practical components of the graduate programme. Real-life challenges affecting GRNs—such as transition shock (Missen et al., 2014a) and undesirable organisation and ward cultures (Phillips, Kenny, Esterman, & Smith, 2014a)—have tangible effects on the GRNs' ability to meet the graduate programme criteria. In their study of GRNs' narratives of their first year of practice, Clark and Springer (2012) concluded that GRN longevity in nursing is underpinned by the support given during their first year. The CNE role was described in this study as constructive and advantageous to GRNs' transition to confident, competent RNs through the process of flexible and adaptable education strategies, evidence-based practice initiatives, and policy translation. Above all, the CNE acted as a role model and provided opportunities to present optimistic attitudes and behaviours that affected the GRNs' positive transition (Perry, 2009). In this manner, CNE role performance is an investment in the professional development of GRNs, which is significant to organisational growth (HWA, 2012a) and retention of nurses for the future (Pollard et al., 2007).

6.2.1.3 Role Negotiation

CNE role negotiation occurs through the hierarchical relationship with the CNM. This association was described in this study as the foundation for shared authority and effective communication integral to GRNs' progress in their graduate programme. The collaborative relationship with the CNM allows for transfer of authority to the CNE, which facilitates and empowers the role for the benefit of the GRNs' safe and quality nursing care (Brennan & Flynn, 2013). Role negotiation is also a feature of the relationship between the CNM and GRNs, where the GRNs' future career in nursing is influenced by their workload and work experiences with their CNM (HWA, 2014b). The CNE acts as mediator between GRNs and staff members, including the CNM, to

reduce the consequences of a negative and stressful environment on newly qualified RNs. Moran (2012) described resilience as a recognised trait required by young and inexperienced GRNs to successfully negotiate relationships in the work setting. Thus, the promotion of a stable ward environment—through effective nursing relationships—is conducive to GRN retention and positively affects patient outcomes (Duffield et al., 2007; Kramer & Schmalenberg, 2008).

Conversely, CNEs in the role who are not considered 'a good fit' cause friction in the nursing team and with the CNM, thereby affecting relationships and performance (Sayers, 2013). In addition, CNE absence in the role affects the GRNs' successful transition to confident practice, as demonstrated by learning gaps and a lack of progress in competence and skill. The expectations and responsibilities of the CNE role described by individual GRNs, CNEs and CNMs were based on their own experiences, which may have been influenced by the number of CNEs in the position (permanent or acting in the role), the amount of time spent with the CNE (part-time hours, annual leave or sick leave) or the absence of the CNE in the role (directed to other roles and lack of backfill).

6.2.1.4 Role Identity

The role of CNEs is linked to their professional identity, in which the supernumerary status is significant. This study highlights the value of this supernumerary arrangement, which allows the CNE to be independent of ward and patient management, and subsequently uniquely positioned to prioritise the GRNs' continuing education and to promote quality patient outcomes (Conway & Elwin, 2007). Ashton (2012) noted that the interactions between the newly qualified GRNs and CNE: (i) are consolidated at orientation, (ii) foster familiarity to new routines and specialties, and (iii) precede other relationships with the nursing team. Ashton further emphasised that the supernumerary CNE role in the individual GRN's transition from novice to competent RN is associated with the uniqueness of the available, accessible CNE who expedites planned and spontaneous professional development at the point of care. A study by Hunt (2014) described the supernumerary practice education facilitator—a mentorship role for supporting undergraduate student practice placements in England. The key attributes ascribed to the practice education facilitator in the clinical setting were approachability, accessibility, clinical knowledge, skill expertise and emotional support. These qualities

correspond to the supernumerary status and visible presence of the CNE role, and further highlight the value of CNE role identity to GRNs' professional growth.

In the last 10 years, emphasis has been placed on the lack of clarity around the CNE role in acute care hospitals globally, including the role title, scope of practice, qualifications and job description (Conway & Elwin, 2007; Guy et al., 2011; Sayers & DiGiacomo, 2010b; Sprinks, 2015). These concerns continue to highlight issues with role identity, and include strain and conflict experienced in the role. Clear role expectations and responsibilities prevent distortion of CNE identity, which is often sandwiched between the contradictory expectations of the CNM and nursing team (Brookes et al., 2007; Sayers, Salamonson, et al., 2015). These conflicting expectations affect the GRNs and affect CNE performance and satisfaction in the role. Additional challenges to role identify include increasing organisational demands that overburden and devalue the CNE role (Guy et al., 2011), staffing deficits that prevent planned and spontaneous education (Conway & Elwin, 2007), and CNEs being used as replacement for direct patient care (Sayers, Salamonson, et al., 2015). This leaves the CNE role lacking the power and influence to meet the role criteria.

Despite the existence of specialised standards for practice for Australian CNEs, there is a lack of endorsement by healthcare organisations that could substantiate and advance professional practice and patient and organisational outcomes. Guy et al. (2011) and Sayers and DiGiacomo (2010b) recognised the value of these specialised standards to prevent role underuse. Role identity is also affected by CNEs' variations in personality, capability and desire, which interfere with the expectations and directives from the CNM, requests from nursing team members, and needs of the graduate programme (McCormack & Slater, 2006). In addition, when the CNE is directed to role relief, such as acting for an absent CNM, the overlapping roles lead to a conflict with the pressing needs of the GRNs' skill and competence development, leading to CNE frustration, anger and unachieved outcomes (MacPhee, Wejr, Davis, Semeniuk, & Scarborough, 2009; McKinley, 2008).

6.2.1.5 Role Evolution

Fellows and Kahn (2013) emphasised the evolution of the CNE role through continual growth and change, associated with the productivity of the RN occupying the position.

In addition, they suggested that there is room in the performance criteria to allow for the personal role creativity that is necessary for the continual engagement of staff and achievement of planned education goals. The study participants described the CNE as a clinical expert who is personable, intentional and flexible in the role, with congruent capability in all facets of ward and patient management. These attributes—in partnership with continuous growth and identification of strengths, limitations, goal setting and resourcefulness—support the consistent and successful progress of the GRNs in the graduate programme (Billings & Kowalski, 2008; McCullough, 2003).

For some RNs, the desire to complete further postgraduate study in nurse education to meet the criteria for a CNE role is a natural career progression for a clinical specialty expert with an interest in sharing knowledge and skills for the benefit of the patient (Sayers, Salamonson, et al., 2015). CNEs who proactively develop their own role determine their performance through negotiation and have a strong sense of identity in the clinical environment. This allows them to be suitable guides to prepare the newly qualified GRNs to be confident, competent and caring nurses who uphold the standards of professional nursing.

6.2.2 Leadership

The findings indicated the congruent leadership of the CNE was central to the GRNs' successful transition to practice and integration into the clinical setting. The CNEs influential presence was highlighted as necessary to engage and promote the GRNs in their professional role at the frontline of care, whereas their absence hindered GRNs progress and undermined nursing team unity. As a clinical leader, the CNE impacted the GRNs successful completion of the graduate program.

A clinical leader is recognised by their clinical expertise and interpersonal skills used to enable healthcare staff to deliver quality patient care (Harper, 1995). Contemporary clinical leadership embraces familiarity with patient-centred care, represents the perspectives of patients and staff, and role models patient-centric behaviours for affirmative action in the acute care clinical environment and organisational culture (ACSQHC, 2011a; HEE, 2015). Drivers to meet the quality of patient care desired by healthcare organisations include investment in the graduate workforce through inspiration and motivation that affect attitudes, behaviours and values. Ashton (2012)

strongly presented the CNE as the appropriate clinical leader to promote patient-centred care by guiding, empowering and motivating the large numbers of active nurses from their first year of nursing and beyond. The CNE as a clinical leader was highlighted by Sayers, Salamonson, et al. (2015); Girard (2009); and McKinley (2008) as necessary to guide nurses and the healthcare team in the current clinical practice environment. The CNE was described by the ACN (2015) as a diverse role where education and clinical leadership intersect. Further, Sayers et al. (2011) determined the CNE as 'well placed to assume a clinical leadership role' (p. 51) in the fast-paced and challenging clinical environment.

This section examines findings of the study and compares it to the literature on clinical leadership. Figure 6.3 illustrates the four aspects of CNE clinical leadership in relation to the GRNs' progression through the graduate programme, integration into the clinical setting and retention in the nursing workforce.

Figure 6.3: CNE Leadership

6.2.2.1 Congruent Leadership Theory

Congruent leadership—an alternative leadership style recently proposed by Stanley (2005)—is activated by the leader's shared values, beliefs and principles, which drive their professional accountability and responsibilities. As previously discussed in

Chapter 2, leadership theory and styles explain successful leadership through many varied ideas, beliefs, attitudes and characteristics, as well as roles and functions. One of the goals of this study was to explore and generate new knowledge and ideas about the leadership of the supernumerary CNE in the context of quality patient outcomes. The adoption of a leadership style is significantly influenced by the organisational culture, vision and values (Kumar, 2010). In this study, the setting was a private healthcare organisation with a strong emphasis on a people-based culture and a clearly identified vision that highlights the value of meeting patients' expectations.

At the clinical ward level, the CNM role incorporates a formal leadership role with legitimate source of power, revealed through policies and delegated authority in the organisation (Marquis & Huston, 2012). In addition, the CNM has control of staff, the environment, budget, time and resources to meet and achieve organisational goals (Andrews & Dziegielewski, 2005; Marquis & Huston, 2012). Conversely, the CNE role is described as one of coordination, implementation, assessment and evaluation of continuing professional education, working in close association with the CNM and other ward and central education-based CNEs (HEE, 2015; NMC, 2015). In regard to salaries, classifications and career structure, the CNM is appointed at the senior RN level (1 to 10), with commensurate pay and career pathway, whereas the CNE role is considered a similar level to the clinical nurse role and generally appointed at the RN level (2.1 to 2.4), with limited pay increases and restricted educational career opportunities (Government of Western Australia, 2016b; Ramsay Health Care, 2011). The differentiation clearly marks the CNE as an informal leadership role without set leadership expectations defined by job description, agreement and awards.

CNEs may define their own leadership role in regard to the strength of their relationship with the CNM and the depth of respect from nursing team members. According to deVer (2009), a person's behaviour in their assigned role can determine their leadership position. In this manner, the CNE can be an informal leader, who is effective in leadership through the many different functions that relate directly to clinical leadership and are described in the literature, such as decision maker, communicator, evaluator, facilitator, mentor, energiser, risk taker, coach, counsellor, teacher, critical thinker, buffer, advocate, visionary, forecaster, influencer, creative problem solver, change

agent, diplomat and role model (Courtney et al., 2015; Marquis & Huston, 2012; Stanley, 2006c).

The appealing features of the congruent leadership style are based on the leader who is guided by concern and compassion, demonstrates clear values, communicates effectively and invests in relationships, without the need for a formal position of leadership in an organisation (Stanley, 2008). In a like manner, the CNE role in this study was portrayed by the participants as a nursing leadership role that demonstrates the positive values necessary to support the clinical education and professional development of all nurses. Overall, the participants provided an understanding of clinical leadership in relation to the CNE role in the acute care hospital setting.

6.2.2.1.1 Congruent Leadership Comparison between Studies

In the questionnaire, the GRNs ranked the clinical leadership quality or characteristic that they **strongly** associated with CNE leadership in the clinical setting. Table 6.1 lists these attributes and their response percentage, alongside the results of the five studies by Stanley.

Table 6.1: Attributes Most Associated with Clinical Leadership

Study Findings			Stanley's Study Findings									
Characteristic/ Quality	%	Rank	Study 1 *In Command of Care: Clinical Nurse Leadership 2005*	Rank	Study 2 *Perceptions of Clinical Leadership in the SJA* in WA 2010*	Rank	Study 3 *Leadership at Home: Perceptions of Clinical Leadership at Swan Care Group 2012*	Rank	Study 4 *Volunteer Ambulance Officers' Perceptions of Clinical Leadership in SJA* Services WA 2012–2013*	Rank	Study 5 *WA Allied Health Professionals' Perceptions of Clinical Leadership 2014*	Rank
Is approachable	72.5%	1	97.3%	1	96.2%	1	100.0%	2	84.0%	5	83.1%	4
Is supportive	70.0%	2	94.1%	4	91.3%	3	100.0%	3			75.5%	7
Is clinically competent	65.0%	3	95.2%	2	96.2%	1	100.0%	1	90.0%	1	83.7%	3
Sets direction	62.5%	4	89.3%	8					75.0%	8	84.7%	2
Sets goals and targets	62.5%	4										
Is a mentor	62.5%	4			90.4%	4					73.3%	8
Is caring/ compassionate	62.5%	4										
Has integrity and honesty	60.0%	5	82.2%	10	93.3%	2	100.0%	4	79.0%	6	83.1%	4
Is an advocate	60.0%	5										
Is an effective communicator	57.5%	6			89.4%	5	100.0%	5	87.0%	3	88.3%	1
Copes well with change	55.0%	7	90.9%	6			100.0%	6			76.9%	6
Is a role model	55.0%	7			93.3%	2			89.0%	2	79.8%	5

for others in practice												
Inspires confidence	55.0%	7	93.0%	5	85.6%	8	100.0%	8	85.0%	4		
Is a critical thinker	52.5%	8			88.6%	6						
Is a motivator	52.5%	8	94.1%	3							72.6%	9
Directs and helps people	52.5%	8	88.8%	9	88.6%	6						
Is a guide	50.0%	9										
Evaluates the performance of staff	50.0%	9										
Is flexible	47.5%	10	90.4%	7					77.0%	7		
Is consistent	47.5%	10			90.4%	4						
Aligns (supports) people	47.5%	10										
Is a teacher	45.0%	11										
Has a healthy sense of humour	45.0%	11										
Copes well with complexity	42.5%	12										
Is visible in practice	42.5%	12			85.6%	8	100.0%	9				
Considers relationships valuable	40.0%	13					100.0%	7				

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Is just/fair	40.0%	13					90.0%	10						
Is inspirational	37.5%	14												
Can be a decision maker	37.5%	14			86.5%	7							70.7%	10

* Note: SJA = St John Ambulance.

This study has provided a profile of the GRNs' perspective of the CNEs' clinical leadership in the ward setting. The results offer a clear view of what attributes the GRNs desire in their CNE associated with leadership and successful completion of the graduate programme. Table 6.2 lists the top eight attributes the GRNs associated most with CNE clinical leadership, and compares them across Stanley's five earlier clinical leadership studies (Cuthbertson & Stanley, 2013; Stanley, 2006b; Stanley et al., 2012; Stanley et al., 2015; Stanley, Latimer, & Atkinson, 2014). The top eight attributes in order of agreement are listed as follows: is approachable, is clinically competent, has integrity and honesty, is supportive, is an effective communicator, inspires confidence, sets direction and copes well with change.

Table 6.2: Summary of Top Eight Attributes Most Associated with Clinical Leadership

Studies / Attribute		RNs Acute Care	Paramedics	Nurses in Aged Care	Volunteer Ambulance Officers	Allied Health Professionals	GRNs (this study)
Study location		UK 2005	WA 2010	WA 2012	WA 2013	WA 2015	WA 2016
Respondent number (% = response rate)	Rank	188 (22.6%)	104 (41.65%)	10 (50%)	61 (12.2%)	307 (6.1%)	40 (33%)
Is supportive	4	94.1%	91.3%	100.0%		75.5%	70.0%
Is clinically competent	2	95.2%	96.2%	100.0%	90.0%	83.7%	65.0%
Sets direction	7	89.3%			75.0%	84.7%	62.5%
Sets goals and targets							62.5%
Is a mentor			90.4%			73.3%	62.5%
Is caring/ compassionate							62.5%
Has integrity and honesty	3	82.2%	93.3%	100.0%	79.0%	83.1%	60.0%
Is an advocate							60.0%
Is an effective communicator	5	Not used in this study	89.4%	100.0%	87.0%	88.3%	57.5%

Copes well with change	8	90.9%		100.0%		76.9%	55.0%
Is a role model for others in practice	9		93.3%		89.0%	79.8%	55.0%
Inspires confidence	6	93.0%	85.6%	100.0%	85.0%		55.0%
Is a critical thinker			88.6%				52.5%
Is a motivator		94.1%				72.6%	52.5%
Directs and helps people		88.8%	88.6%				52.5%

The GRNs also ranked the leadership qualities or characteristics **least associated** with the CNE leadership in the clinical setting. Table 6.3 lists these attributes alongside the results from Stanley's studies.

Table 6.3: Attributes Least Associated with Clinical Leadership

Study Findings			Stanley's Study Findings									
Characteristic/ Quality	%	Rank	Study 1 *In Command of Care: Clinical Nurse Leadership 2005*	Rank	Study 2 *Perceptions of Clinical Leadership in the SJA* in WA 2010*	Rank	Study 3 *Leadership at Home: Perceptions of Clinical Leadership at Swan Care Group 2012*	Rank	Study 4 *Volunteer Ambulance Officers' Perceptions of Clinical Leadership in SJA* Services WA 2012–2013*	Rank	Study 5 *WA Allied Health Professionals' Perceptions of Clinical Leadership 2014*	Rank
Is controlling	55.0%	1	78.1%	1	84.1%	1	80.0%	1	83.6%	1	83.7%	1
Works alone	47.5%	2			68.8%	2	40.0%	3	75.4%	2	81.4%	2
Takes calculated risks	37.5%	3	47.3%	5	44.3%	8	20.0%	9	42.6%	5		
Is an administrator	30.0%	4	33.5%	7	51.1%	5	30.0%	4	31.1%	8	28.0%	9
Is artistic/ imaginative	30.0%	4	65.9%	2	52.3%	4	50.0%	2			33.9%	5
Deals with reward/ punishment	30.0%	4	39.3%	6	47.7%	6	30.0%	6	34.4%	7	28.7%	8
Must have relevant postgraduate training	25.0%	5					30.0%	5	47.5%	3	38.4%	4
Is conservative	25.0%	5	62.2%	3	56.8%	3	20.0%	7	37.0%	6	46.3%	3
Is courageous	17.5%	6										
Deals with resources allocation	17.5%	6										
Is a negotiator	17.5%	6										

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Has management experience	17.5%	6									22.8%	10
Is a change agent	15.0%	7										
Is creative/ innovative	15.0%	7										
Is a regulator/ supervisor	12.5%	8	32.4%	8					44.2%	4	29.3%	7
Resolves conflict	10.0%	9										
Manages staff	10.0%	9					10.0%	10				
Is a visionary	10.0%	9										
Deals with routine	10.0%	9	57.4%	4			20.0%	8			33.6%	6
Is articulate	7.5%	10										
Has a healthy sense of humour	7.5%	10										
Can be a decision maker	7.5%	10										
Is a coach	5.0%	11										
Is analytical	5.0%	11										
Is visible in practice	5.0%	11										
Is responsible for others	5.0%	11			45.5%	7						

* Note: SJA = St John Ambulance.

The top eight attributes the GRNs associated least with CNE clinical leadership were compared with Stanley's five earlier clinical leadership studies (Cuthbertson & Stanley, 2013; Stanley, 2006b; Stanley et al., 2012; Stanley et al., 2014; Stanley et al., 2015). The top eight attributes in order of agreement are listed as follows: is controlling, is an administrator, deals with reward and punishment, is conservative, works alone, takes calculated risks, is artistic/imaginative and has relevant postgraduate training. Table 6.4 provides a comparison of the top eight least associated attributes from the five studies.

Table 6.4: Summary of Top Attributes Least Associated with Clinical Leadership

Studies / Attribute		RNs Acute Care	Paramedics	Nurses in Aged Care	Volunteer Ambulance Officers	Allied Health Professionals	GRNs (this study)
Study location and year		UK 2005	WA 2010	WA 2012	WA 2013	WA 2015	WA 2016
Respondent number (% = response rate)	Rank	188 (22.6%)	104 (41.65%)	10 (50%)	61 (12.2%)	307 (6.1%)	40 (33%)
Works alone	5		68.8%	40.0%	75.4%	81.4%	47.5%
Takes calculated risks	6	47.3%	44.3%	20.0%	42.6%		37.5%
Is an administrator	2	33.5%	51.1%	30.0%	31.1%	28.0%	30.0%
Is artistic/ imaginative	7	65.9%	52.3%	50.0%		33.9%	30.0%
Deals with reward/ punishment	3	39.3%	47.7%	30.0%	34.4%	28.7%	30.0%
Must have relevant postgraduate training	8			30.0%	47.5%	38.4%	25.0%
Is conservative	4	62.2%	56.8%	20.0%	37.0%	46.3%	25.0%

Congruent leadership is expressed as 'a match (congruence) between the leader's values and beliefs and their actions' (Stanley, 2011, p. 56). Table 6.5 lists the key features of congruent leadership (Stanley, 2005, 2006b, 2006c, 2011).

Table 6.5: Key Features of Congruent Leadership

Motivating and inspiring
Approachable/open
Actions based on values and beliefs
Foundation principles
Effective communicator
Visible
Empowered
Any level—not necessary to have a title or hierarchical position
Guided by passion and compassion
Builds enduring relationships

The level of consistency of the congruent leadership theory features and clinical leadership attributes identified by the GRNs confirm the CNE as a congruent leader in the clinical ward setting. The following section links the congruent patient care-centric values described by Stanley (2011) with the literature that highlights the practical reality of CNEs' clinical leadership practice.

6.2.2.1.2 Shares Values, Beliefs and Principles

By sharing their own patient-centred care values and beliefs, CNEs express the importance of leading quality care in the clinical ward environment. The CNEs use their professional influence to cultivate similar values in the GRNs during their transition to practice year. Ferguson-Paré (2011) communicated a view of leadership that is lived in the frontline of care and in the presence of the nursing team members. This type of leadership is associated with the CNE role, whereby CNEs continually urge the nursing profession forward, sharing firm convictions of excellence in bedside nursing care. Adelman-Mullally et al. (2013) further emphasised the CNEs' core educational role in facilitating experiences as opportunities to share their values and inspire commitment to professional and organisational goals.

In the context of contemporary healthcare's financial and workforce challenges, there is a greater need for leadership that embraces values and beliefs that augment effective and efficient productivity to improve the quality of patient care (HWA, 2012b). According to Duffield, Gardner, and Catling-Paull (2008), nurses such as the CNE— with education and experience for a specific task—are essential to promoting efficiency

and spearheading patient care values. Further, in the study by Duffield et al. (2007), the CNEs' role in safeguarding patient care has not gone unrecognised and can be further extrapolated to an informal leadership role. This type of leadership is described by Turnbull (2011) as decentralised leadership, where the CNE leads at the frontline by empowering others (the GRNs) to provide quality care.

6.2.2.1.3 Concern and Compassion

The CNEs' aim is for the GRNs to follow a positive trajectory along the graduate programme continuum, resulting in successful completion and retention in the healthcare organisation. To this end, the CNE combines concern and compassion as a foundation for assisting the GRNs to meet the goals of the programme and to engender positive patient outcomes. A key finding of a qualitative study in a large NHS trust hospital was the correlation between clinical nurse leaders and their holistic approach and enthusiasm for patient care (Stanley, 2006b). Peers identified leaders in the clinical environment as those who remained connected with concern and compassion—not the higher grade staff with more of a management focus and less patient interaction. As such, the CNE is a positive and optimistic leader who understands the challenges and changes the GRNs will need to overcome to meet the expectations of the patient and organisation (Perry, 2009). In meeting the GRNs' needs at their level of confidence and learning, the CNE exhibits kindness and allays fears in order to achieve the hope, commitment, courage and collaboration necessary for long-term nurse retention (Spurr et al., 2010).

6.2.2.1.4 Demonstrates Clear Values

The CNEs' values are not obscured or secretive, but are regularly displayed in practice. Davidson, Elliott, and Daffurn (2003) linked the practical demonstration of values to the nurse leader's knowledge, experience and aspirations. Similarly, in this study, the GRNs highlighted the visibility of CNE values as an attribute of a significant leadership role that fulfils the expectation of a high standard of patient care associated with evidence-based practice (Adelman-Mullally et al., 2013; Malik, McKenna, & Plummer, 2015). Lyneham and Levett-Jones (2016) conducted a study to identify the values regarded by graduating students as important to their practice. The results confirmed that nurses who demonstrated professional values such as a patient-centred approach and were perceived

as caring, kind and committed to student learning had an influence on the nursing team and quality of patient care.

6.2.2.1.5 Professional Accountability and Responsibility

The CNE has a strong awareness of professional accountability and responsibility in the clinical setting related to their own nursing actions, conduct and capability to practice (NMBA, 2016b). In working alongside the GRNs, the CNE is a leader in modelling professional behaviours and attitudes in all aspects of the learners' experiences (Sayers, Lopez, et al., 2015). Wangensteen et al. (2008) noted that feelings of being overwhelmed and underprepared were common among the newly qualified GRNs when faced with unfamiliar ward settings and new clinical specialties. However, these feelings were mitigated by the CNEs, who guided the GRNs' professional development by providing appropriate and timely direction and support.

The ward CNM has fewer opportunities to provide direct clinical leadership due to less available time and more administrative tasks (Duffield et al., 2007). Yet maintaining patient care standards requires continual empowerment of the nurses who deliver this frontline patient care (Twigg et al., 2010). The discernible influence of the supernumerary CNE, working closely with the CNM, provides a stable and positive leadership that promotes educated and skilled GRNs to accept their professional responsibility to defend positive patient outcomes.

6.2.2.1.6 Caring

The act of caring—demonstrating kindness and interest—for the GRNs is a significant function of the CNE role. A caring culture occurs when leadership is effective, inclusive and shared (HEE, 2015). In order to promote a teaching–learning environment that values and encourages nurses, Spurr et al. (2010) underlined the necessity for the CNE to be passionate about caring. Further, a caring environment enables the CNE to evoke the trust and honesty that are conducive to the expression of ideas in order to accept constructive criticism and reduce anxiety. Conversely, without caring leadership, the difficulties of the clinical environment experienced by the GRNs—such as staffing issues and increased workloads—create an even greater challenge to ensuring quality patient outcomes (Duffield et al., 2011; HEE, 2015).

6.2.2.1.7 Effective Communication

The quality of communication is important to the CNE role. Levett-Jones and Bourgeois (2011) described effective communication between nurses in the clinical setting as necessary for teamwork and enhancing decision making and clinical reasoning skills. Thus, the relationship between the CNE and GRN demands open communication, where the GRN is able to successfully debrief and receive feedback, while avoiding conflict or damaging trust (WHO, 2011). To ensure the GRN delivers quality patient-centred care, the pathway of communication is as follows: establish early communication, move beyond the superficial, correct misunderstandings, ease frustrations between team members, and reach an understanding of the accepted organisational procedures and patterns of communication (WHO, 2011).

6.2.2.1.8 Invests in Relationships

An examination of the literature by Germain and Cummings (2010) found that positive working relationships in the clinical environment supported quality patient care. When the CNE works alongside the GRN to meet specific competencies or gain learning experiences, a relationship is formed based on identified objectives to meet patient outcomes (MacPhee et al., 2009). The CNE invests in positive connections based on their identified attributes of approachability, integrity and honesty, inspiring confidence and acting as a role model in practice. According to Adelman-Mullally et al. (2013), without such an investment, the learner (the GRN) is less willing to invest effort into critical thinking and be immersed in learning opportunities. The literature has identified that a significant part of building and maintaining relationships, while projecting patient safety goals, is celebrating achievements and success (Cleary, Horsfall, Deacon, & Jackson, 2011; Howell, 2015; Sayers, Lopez, et al., 2015). Positive affirmation by the CNE encourages and influences GRNs to work towards collective patient-centric goals (Weihrich & Koontz, 2005).

6.2.2.1.9 Influences Harmonious Teamwork

The attitude of clinical healthcare leaders significantly affects the morale of the whole team (Perry, 2009). In the ward setting, the nursing team members easily recognise the CNE's tacit clinical influence, which stimulates loyalty and creates harmony in the nursing team (Bishop, 2009; Stanley, 2009). Harmony affects job satisfaction (Dar,

Ahsan-ul-Haq, & Quratulain, 2015), which has been identified as a factor that significantly influences patient safety and quality of care (Duffield et al., 2007). In addition, a reduction in the number of permanent staff and continuing staffing and workload issues can negatively affect teamwork and further reduce job satisfaction. Maintaining a harmonious team when working together in complex environments takes effort and requires effective leadership (Duffield et al., 2007). The CNE is well positioned to actively work towards upholding the collective, collaborative and coherent morale of the team, while being open to and inclusive of diverse ways of thinking, problem-solving approaches and enthusiastic engagement in innovation, as suggested by Ferguson-Paré (2011).

In summary, the CNE congruent leader is often an informal leadership role that occurs at the frontline of care in the presence of graduates and the nursing team members. The CNE congruent leader encourages, supports and urges the profession forward and towards excellence in patient care.

6.2.2.1.10 Comparison of Nursing Studies Related to Time and Country Variance

The nurses in Stanley's first study were newly qualified senior RNs in clinical roles in 36 clinical ward areas in one UK NHS acute trust hospital (Stanley, 2005). At the time of the study, the UK healthcare system was in an uncertain phase. According to a Royal College of Nursing review on the nursing labour market by Buchan and Seccombe (2005), the NHS was experiencing reductions in the level of funding, restructuring and workforce changes to meet the workforce limitations and gaps identified for future healthcare requirements. The NHS nursing workforce had increased over the previous eight years, with international nurses comprising 45% of all registrations, and with an increase in the growth of managers. However, reports of nurse supply and workload issues, extra unpaid work hours and ageing nurses presented a critical and growing challenge. Education programme positions for RNs were increased, yet new RNs had difficulty finding employment due to local labour issues and financial constraints.

The nurses in Stanley's third study were senior clinical RNs and residential care CNMs in one residential care organisation in WA, who had been qualified for between six months and four years, and worked in 10 clinical ward areas in three acute care hospitals (Stanley et al., 2014). Similar to the UK, Australian healthcare in the years

2012 to 2016 was complex and multifaceted, with the need for reforms in health funding and workplace and future workforce planning and policy to meet the predicted future workforce requirements. In addition, health needs were related to geographic distribution (metropolitan, regional and rural communities), equity and accessibility (Aboriginal and Torres Strait Islanders) (HWA, 2014a). Limitations in the delivery of healthcare were identified as increasing costs, rising chronic disease, reliance on international recruitment, a lack of specialty trained nurses, nurse shortages, heavy workloads, part-time and casual employment affecting retention, ageing RNs and rapid technological change (ACN, 2015; AIHW, 2016a). The lack of recruitment, despite patient care needs increasing, has proven detrimental to the significant number of newly qualified RNs, with difficulty in securing graduate programmes and permanent, full-time employment (ANMF, 2014a).

In comparing the context of the nursing studies, despite the time and country variance, there is little disparity. The current issues of healthcare persist, including flawed health systems needing reform; the concerns of the projected needs of patients; and the workforce challenges of nurse shortage, increasing workload, recruitment and retention. Nurses (who represent more than half the healthcare workforce) need to meet these challenges. These nurses work across all settings of care delivery, have a patient-centred approach to frontline care and are the leaders to inform and drive the changes necessary to meet the complex challenges of healthcare. Therefore, congruent leadership offers a solid foundation for CNEs to further develop innovative educational and leadership strategies in order to unify nursing teams and individual GRNs around the patient-centred, safe and quality care necessary and expected in 2017 and beyond.

6.2.2.2 CNE Leadership—An Influential Presence

An examination of the influence of nursing leadership on nurse performance suggests that positive patient outcomes and quality of care are the goals of healthcare organisations (Germain & Cummings, 2010). The findings from this study on CNE leadership concur with the findings of Germain and Cummings (2010)—that is, that the CNE is a significant influential presence in supporting GRNs to provide quality patient care. This occurs through a number of processes, such as the comprehension of patient needs, empowered practice with learning resources, motivation and encouragement through accessible support, and promotion of constructive working relationships with

nursing and inter-professional staff. The GRNs' performance outcomes in their first year of nursing are affected positively by available and accessible CNEs, and through influence and investment opportunities that promote safe and quality patient care and thus organisational outcomes.

Contemporary clinical leadership is closely linked with patient-centred care and the leaders' influence on retention of nurses to meet the future health workforce needs (ACN, 2015; ACSQHC, 2011a; HEE, 2015; IOM, 2010; Willis Commission, 2012). The study findings on CNE leadership emphasise the GRNs' transition to effective and safe practitioners, and subsequent employment after their graduate year. The literature presents CNE leadership as influential (Henderson et al., 2011) and relationship orientated (Dattilo et al., 2009), which corresponds to the CNE attributes deemed necessary in supporting GRNs and the ward nursing team. CNE leadership is recognised in the following processes: change (Sayers, Lopez, et al., 2015), communication and reflection (Conway & Elwin, 2007), quality improvement (Linsley et al., 2008) and research (Milner et al., 2006). This study features the CNE as a genuine presence and tangible influence integrating leadership attributes and skills to positively support the GRNs' career progression and successful transition during their graduate year to confident and competent RNs.

Flexibility in leadership is an area of focus associated with the changeable learning environment and essential to meet the expected standards of care. Change is significant in nursing; thus, the success of clinical nurse leaders can be measured by their ability to adapt and adjust rapidly to the continuous changes affecting current healthcare (Adelman-Mullally et al., 2013; Kerfoot, 2009; Sayers, Lopez, et al., 2015; Sayers, Salamonson, et al., 2015). The findings of this study described the overall flexibility of the CNEs' clinical leadership, noted through availability and visibility, which proved to be an essential feature that promotes nursing practice and patient outcomes specifically related to the GRNs' development. The CNE leadership role flexibility extends to sharing the political and economic perspectives in national, state and organisational nursing and education (Conway & Elwin, 2007; Sayers & DiGiacomo, 2010b) through the promotion and translation of policy and procedure to influence the GRNs' positive patient outcomes (Sayers, Lopez, et al., 2015; Sayers, Salamonson, et al., 2015).

Jackson, Clements, Averill and Zimbro (2009) advocated for professional optimism in education to support resilience in the face of challenges and change. Likewise, the positive and affirming CNE leadership traits engage the GRNs through respect, appropriate interpersonal skills, cheerful disposition and the ability to work harmoniously in the nursing team to support the GRNs and their patient care. The literature affirms the GRNs' requirements for ongoing mentorship for effective learning (Adelman-Mullally et al., 2013; HEE, 2015). This bond between CNEs and GRNs was described by Cowden, Cummings, and Profetto-Mcgrath (2011) as the relational aspects of clinical leadership, instrumental in the quality of ward standards through the attitudes, behaviours, practices and partnerships necessary to successfully meet the organisation's goals. Leadership at the CNE level also becomes more conspicuous during times of evaluation of care related to hospital quality cycles (Linsley et al., 2008). Processes such as the national standard accreditation and RN standards for practice require leadership to support the dissemination of knowledge to newly qualified GRNs on evidence-based care and research activities (ACN, 2015; ACSQHC, 2015b; Girard, 2009; HEE, 2015).

Nonetheless, the unity in the nursing team was affected by underperforming CNEs who did not display leadership attributes, skills or mentorship, and refused or avoided the responsibility for GRNs in the role. Sayers (2013) described challenges that affect identity and confidence in the CNE role, such as ambiguity, blurring and conflict, as well as the overarching organisational culture. This leads to the absence of clinical leadership, powerlessness, personal dissatisfaction and role stasis (Manojlovich, 2007). The current study's findings indicated that successful CNE leaders have a compatible relationship with their CNM and demonstrate similar people skills and patient care goals (Schmalenberg & Kramer, 2009). Hence, the necessity for the CNE as clinical leader to be the 'right fit' in the ward environment is established by the acceptance of devolved responsibility and ability to work autonomously with the leadership attributes and skills that provide a consistent approach to enable the GRNs' successful progress.

6.2.2.3 In Absentia

As discussed above, effective relational clinical leadership affects patient care, staff attitudes and organisational outcomes (Sayers, Lopez, et al., 2015). Stanley (2006b) suggested that a clinical leader does not need to be in a management position to lead and

influence colleagues. However, in this study, the CNEs' influence was inconsistent because of displacement from their core educational duty and allocation to clinical patient care, as directed by senior hospital leadership to meet shortfalls in nurse supply and workload or financial deficits (Conway & Elwin, 2007; Sayers, Salamonson, et al., 2015). The CNE supernumerary status was initiated to reflect the significance of nursing staff clinical education and professional development, and to reduce the conflict of concurrently managing patient workload and educational responsibilities (Pollard et al., 2007). It is argued that this misuse of the CNE supernumerary status reduces control over the planning, implementation, assessment and evaluation of GRNs and staff education (NMC, 2015) and creates GRN disconnect and conflict for those who have difficulty meeting the graduate programme criteria (Swearingen, 2009). Sayers, Salamonson, et al. (2015) discussed the competing priorities of the role, where the CNE is expected to simultaneously cover other positions, which creates frustration and stress in attempting to meet the multiple expectations of senior managers and nursing peers. Effective leadership is central to nursing (Curtis et al., 2011); thus, the CNEs' absence from the clinical environment removes the benefit of available, accessible and visible clinical leadership. The CNE leadership was viewed by all participants as vulnerable and subsequently insignificant and of minimal value when CNEs were displaced from their substantive position.

The current study's findings described the expectation for team members to assist and complete the GRNs' skill and competency requirements in the absence of the CNE, as similarly highlighted by Girard (2009). However, the team members' own patient workload often presented time and opportunity challenges that prevented the supervision of GRNs and resulted in learning gaps. The nursing team specifically indicated that the absence of the supernumerary CNE resulted in the GRNs struggling—particularly during the first weeks of a new ward allocation and beyond. Combined with a lack of clarification and direction, this absence generated uncertainty in patient care issues and complex situations (Dyess & Sherman, 2009; Moran, 2012).

Regardless of the presence or absence of the CNE, when the GRNs needed immediate assistance with their patient care or patient error management, their first preference was to discuss issues with their nursing team members. These nurses, on the frontline of patient care, provide a caring, passionate practice environment through effective team

work (Harris et al., 2006). In fostering this teamwork, the CNE is available to translate professional knowledge and competence development at the bedside through ongoing facilitation and collaboration with the nursing team (Ashton, 2012; Gaberson & Oermann, 2010). Nonetheless, the GRNs identified that the limitations of the CNE leadership were directly related to availability. This included their absence due to reassignment, days off, annual leave or not fulfilling the requirements of the CNE role related to the GRNs' graduate programme (Girard, 2009). Thus, the absence of the CNE deepened any existing GRN uncertainty or dissatisfaction related to fulfilling the graduate programme criteria.

Underperforming CNEs also inhibited the GRNs' successful progress and weakened nursing team unity, resulting in reduced benefits of educational leadership assumed by the nursing team. Avoidant leadership in relation to nursing occurs when the leader does not accept responsibility and lacks decision-making capabilities, thereby undermining the safety and quality of patient care and raising nurses' concerns (Daly, Jackson, Mannix, Davidson, & Hutchinson, 2014). This type of behaviour was identified in the current study as detrimental to the nursing team and creating conflict between the CNM and CNE. The effect of CNE leadership was felt when the CNE was not focused on themselves, but committed to the GRNs' achievements to realise positive patient-centred outcomes and organisational goals (Yalong, 2012), in addition to the benefits of improved retention (Rudman, Gustavsson, & Hultell, 2014).

6.2.2.4 Optimising as a Leadership Process

As previously described, the CNEs' leadership is evident in fulfilling a number of role criteria and role essentials required to meet effective practice demands in an ever-changing and challenging clinical environment. HWA (2014b) suggested that the process of optimising (making the best of the situation, or effective and optimal use of available and potential resources) is an important and necessary function of leadership in contemporary nursing. Irurita (1992) previously explored the notion of optimising as a way to view leadership, yet this is not identified in any other nursing research. Irurita examined nursing leadership in WA over four years in the mid-1980s, with a focus on RNs in top-level leadership positions and the situations they experienced. This innovative research sought to determine why nurses failed to attain a more influential leadership role in the delivery of healthcare and development of the nursing profession.

Irurita (1994) dismissed leadership theories as inadequate to describe effective leadership behaviours in the changeable climate of healthcare, where budget concerns and consumer demands dominate.

In 1988, the two dominant aspects of the leadership context in Irurita's (1992) research were labelled 'repression' and 'turbulence'. Repression occurred when nurse leaders were disadvantaged by the nursing and medical systems, culture and apprenticeship processes of the time, while turbulence was identified as the many changes that were occurring in the contemporary nursing environment—such as the change from the apprenticeship model to a university degree, new career and pay structures, and new models of nursing care delivery. In 2016, repression is similarly identified by the difficulties inherent in the overburdened healthcare system, such as the demands of an ageing population, increasing incidence and risk factors for chronic disease, and the effect of obesity (Biggs, 2013). Turbulence is currently identified by the challenges affecting nursing in the clinical environment, such as the effort required to sustain a nursing workforce that can meet the demands for healthcare, including supply, workload, retention and productivity (HWA, 2014b).

Analysis of Irurita's (1994) data in 1992 revealed that nursing requires leaders who are able to overcome repression and move forward through turbulence to deliver excellent care. The grounded theory research identified a core process called 'optimising' that explained the way nurse leaders make the best of situations, with optimal use of available and potential resources to overcome difficulties during the evolution of the new nursing practices (Irurita, 1992). Different levels of optimising revealed the reliability and degree to which leaders used strategies and resources. These levels were categorised as 'surviving' (basic performance), 'investing' (advanced performance) and 'transforming' (exceptional performance), while performance failure was labelled 'floundering'. HWA (2014b) recommended that leadership is significant to nursing retention and productivity at the clinical level. To be effective in the current healthcare culture, leadership roles must be developed by using workplace innovation with a focus on middle management. Positive change occurs when authority is devolved to those at the frontline of care, who have the ability to improve nursing staff attitudes and patient care outcomes. In this manner, the CNE is well placed to provide leadership to newly qualified nurses as a means to support GRN retention and increased productivity.

Figure 6.4 illustrates the model of leadership developed by Irurita (1992) to explain the research findings. It details the levels of optimising and contextual factors related to the environmental and organisational state and individual attributes.

OPTIMISING PROCESS/LEADER	RETARDATION	MEDIOCRITY	TURBULENCE	EXCELLENCE
Floundering/ flounderer	Equilibrium			
Surviving/ survivor		Equilibrium		
Investing/ investor	Not supported		Equilibrium	
Transforming/ transformer	Not supported			Equilibrium
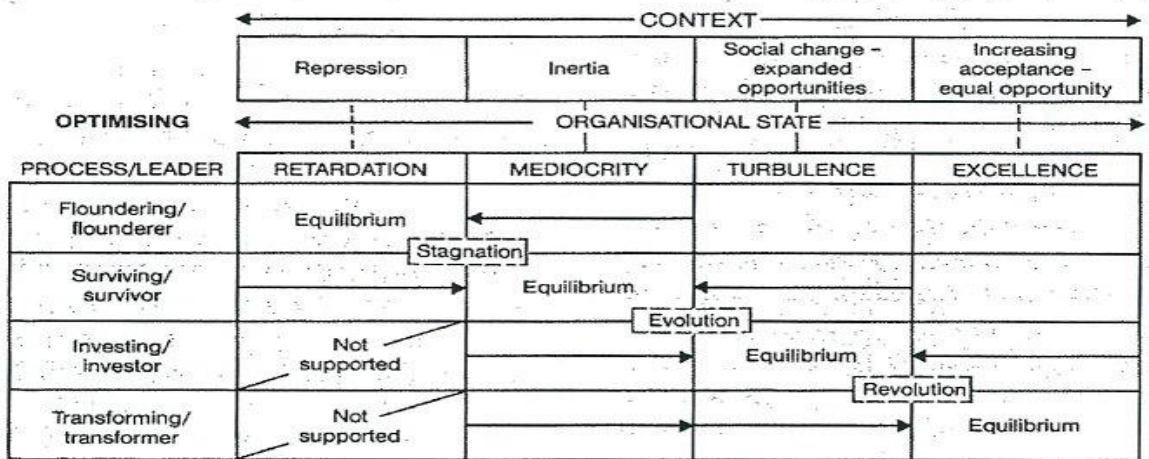
Figure 6.4: Irurita's (1992) Optimising as a Leadership Process

Irurita (1992) identified optimising as occurring over time and under different conditions that generated change. At the time of the research, the nurse leaders were failing to achieve a more influential leadership role in developing the nursing profession and delivering healthcare. The core problem was identified as 'overcoming and compensating for disadvantage related to a repressing context' (Irurita, 1992, p. 16). The management of this contextual repression was through the core process of optimising. Irurita distinguished three levels of performance or progressive phases in this process, as well as the state of failing to optimise. The levels of optimising each related to context, involved specific strategies and conditions, and were built on the proceeding level (Figure 6.5).
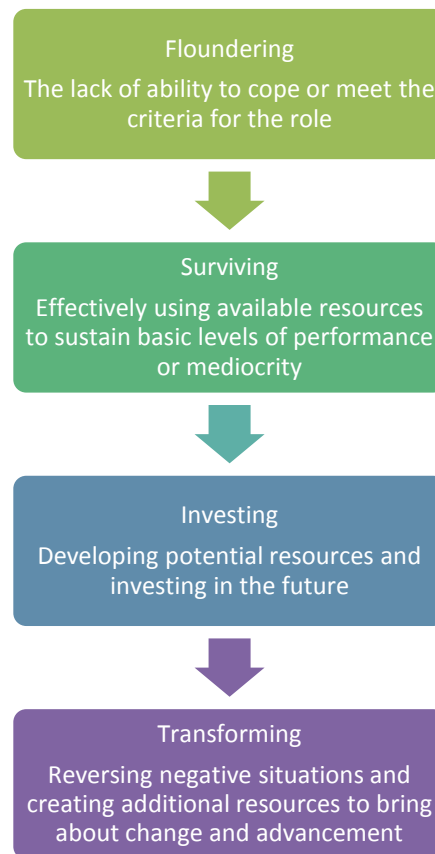
Figure 6.5: Progressive Phases of Optimising

The current study did not explore the levels of optimising described by Irurita (1992). However, the expression of CNE leadership described by the study participants— associated with the GRNs' successful transition and career progression in their graduate year—was explained by the phases of 'transforming' and 'investing'. The effect of CNEs who did not feel empowered to lead and found their role challenging and CNEs who were part time and absent through assignment to a different role was similar to the phase of 'surviving'. Likewise, underperforming CNEs who created opposition to GRNs' growth and negatively affected the nursing team and efficient operation of the ward indicated a failure to optimise—that is, 'floundering'.

Irurita (1992) recognised *optimising* as a conceptual explanation for the major achievements and variation in the behaviour of nurse leaders. Progression through the phases of optimising is influenced by the context of time and leader attributes. Figure 6.6 identifies the environmental factors that contribute to this development of leadership and ability to engage in the optimising process.
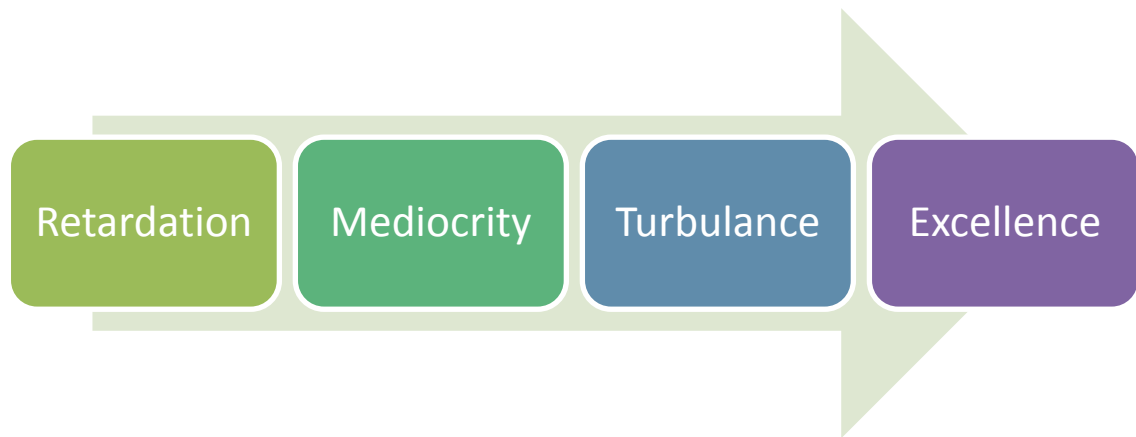
Figure 6.6: Environmental Factors Affecting Leadership

In 1988, the nursing issues of the time varied greatly from the current challenges facing nursing today. Irurita (1992) described a period of stagnation in which nursing advancement was opposed by the medical profession, obstructed by the matriarchal system in nursing and paternalism in the healthcare system, and hindered by the image and societal expectations of nurses and a lack of professional development opportunities. These conditions created 'retardation' (this word is used in the original text) and resulted in 'mediocrity'. As significant changes began (such as expanded opportunities for women and nurses, and expectations to deliver safe patient care), uncertainty created the subsequent state of 'turbulence'—the sudden and urgent need to overcome the rapid changes and ensure the survival of the nursing profession and progress towards excellence. In a similar manner, current challenges affect the practice of CNEs as leaders in the clinical environment and are reflective of organisational expectations and financial constraints related to nurse supply, skill mix, workload (Girot & Albarran, 2012) and consumer expectations for the delivery of safe and quality patient care (ACSQHC, 2011a). In this study, CNEs were directed from their core role to replace patient care nurse in order to meet shortfalls related to nurse supply, workload or financial deficits. Therefore, the CNE role could be seen as vulnerable and their leadership as less important. Consensus in the literature on leadership indicates that a healthy clinical work and learning environment will itself affect the development and endurance of clinical leaders (Pearson et al., 2007).

McBride (2011) contended that 'nursing equal's leadership', while Sayers, Lopez, et al. (2015) emphasised that clinical nurse leadership is a professional responsibility of RNs—not an optional extra. Quality patient care, healthy work environments and the

progression of professional and educational practice will not occur without clinical nurse leadership (Kramer & Schmalenberg, 2008; Sayers, Lopez, et al., 2015; Wylie & Gallagher, 2009). Organisational sponsorship of CNEs' clinical leadership is an investment in bedside nurses and their professional development, and leads to improved performance, improved retention, and greater capacity and capability at ward level (Clark & Allison-Jones, 2011; Sayers, Lopez, et al., 2015).

6.2.3 Safety Warden

The findings determined the supernumerary CNE role in the acute care clinical setting is instrumental in safeguarding the GRNs and their patients' quality and safe care. Through assistance in evidence based care delivery and engagement in professional role development the CNE invests in the GRNs; promoting resilience through safe practices and professional accountability. The literature confirms that the presence of the CNE at ward level is necessary for quality patient care (Duffield et al., 2007; Duffield et al., 2011; Pollard et al., 2007). More significantly, the finding by Duffield et al. (2007) highlighted that the employment of a CNE is associated with decreased adverse events. Without the CNE presence, adverse patient outcomes were found to increase (Duffield et al., 2007). Adverse events in the acute care setting result in harm and suffering to patients and their families, and a financial drain on the country's health system and economy (Australian Nursing Federation, 2009; WHO, 2015).

In this study, the CNEs' influential role in supporting the GRNs' safe and quality patient care occurred through the CNEs' approach to the theoretical, practical and emotional support of the GRNs throughout the graduate programme. The GRN participants perceived the CNE role as a safety warden who devoted time to their patient care concerns and comprehensions of policy and procedures. The CNEs linked their role in the graduate programme to a safety zone—their accessible presence fostering GRNs' autonomy through empowerment. The CNMs confirmed the CNE role as being a safe haven for the GRNs—providing protected time and extra supervision to safeguard GRNs' patient safety. Collectively, these findings reflect the CNEs' safety role in supporting the GRNs' evidence-based care practices, professional development to confident and competent RNs, and collaborative work with the nursing team. Figure 6.7 depicts these three aspects of the CNE role in GRNs' safe and quality patient care.
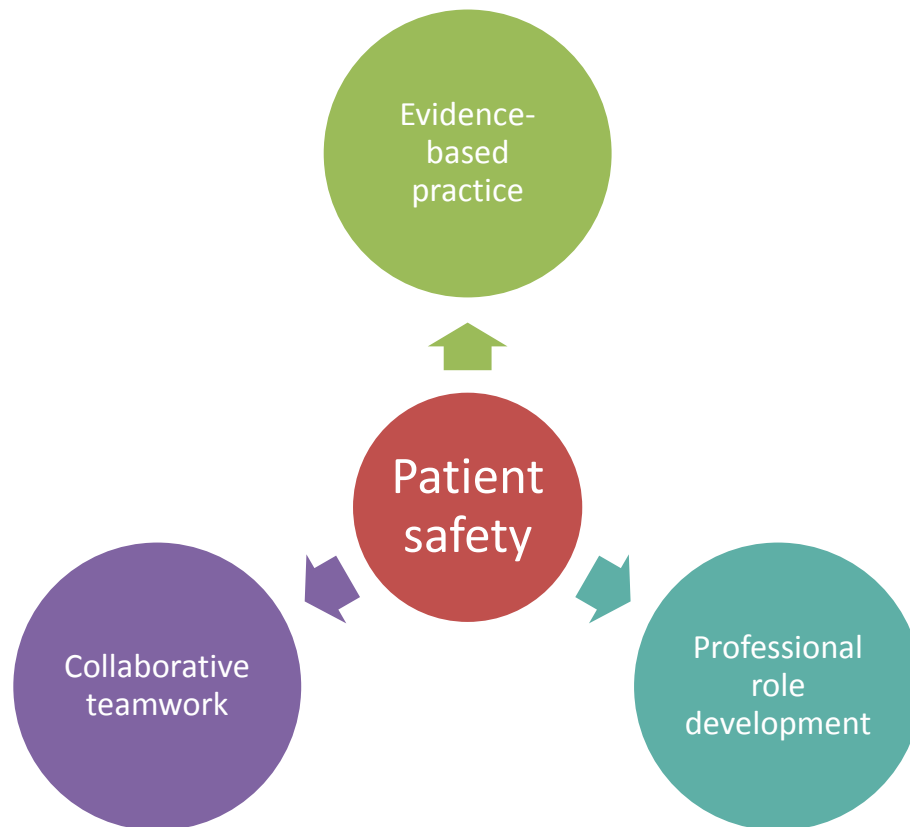
Figure 6.7: CNE Patient Safety Focus

6.2.3.1 Evidence-based Care

Globally recognised healthcare challenges create barriers to nurses' application of evidence-based care practices (Hughes, 2008). According to the Institute of Medicine (IOM) (2003), these challenges are patient focused; team orientated; and related to the work environment, culture and practices. Examples affecting GRNs in their first year of nursing include heavy workloads, increasing acuity and complexity of patient conditions, greater work demands and interruptions, and expectation of new knowledge and technology with inadequate time for training and insufficient supervision (Beal, Riley, & Lancaster, 2008; IOM, 2003; Twigg et al., 2010). Overarching these concerns are the financial constraints affecting adequate and suitable staffing (Daly et al., 2008; Koontz et al., 2010; Salminen et al., 2010). In this context, newly qualified GRNs encounter patients while simultaneously trying to meet the expectations of their own organisational policies and procedures; their registration authority's expectations to use recent and relevant best available evidence (NMBA, 2016b); and the relevant national and state legislation, guidelines and patient-centred standards (ACSQHC, 2011a, 2015a;

Sayers, Salamonson, et al., 2015). Therefore, in their role of promoting patient safety, the supernumerary CNE acts as a buffer to the pressures of the contemporary practice environment experienced by the GRNs.

6.2.3.1.1 Policy and Procedure

The WHO (2015) describes evidence-based care as central to all nurses' CPD. Newly qualified GRNs have an understanding of the concepts from their undergraduate study, but require guidance on practical application in their new ward specialty (Girot, 2000). The CNE is described in the findings as the available and accessible clinical expert who provides the necessary support for the GRNs' interpretation, translation and application of organisational policies, guidelines and procedures. This can occur as a planned or spontaneous event at the bedside, through supervision of care activities, and through assistance to access policies and procedures and appraise the contents relevant to patient care. An example of CNE support during the GRNs' transition year is the supervision of GRNs' medication administration. Medication errors by nurses are a focus in the literature, and the CNE's collaboration with the GRNs on risk assessment and safe administration promotes patient safety (Caple & Woten, 2015; Hughes, 2008). The study participants linked CNEs' time and capacity to the growth of GRNs' decision-making and clinical assessment skills that foster confidence and autonomy.

Using evidence to improve the quality of patient care is problematic for GRNs without the extra labour force provided by the CNE. This was reflected in the Francis (2013) report, which described the investigation of serious patient errors and safety concerns at the Mid Staffordshire NHS Foundation Trust. The recommendations highlighted the need to position patients in the front and centre of healthcare, and included using the CNE role as a professional gatekeeper to optimise nurses' evidence-based patient-centred care. In addition, a Cochrane intervention review supported specialist nursing roles (such as the CNE) as a defence against patient errors by supporting staff to consistently improve their patient care outcomes (Butler et al., 2011).

6.2.3.1.2 Protected Time and Confidence

The supernumerary aspect of the CNE role provides the protected time required to support GRN learning and reflection on patient safety outcomes. The IOM (2003) outlined the need for regular formal and informal professional development without the

pressures of time and performance targets. Similarly, the CNE role provides real-time facilitation and supervision of patient care activities to progress the GRNs along the continuum from beginner to competent nurse in their first year of nursing, as described in Chapter 1 (Benner, 1984). Ashton (2012) identified that the close rapport between the CNE and GRNs—resulting from working alongside each other in learning and practice—further activates safe and quality patient care. Rapport is linked to trust that is initiated and maintained through honesty and openness. GRNs need to be willing to exhibit their vulnerabilities to the CNE in order to develop self-confidence (Rudman & Gustavsson, 2011). In this study, the GRNs characterised their CNE as non-judgemental and comfortable, enabling the sharing of experiences and struggles. However, without this rapport, patient care can be compromised by the new GRNs' lack of confidence, coupled with the overwhelming need to survive their first year of nursing (Henderson & Eaton, 2013).

The GRNs' confidence was affected when unable to access extra help from team members, and further exacerbated when the CNE was absent from the role. To increase bedside support and allow RNs to provide more complex care, Twigg, Duffield, and Evans (2013) described a strategy of using unregulated nurses. However, as underscored by the Francis (2013) report, the use of unregulated nurses has implications for patient safety. Conversely, this study suggests that the use of a specialist education nursing role—the supernumerary CNE, with clinical expertise and specialty experience—is beneficial to the GRNs' safe and quality patient care in the acute care setting. The CNE role provides the evidence-based care oversight and monitoring that is required for patient and organisational expectations of safe and quality care.

6.2.3.2 Professional Role Development

The GRNs' professional role development occurs in the context of their first year of nursing and transition to practice. The RN is a responsible and accountable professional practitioner, governed by standards required as part of annual registration (American Nurses Association, 2016; NMBA, 2016b; NMC, 2015). In this study, the CNE is a significant contributor to the newly qualified GRNs' professional development through the progression of their levels of knowledge, skill proficiency and competency.

6.2.3.2.1 The Open Door

The GRNs' unrestricted face-to-face access and interaction with the CNE was a feature of this study. The availability and accessibility of the CNE prioritised the GRNs' professional role development by moderating the effects of the challenging clinical environment on the GRNs' daily professional practice. The function of the CNEs' 'open door' was to provide open communication to support the GRNs' opportunities to develop their critical thinking and reasoning skills. According to Randall (2015), the key elements of open communication used by the CNE in the clinical environment are knowing the local context (organisational values and national standard priorities), using innovative practices and new ideas that meet the needs of the staff (planned and spontaneous CPD), and using engaging practices to promote adherence to patient safety requirements (comprehending policies, guidelines and procedures). In the current study, the GRNs felt confident in waylaying the CNE at any time for any purpose. This allowed the CNE to engage and develop the GRNs' skill acquisition levels from novice to expert, as described by Benner (1984). The CNE led the pursuit of real-world experiences, leading to higher levels of proficiency and integration of safe practices.

6.2.3.2.2 Debrief and Feedback

Debrief and feedback are well-known methods for promoting a patient safety culture (ACSQHC, 2011b; WHO, 2015). With a focus on the newly qualified GRN, Benner and Wrubel (1982) linked engagement in debrief and feedback as further extending professional role development. According to Cant and Cooper (2011), debrief is a confidential and voluntary discussion that follows any patient care events, critical or otherwise, with the goal of finding perspective and moving forward. Feedback provides information on performance or reactions in the clinical environment as a foundation for improvement (Cant & Cooper, 2011). In this study, the CNE used regular confidential debrief and feedback meetings to promote a holistic perspective of GRNs' patient care and an opportunity to examine their actions, attitudes and behaviours. Literature confirms the GRNs' transition period as stressful, overwhelming and traumatic (Cheng et al., 2014; Nash et al., 2009). Therefore, effective strategies are required to avert or reduce difficulties related to inexperience.

The participants in this study found that the CNE was instrumental in providing debrief and feedback to allow the GRNs to process the psychological feelings related to graduate year distress and patient error (Pinto, Faiz, & Vincent, 2012). These feelings included anxiety, guilt and loss of self-confidence, combined with concern for patient safety and fears of disciplinary action (Sahay et al., 2015). The CNEs also described the use of reflective practice during debrief and feedback meetings to further assist the GRNs to understand their clinical experiences. Reflective practice was also useful to provide reassurance (Morgan, 2009) and celebrate success (Cheeks & Dunn, 2010). In this manner, the CNEs' investment in the GRNs' professional role development is integral to understanding professional role expectations and boundaries of practice that promote retention in the organisation and nursing profession (Duffield et al., 2007; Sayers, Salamonson, et al., 2015; WHO, 2011).

6.2.3.3 Collaborative Teamwork

Collaborative teamwork can be explained through a continuum that begins with cooperation (the information shared in the pursuit of an individual's goal) and ends with collaboration (a requirement for a team to work together and have a shared purpose) (Schreiman, 2014). At the beginning of their graduate programme, the GRNs in this study—although inexperienced and vulnerable—built on their undergraduate learning and embarked on a transition journey in the active presence of the ward nursing team. According to Gluyas and Morrison (2013), when the nursing team shares the same purpose of excellence in patient care, they adapt, adjust and anticipate the actions of other team members, resulting in collaboration and improved coordination of care.

6.2.3.3.1 Adjustment to Teamwork

The role of the CNE in the collaborative team was indicated by participants as supporting the GRNs in this adjustment process, reducing the disadvantage of inexperience affecting the team, and promoting collegiality in order to manage and prioritise patient care (Chang, Li, Wu, & Wang, 2010; Clark & Springer, 2012; HEE, 2015). In addition, the study indicated that the CNEs who did not work in isolation—but identified the existing partnerships between the CNE, CNM, team members and organisation—were supportive of the reciprocal benefits of collaboration (McSherry, Pearce, Grimwood, & McSherry, 2012). In this manner, CNEs share their intentional

pursuit of excellence in nursing care with the nursing team, and use their collaborative influence to augment the GRNs' safe and quality patient care.

6.2.3.3.2 GRN Patient Error Management

The goal of GRN support is to create resilient RNs who develop awareness of their own capability, acquire effective relationships, and are able to secure resources and optimise each patient care experience (Hodges, Troyan, & Keeley, 2010). As stated in Chapter 1, the WHO (2011a) describes the CNEs' educational approach to enhancing GRNs' resilience as patient safety education on human factors and team nursing, learning from errors through debrief and feedback, and specific medication safety and patient engagement activities. In this study, the majority of GRN patient errors were managed in the short term by the nursing team members. The role of the CNE in GRN errors was expressed by the participants as an investment in their evidence-based care capabilities and professional role development, preceding patient care and post-patient care activities. In contrast, the nursing team members' involvement occurred during and immediately after patient care episodes. The GRNs' concerns with patient care and potential or actual errors were addressed to the nursing team members—notably, the nursing team member, coordinator of the shift or CNM. Thus, the CNE management of patient errors was viewed by the GRNs as a secondary role of constructive support for personal and professional accountability, given through debriefing and reflection activated after any patient error incidents.

In summary, CNEs support GRNs' safe patient care by advancing their scope and practice via education strategies to expand patient-centric knowledge capacity, develop career pathways and participate in collaboration—all of which are important for early career retention (IOM, 2010). As described by the WHO (2011a), the CNE is an important component of organisational engagement that is essential for sustaining and building patient safety capacity. The following sections outline the significant outcomes of this study and address the research questions.

6.3 Salient Outcomes of the Study

This study set out to determine the effect of the CNE role on GRNs' clinical confidence and quality of patient outcomes in the acute care setting. Chapter 2 provided a review of the current literature on the role of the CNE. This chapter also identified the need for

further research on the role, function and influence of the CNE on the achievement of safe and quality patient outcomes (Conway & Elwin, 2007; Pollard et al., 2007; Sayers & DiGiacomo, 2010b; Sayers et al., 2011; Sayers, Salamonson, DiGiacomo, & Davidson, 2016; Sayers, Salamonson, et al., 2015). The same literature also reported the difficulty in measuring the CNE role's influence on patients' safe and quality care due to the complexity of the CNE scope of practice and indirect contact with patients in the healthcare organisation. This study provided an innovative solution to evaluating the effect of the CNE role on patient quality of care—by using the newly qualified GRNs as the lens to explore the relationship between the CNE role and GRNs' quality of patient care.

As outlined in Chapter 3, a mixed-methods approach was chosen as the research framework. Chapters 4 and 5 detailed the study analysis, and the subsequent findings identified the supernumerary CNE role as advancing the GRNs' quality of patient care through their clinical educator support role and leadership in the transition to practice year. Chapters 4 and 5 described the CNE role through their supernumerary presence, resource-rich role and provision of GRN experiential learning opportunities. Their congruent leadership attributes at the point of care illustrated the CNEs' connection to and compassion for patient care. The CNEs' influential presence affected the GRNs' positive patient outcomes—that is, safe and quality care at the bedside—through the translation into practice and supervision of evidence-based care theory and policy, and the use of reflective practices that influenced GRNs' professionalism and maturity. The findings corroborate the CNE role described by Pollard et al. (2007) as pivotal to the professional development of the next generation of nurses, and support Sayers et al. (2011), who identified the CNE as 'well placed to assume a clinical leadership role' (p. 51) in the clinical environment.

Chapter 1 of this thesis outlined the research questions for this study. The following section reviews these questions and provides a summary of the findings.

6.3.1 Research Questions

The overarching research question outlined in Chapter 1 will be answered following the answers to the guiding questions below.

Question 1: Is there a link between the CNE role and the GRNs' safe and quality patient care?

In this study, the descriptive statistics described in Chapter 4 and qualitative findings in Chapter 5 provided some degree of evidence for a connection between the GRNs' quality of patient care and the supernumerary CNE role. The participants' comments described the acute care clinical environment as fast paced, constantly changing and often confronting for the new GRNs. In this challenging setting, the findings described the CNE role as counteracting undesirable or incorrect patient care practices by guiding the GRNs on the correct use of clinical guidelines, standards of care, and policies and procedures. The participants commented on the use of debrief, feedback and reflective practices as consolidating safe patient practices by reducing GRN anxiety and alleviating concerns. This led to improving GRNs' acceptance of accountability and responsibility for their clinical skills and competence. The quantitative findings articulated the GRNs' attitudes to support related to patient errors and the role of the CNE in error management. The qualitative findings confirmed the collaborative aim of the nursing team in working together with the CNE to develop GRN resilience and self-efficacy on matters related to patient safety and effective patient error management during the GRNs' first year of practice.

Question 2: In what way does the CNE promote clinical confidence among GRNs?

The findings described in Chapters 4 and 5 identified the available, accessible educator role of the CNE as necessary to promote, influence and strengthen the clinical confidence of the GRNs in their first year of nursing. The participants noted that the CNE role with protected time was instrumental in providing specific learning opportunities required by individual GRNs to advance their practice and meet the graduate programme criteria. The findings were supported by comments about GRNs' negative experiences and the CNE's important role in maintaining optimistic attitudes and behaviours to influence clinical situations and augment GRNs' self-confidence and retention in the organisation. The qualitative findings confirmed the presence of desirable personal qualities in the CNE (such as approachability and caring) as affecting GRNs' clinical confidence. Further, the participants provided statements strongly advocating for the presence of the CNE when their absence due to role reassignment,

role relief, annual leave or sick leave was described as leaving the GRNs frustrated, which affected their clinical support and confidence development.

Question 3: To what extent is the CNE perceived as a clinical leader by GRNs, CNEs and CNMs?

The descriptive statistics included in Chapter 4 articulated the GRNs' insights on the CNE as a clinical leader. The GRNs confirmed that the CNE leadership was compatible with the congruent leadership style, based on their affirmation of the CNEs' concern and compassion for patient care, demonstration of clear values and beliefs, and confirmation of the features of the CNE supported by the literature on congruent leadership. The qualitative findings in Chapter 5 further described the participants' views on the importance of leadership as part of the CNE role. The participants expressed how the influential CNE presence on the frontline of care—by providing consistent direction and guidance on patient-centred care standards and accreditation requirements—confirmed clinical leadership. This study also determined that the clinical leadership of the CNE was considered vulnerable and insignificant in the organisation by participants when the role was reassigned or annual or sick leave absences were not backfilled.

Overarching question: Does the role of the supernumerary CNE influence first-year GRN patient outcomes?

The findings articulated in Chapters 4 and 5 substantiated the supernumerary CNE role as positively affecting newly qualified GRNs. The study findings supported the CNEs' influential presence as affecting the GRNs' quality of patient care and clinical confidence, which are necessary for the successful completion of the graduate programme and subsequent retention in the organisation. As a congruent leader, the focus is on being connected and passionate about patient care and sharing this enthusiasm with the GRNs through communication, collaboration, compassion and concern. In this manner, the CNE role has a positive influence on the GRNs' first year of nursing in the acute care context of increasing patient acuity, condition complexity, rapid change, and continually increasing organisation and consumer expectations. In seeking to answer each of the above research questions, the researcher also acknowledges the limitations of this research project, as discussed below.

6.4 Limitations

The limitations of this study relate to the workplace of the participants. The study focused on one healthcare organisation in the private sector that provided both public and private care under the WA government's public–private partnership service agreement. The study setting included three separate acute care hospitals owned by this healthcare organisation, each with their own unique culture. While the perceptions of the GRNs, CNEs and CNMs from this study setting provided data, representation from the wholly public sector was not included because of practicality reasons. The inclusion of participants from both sectors of the health system would have provided a richer data source to compare and make recommendations.

The sampling strategy provided a practical and realistic way to explore the CNE role in the acute care hospital setting. However, during the recruitment process, the appointment of a third party—perceived by the healthcare organisation as eliminating bias associated with the researcher's current employment in one of the hospitals—may have affected the response rate of the GRN questionnaire. By distancing the researcher in the data collection process, the response rate may have been further restricted. Despite the limited response, the anonymous GRN questionnaire provided comment on the role and leadership of the CNE, without any unintentional yet possible power differential that may have existed in the interviews, where the GRNs may have felt they needed to give positive feedback.

Despite these limitations, this study has provided a snapshot of the CNE role in a private healthcare organisation in WA. As such, it is not representative of the CNE role in Australia, but rather builds on previous research to provide a deeper understanding of the CNE role, with a focus on the newly qualified GRNs' experience and the influence of the CNE role and clinical leadership on the GRNs' first year of nursing.

6.5 Chapter Summary

The role of the supernumerary CNE in the acute care setting has been the subject of limited investigation. This chapter has presented this study's overall findings and made comparisons to identify convergence and divergence between the study datasets, the relevant literature, and role and leadership theories. The mixed-methods research design

was a valuable approach to answer the research questions and provide a comprehensive portrait of the CNE role.

This study used a variety of nurses' perspectives to evaluate the changes in the GRNs' confidence and competence in patient care as a result of support from the CNE. By measuring the influence of the supernumerary CNE role, new knowledge and ideas were generated about the supernumerary CNE in the context of safe and quality patient outcomes. The audience that will profit from this study includes present and future CNEs, nurses, clinical and administrative leaders, and healthcare organisations, with implications not only for the transition to practice of GRNs in the acute care hospital setting, but also for the development and delivery of healthcare policy.

The following Chapter 7 discusses the implications of the study findings and recommendations for the CNE role and leadership practice.

Chapter 7: Implications and Recommendations

7.1 Introduction

This thesis has reported on the influence of the supernumerary CNE role on patient outcomes, specifically related to newly qualified GRNs in the acute care hospital setting. The study findings identified the CNE role as having an influence on the GRNs' quality patient care through the ongoing advancement of professional education and confident clinical practice, revealed through the CNEs' role as educator, congruent clinical leader and safety warden. This research was implemented to comprehend the value of the supernumerary CNE role for the GRNs' transition to practice and patient outcomes.

The findings from this study demonstrate the advantages of the supernumerary arrangement that allows the CNE to be independent of ward and patient management and uniquely positioned to positively influence the GRNs' first year of practice. The participants endorsed the supernumerary CNE role as vital for GRNs' professional development at the point of care, and as an effective resource to enhance and extend practice in the context of increasing patient acuity, complexity and change.

The findings also indicate deterrents to the full scope of CNE practice. These include absence from the role as a result of specified part-time work hours, role reassignment and lack of backfill. Reduced value was also connected to a dearth of postgraduate educational qualifications, lack of clarity around role expectations and performance, and insufficient recognition of clinical leadership as integral to the role.

The implications of these findings are important to substantiate the educational and leadership role of supernumerary CNEs in healthcare organisations as necessary for newly qualified GRNs' positive patient care outcomes. Figure 7.1 presents a summary of the study implications.
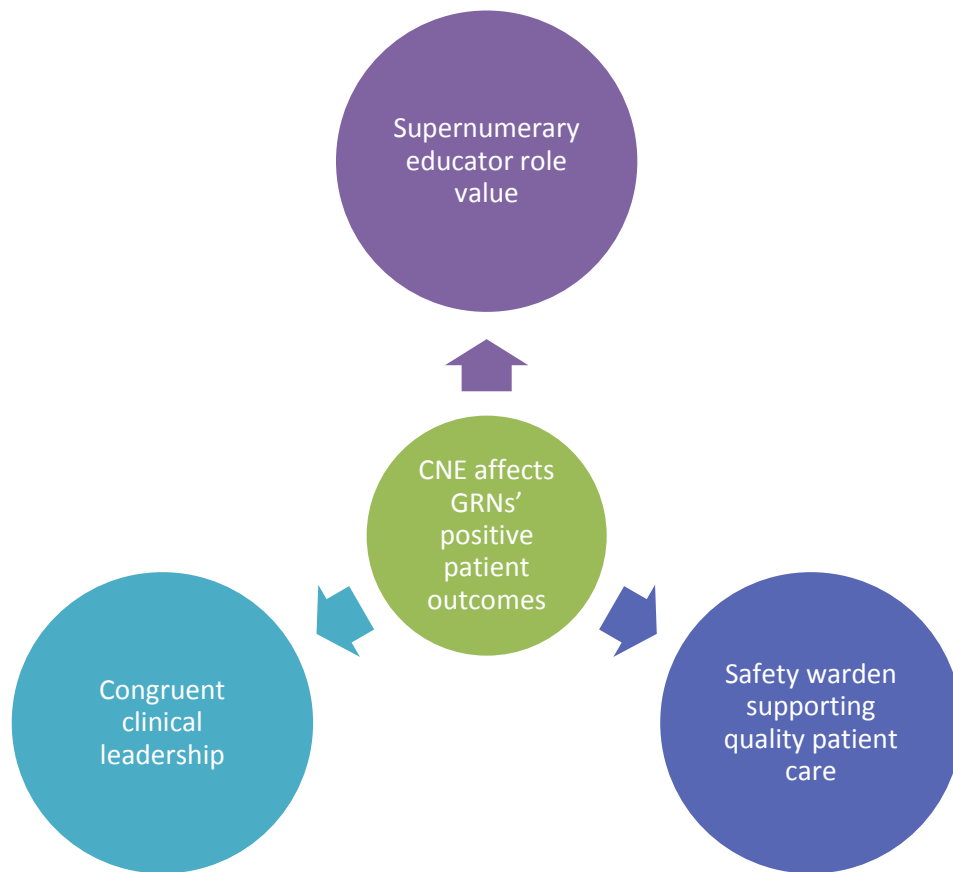
Figure 7.1: Summary of the Study Implications

This chapter provides a summary of the study's key findings; identifies the study implications for education, clinical practice, nursing leadership and research; and makes recommendations for the further development of the CNE role and clinical leadership linked to newly qualified GRNs in graduate programmes.

7.2 Key Findings

This study has described the value of the supernumerary CNE role and clinical leadership specifically related to GRNs in the contemporary and challenging clinical environment and future workforce requirements. The influence of the CNE role highlights the educator value of the supernumerary presence and resource-rich role, and the range of experiential learning opportunities significant to GRNs' successful transition to practice and clinical confidence. GRNs' safe and quality patient care is connected to CNEs' translation to point-of-care practice of evidence-based care theory, policy and procedure, and collaborative teamwork management of patient errors. The

use of reflective practices, such as debrief and feedback, progress GRNs' clinical confidence, professionalism and maturity. The CNE clinical leadership role was perceived by the study participants as associated with the congruent leadership style by means of an influential presence to enhance the GRNs' patient outcomes positively.

The value of the CNE role is restricted by financial constraints, role reassignment and lack of backfill for leave absences. In the absence of the supernumerary CNE, the GRNs' transition to practice is affected by the reduced level of support and resources.

Variations in CNE personality, capability and desire affect their 'fit' in the role and negatively influence nursing team relationships, role progression and leadership. The emphasis on VET over postgraduate education qualification reduces professional educator role value and knowledge use. CNE role performance and leadership suffers from contradictory expectations, organisational demands, and staffing deficits, which affect the GRNs' transition to practice competence and confidence.

7.3 Education Implications

Sayers and DiGiacomo (2010b) suggested that the role of the CNE—with appropriate education qualifications and clinical expertise—will affect the new and transitioning GRNs. This study has found that the supernumerary CNE role has significant value and benefit to GRNs in their first year. The CNE, in cooperation with the CNM and nursing team, works best with protected time to meet the professional development needs and subsequent retention of confident, capable and proficient GRNs in the organisation. The absence of the CNE from the supernumerary role reduces the support provided to the newly qualified GRNs in the delivery of safe care. The CNE absence occurs through part-time hours dictated by budget concerns, reassignment of the role to direct patient care, role relief directed by CNMs or senior nurse leadership, and the lack of backfill for annual or sick leave.

The CNE role provides a positive presence that combats the effect of the demanding, unpredictable and fast-paced clinical environment on the novice GRNs' practice. With a focus on the patient-centred standards necessary for professional practice, the CNE consolidates GRNs' learning using clinical opportunities and experiences to meet competency and graduate programme criteria.

The CNE offers the GRNs time and opportunity to access, comprehend and apply evidence-based practice through practical interpretation and translation of policies and procedures at the point of care. This strategy promotes quality patient care actions and positive patient outcomes (Duffield et al., 2007). In being a role model, the CNE offers optimistic attitudes and behaviours that affect the GRNs' positive transition and reduce the effects of transition shock and negative ward culture experiences (Perry, 2009).

The CNE role value is evident in the investment in GRNs' learning and professional development in relation to organisational workforce retention in order to mitigate future nurse shortages. However, validation of this professional educational role will only occur if it is safeguarded from role reassignment to direct clinical care and role relief.

7.4 Clinical Implications

The literature highlights that the introduction of the CNE at ward level is necessary for quality patient care (Duffield et al., 2007; Duffield et al., 2011; Pollard et al., 2007). In this study, the supernumerary CNE was committed to patient-centred care, with a specific focus on optimising GRNs' safe and quality patient care in their transition to practice year. This occurs through the CNEs' influential presence that supports knowledge use at the point of care and nurtures reflective practices. The CNE promotes evidence-based practice through policy and procedure translation and quality improvement initiatives that are embedded at ward and patient level (ACSQHC, 2015b).

The novice GRNs' progress to competency and proficiency through continued growth and learning results in the responsible and accountable practice of professional RNs who have resilience and self-efficacy to successfully meet the mental and emotional challenges faced in contemporary nursing. Patient safety management occurs in collaboration with the nursing team and is supported by the CNE, ensuring consolidation of theory to practice that is conducive and constructive to GRN retention and longevity in nursing.

7.5 Leadership Implications

The CNE is described by the ACN (2015) as a diverse role where education and clinical leadership intersect. Further, Sayers et al. (2011) determined the CNE as 'well placed to assume a clinical leadership role' (p. 51) in the fast-paced and challenging clinical

environment. This was reflected by the current study's findings that suggest that the CNE is a congruent leader in the clinical ward setting. The visible, approachable and relational CNE acts on clearly identified values and beliefs, with passionate patient-centred principles, and is empowered by the CNM to connect through effective communication in order to motivate and inspire the new generation of GRNs (Stanley, 2014). As a clinical expert, the CNE uses role and leadership flexibility and professional optimism to influence frontline care and drive the changes necessary to meet the challenges of increasing organisation and patient expectations. The CNE has a clear role in supporting GRNs to meet the expected standards of care by leading and influencing a positive and supportive work and learning environment that produces determined clinical growth and professional accountability.

7.6 Research Implications

Positive patient outcomes through the practice of new knowledge are a goal of nursing research (Drenkard, 2013). This research provides an understanding of the influence of the supernumerary CNE on patient outcomes by using GRNs as the lens to explore the relationship between the CNE role and the safety and quality of patient care.

Previous studies, reports and reviews identified limited empirical evidence on the influence of the CNE role and clinical leadership on patient outcomes (Conway & Elwin, 2007; Pollard et al., 2007; Sayers & DiGiacomo, 2010b; Sayers et al., 2011; Sayers, Salamonson, et al., 2015). Other reports indicated the need for frontline leadership to influence patient outcomes and nurse retention (ACN, 2015; HEE, 2015; IOM, 2010; Willis Commission, 2012). A significant study by Duffield et al. (2007) highlighted that the presence of the supernumerary CNE is associated with decreased adverse events, while the absence of the CNE is associated with an increase in adverse patient outcomes. The current study provides further evidence to describe the CNE role's influence in the acute care hospital by using GRNs as a lens to identify the connection between CNEs and patient outcomes. This includes the CNE's influence on GRNs' advancing practice and patient safety, CNE role use in the ward setting and healthcare organisation, and CNE contribution to educational initiatives and innovation. The leadership style of the CNE is identified as congruent (Stanley, 2014), with the processes of optimising considered useful to CNE leadership practice (Irurita, 1992).

Further research to promote the supernumerary CNE role in national and international contexts is essential to meet the safe and quality care delivery of healthcare in public and private healthcare organisations. It is crucial to undertake research that informs and further progresses healthcare policy at local and national level, and increases commitment to future patient expectations related to nursing workforce and patient-first initiatives. This study has highlighted CNE leadership as relevant in the contemporary nursing context of healthcare culture, organisational changes and concerns, and overarching patient expectations.

7.7 Recommendations

The early supporters of the CNE role suggested that effective staff development required the CNE to have a position of status in the organisation (Tobin & Beeler, 1988). This study recommends that the supernumerary CNE role be used by healthcare organisations as a strategically placed and socially adept position of importance to meet contemporary patient and healthcare expectations, uphold commitments to standards and policy, and promote GRN patient-centred practice and retention in the health service. The CNEs' nursing practice, in conjunction with higher AQF levels of qualification, is advantageous for GRN growth and patient safety. Postgraduate study provides sequelae related to theory to practice, such as transmission of expert knowledge and skills and application of evidence-based practice (Barnhill et al., 2012).

However, the challenges to CNE role and leadership value—such as short-term staffing needs that overwhelm role value and success—need to be overcome. The supernumerary status should be protected and acknowledged as significant to continuing education, professional development and leadership acumen for the benefit of patient safety and the future nursing workforce (Clark & Allison-Jones, 2011).

This study has focused on the GRN; however, the CNE role and clinical leadership has benefits for all levels of nursing staff in the acute care hospital in relation to CPD. Further study on the CNE role and clinical leadership associated with patient outcomes and other nursing roles in the healthcare organisation would be useful and add to the literature already discussed. Further, additional study on Irurita's (1992) model of leadership and optimising as a leadership process in the contemporary context would be worthwhile. The frameworks presented in Chapter 1—specifically, the standards and

competencies for the specialised role of the CNE—should be considered as a monitoring and evaluation tool to ensure CNEs are effective, appropriate and responsive to all nursing staff needs. This would benefit and enhance confidence in the CNE role for the incumbent and the employer.

The stakeholders who will profit from this study include present and future CNEs, nurses, clinical and administrative leaders and managers, and healthcare organisations, with implications not only for the transition to practice of GRNs in the acute care hospital setting, but also for the development and delivery of healthcare policy.

7.8 Conclusion

This descriptive study has presented the value of the supernumerary CNE role and clinical leadership for the transition to practice of newly qualified GRNs in the acute care hospital setting. The findings have affirmed that the CNE has a positive influence on GRNs and their patient outcomes.

The research participants identified that the supernumerary CNE role—encompassing continuing education, patient safety and clinical leadership—is essential to frontline nurses influencing the delivery of quality patient care and as a practical solution to champion longevity in nursing for newly qualified RNs and the future nursing workforce. Further, the supernumerary CNE role described in this study provides one aspect of the multifaceted professional roles in the acute care healthcare team, who, together, provide and pursue excellence in practice by working towards the patient-centred quality care necessary to meet organisational and national healthcare goals.

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Appendices

Appendix A: Stanley's Perceptions of Clinical Leadership Questionnaire Tool

PERCEPTIONS OF VOLUNTEER AMBULANCE OFFICER CLINICAL LEADERSHIP QUESTIONNAIRE

Date of design: June 2012

Please read the information in the box below and on the covering letter carefully **BEFORE** answering any of the following questions.

Any information provided will be dealt with in the strictest confidence.

The information you provide will only ever be available to the researcher.

You do not need to put your name or any other name on this questionnaire.

You can be assured that this questionnaire is related only to this research and NOT to your employer or employment, again any information you provide will be kept safe and confidential.

Please complete every part of the questionnaire and do not leave any questions unanswered.

Please return the questionnaire at the end of refresher training or post back to the researcher with the envelope provided. Thank you for your assistance and participation.

1. Please put a tick ✓ next to the qualities/characteristics listed below that you would MOST identify with clinical leadership and a ✗ next to the qualities/characteristics you would LEAST identify with clinical leadership. Consider each quality/characteristic carefully and if you can't decide, leave the space blank.

Copes well with change		Is a motivator		Deals with routine	
Sets direction (planning)		Is controlling		Is consistent	
Considers relationships valuable		Has management experience		Copes well with complexity	
Flexible		Is a teacher		Is visible in practice	
Is a guide		Is a mentor		Is a visionary	
Sets goals and targets		Is a negotiator		Directs and helps people	
Has integrity and is honest		Is responsible for others' duty/ responsibilities		Deals with reward/ punishment	

Is inspirational		Takes calculated risks		Aligns people	
Is a critical thinker		Is a regulator		Counts on trust	
Is creative/innovative		Is analytical		Deals with resources allocation	
Is clinically competent		Is an administrator		Maintains relationships	
Is artistic/imaginative		Is conservative		Inspires confidence	
Is supportive		Is an advocate		Is articulate	
Is a change agent		Is approachable		Is just/fair	
Can be a decision maker		Is a coach		Manages staff	
Has a healthy sense of humour		Is caring/ compassionate		Is an effective communicator	
Evaluates the performance of staff		Is a role model for others in practice		Resolves conflict	
Works alone		Must have relevant postgraduate training		Is courageous	

2. Are there any other qualities or characteristics that are not on the list above that you would identify with clinical leadership in your Volunteer Ambulance Officer role?

_____

_____

_____

3. Based on these qualities, do you see yourself as a clinical leader?   YES   NO
Please state why.

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. Would you say your role as a Volunteer Ambulance Officer allows you to engage in leading and collaborating in clinical practice?   YES   NO

Please state why.

_____

_____

_____

_____

5. Do you think your colleagues see you as a clinical leader?   YES   NO

(Why or why not?)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

6. Are there any barriers that hinder or diminish your ability to be an effective clinical leader?   YES   NO

If so, please describe them.

_____

_____

_____

_____

_____

_____

_____

7. With reference to your experience, perceptions and understanding of clinical leadership:

rate the following statements on a scale of 1–10 (circle the number closest to your view, with: 1 = 'not relevant' or 'not important' and 10 = 'very relevant' or 'very important')

Clinical leaders I recognise…

7.1 Have the skills and resources necessary to perform tasks effectively.

1 2 3 4 5 6 7 8 9 10

7.2 Are able to observe on the job activity without involvement.

1 2 3 4 5 6 7 8 9 10

7.3 Are able to work within the team.

1 2 3 4 5 6 7 8 9 10

7.4 Encourage initiative, involvement and innovation from coworkers.

1 2 3 4 5 6 7 8 9 10

7.5 Recognise optimal performance and express appreciation in a timely manner.

1 2 3 4 5 6 7 8 9 10

7.6 Initiate care and lead action and procedures.

1 2 3 4 5 6 7 8 9 10

7.7 Have high moral character, know what is right and wrong and act accordingly.

1 2 3 4 5 6 7 8 9 10

7.8 Are willing to take risks for something they believe in, whether for people or ideals.

1 2 3 4 5 6 7 8 9 10

7.9 Are able to communicate well, presenting ideas logically and effectively.

1 2 3 4 5 6 7 8 9 10

7.10 Are flexible, able to improvise and can respond to a variety of situations with appropriate skills and interventions.

1 2 3 4 5 6 7 8 9 10

8. How would you define clinical leadership?

_____

_____

_____

_____

_____

_____

9. If clinical leaders are to lead in all dimensions of Volunteer Ambulance Officers' practice, what skills do you have (or need) to facilitate this or allow you to achieve this?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

10. With reference to your experience, perceptions and understanding of clinical leadership:

rate the following statements on a scale of 1–10 (circle the number closest to your view, with: 1 = 'strongly disagree' and 10 = 'strongly agree')

Clinical leaders I know are able to…

10.1 Influence organisational policy	**1 2 3 4 5 6 7 8 9 10**
10.2 Influence the way clinical care is delivered	**1 2 3 4 5 6 7 8 9 10**

10.3 Be involved in staff development education	**1 2 3 4 5 6 7 8 9 10**
10.4 Provide staff support	**1 2 3 4 5 6 7 8 9 10**
10.5 Be constantly available across shifts	**1 2 3 4 5 6 7 8 9 10**
10.6 Show road experience of greater than five years	**1 2 3 4 5 6 7 8 9 10**
10.7 Demonstrate advanced critical care training	**1 2 3 4 5 6 7 8 9 10**
10.8 Demonstrate advanced critical care experience	**1 2 3 4 5 6 7 8 9 10**
10.9 Demonstrate teaching/tutorial experience	**1 2 3 4 5 6 7 8 9 10**
10.10 Demonstrate teaching/tutorial training	**1 2 3 4 5 6 7 8 9 10**
10.11 Demonstrate international paramedic experience	**1 2 3 4 5 6 7 8 9 10**
10.12 Demonstrate local (Perth/WA regional) experience	**1 2 3 4 5 6 7 8 9 10**
10.13 Demonstrate research training	**1 2 3 4 5 6 7 8 9 10**
10.14 Demonstrate research experience	**1 2 3 4 5 6 7 8 9 10**
10.15 Hold an undergraduate qualification	**1 2 3 4 5 6 7 8 9 10**

11. Please feel free to add any other comments related to your understanding of clinical leadership.

_____
_____
_____
_____
_____
_____
_____
_____

About you:

12. How long have you been an Volunteer Ambulance Officers (years/ months)
_____/_____
_____

13. Have you undertaken any formal education in relation to leadership?   YES   NO If so, what?
_____

14. Have you undertaken any formal education in relation to management?   YES   NO
If so what?

_____

15. Are you male/female (Please circle as appropriate)

_____

16. Please indicate your age with a tick next to the corresponding figures on the scale below.

  Below 20
  21–30
  31–40
  41–50
  51–60
  Above 60

17. Please indicate the nature of your work location with a tick next to the locations offered below:

  Metropolitan
  Regional

Thank You

Again, you can be reassured that any information provided will be kept confidential and dealt with in the strictest confidence.

Thank you for your assistance in completing this questionnaire. If you have any questions or concerns that this questionnaire has raised, you can contact the researcher at david.stanley@uwa.edu.au

Please return the completed questionnaire in the envelope provided or to the appropriate collection point.

Date of Design: 7 June 2011

Participant Information Sheet: Questionnaire

PERCEPTIONS OF VOLUNTEER AMBULANCE OFFICER CLINICAL LEADERSHIP QUESTIONNAIRE

Dear Volunteer Ambulance Officer Colleague,

You are invited to take part in this research study; however, before you decide to do so or not, it is important for you to understand why the research is being undertaken and what it will involve. Please read the following information carefully.

This research project aims to identify how clinical leadership skills are perceived by Volunteer Ambulance Officers in the course of their everyday work, and the effectiveness and consequences of such skills in pre-hospital care delivery.

The purpose of this study is:

1. To identify who the clinical leaders are in the ambulance service.
2. To identify the attributes and characteristics of clinical leaders in pre-hospital care.
3. To identify clinical leadership skill sets/practices/elements that influence effective pre-hospital care.

How were you selected?

The questionnaire is being offered to all volunteer Ambulance Officers in Western Australia.

Methods:

You are being asked to take part in completing a questionnaire.

Risks:

It is hoped that you feel confident to be able to help with this study. The research is purely related to a St John Ambulance Service/The University of Western Australia research project and is **in no way** related to your engagement in volunteer activity. As such, you can be assured that any information provided will be dealt with in the strictest confidence. The information you provide will only be available to the researcher and is unable to be linked with your name, voluntary position or address. All the information collected will be kept safe and confidential. You are not identifiable as a result of participating in this study.

Inconveniences:

There are no inconveniences involved in this study, other than the time it will take to complete the questionnaire (about eight to 12 minutes).

Benefits:

1. Support for or insight to theories of leadership that better support an understanding of leadership in clinical practice, and thus an ability to offer support to apply leadership in clinical practice.
2. Information that leads to the development of more appropriate and focused education to better support leadership development for Volunteer Ambulance Officers.
3. A guide may be offered into how to better support service improvement initiatives for pre-hospital care. This will support both the participants and clients of the St John Ambulance Service in Western Australia.
4. The most significant outcome is the potential to develop an understanding of how leadership practices affect volunteer morale, volunteer retention, volunteer satisfaction and the implementation of care practices that lead to more effective pre-hospital client care.

What will be done with the data?

The information you provide will be analysed and used to help the researchers understand more about clinical leadership in the St John Ambulance Service. It will be used to produce a report for St John Ambulance and possibly result in an academic publication for the wider ambulance service. It may also be used to develop specific educational provision for Volunteer Ambulance Officers within the St John Ambulance Service.

Ethics process:

Participation **is not compulsory** and you are free to withdraw from the study at any time without prejudice in any way. If you chose to withdraw, you need give no reason or justification for withdrawing and any record of your being in the study will be destroyed. Simply do not complete or return the questionnaire.

Who to contact:

Approval to conduct this research has been provided by The University of Western Australia, in accordance with its ethics review and approval procedures. Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time.

In addition, any person not satisfied with the response of researchers may raise ethics issues or concerns, and may make any complaints about this research project by contacting the Human Research Ethics Office at The University of Western Australia on (08) 6488 3703 or by emailing hreo-research@uwa.edu.au.

All research participants are entitled to retain a copy of any Participant Information Form and/or Participant Consent Form relating to this research project.

Thank you for your time in considering this request to be involved in this study.

Respectfully yours,

David Stanley

Dr D. Stanley.
NursD, MSc HS, BA (Nursing), Dip HE (Nursing), RN, RM, TF, Gerontic Cert.
Date of Design: June 2012

Appendix B: Permission to Use Stanley's Perceptions of Clinical Leadership Tool

Hi Tracey,

So has Africa got into your blood. It can do that it is such a special place. If we get a chance I would like to hear more about your Uganda experience. I am hoping to go to Kenya next year with some students from here.

I am now working in NSW (see new email address).

As for clinical leadership

Your Master's thesis sounds interesting and I would have thought that (depending on the values the SDN has on show) they would be seen as Congruent Leaders. But you are very right to seek confirmation of this.

I have done a number of studies on clinical leadership now and will attach some of the questionnaires I have used. You will note a number of similarities between them although they were used for different professional groups. These questionnaire were built upon my original questionnaire for my these but I do not have a copy of this as it was so long ago the data was on a floppy disk that I cannot now access. But these attachments will give you a guide.

My aims were similar you yours and I was keen to identify the type of leadership used as well as people understanding of leadership (at the bed side or in the clinical area).

Most managers don't see that it could be different.

When you do complete your Masters please seek to publish your results as I am sure they will be useful for other SDN.

Let me know if this is what you wanted or if I can be of further help.

Cheers David

_____

From: Tracey Coventry team.t@bigpond.net.au
Sent: Tuesday, 23 September 2014 2:59 PM
To: David Stanley dstanley@csu.edu.au
Subject: Question on Congruent leadership

Hi David,

My name is Tracey Coventry and I have met you previously at an ANTS meeting where you spoke on clinical leadership, which was excellent and very useful.

I have also enjoyed reading of your experiences in your book The Pangolin Diary and have myself recently spent 3 weeks in Uganda volunteering in baby homes and children's villages. An amazing and worthwhile experience, that I will hopefully repeat for a longer time in the future.

I am currently working at JHC as Policy Analyst seconded from my role as Undergraduate Placement Coordinator and Staff Educator.

I am doing a Masters of Nursing (Research) through ECU with the topic of my thesis: The impact of the supernumerary staff development nurse on patient outcomes specifically related to graduate nurses.

As part of this study looking at the supernumerary role of the SDN I am also looking at the extent that the SDN is perceived as a clinical leader by the GRN, particularly in relation to the congruent leadership style. I am developing a questionnaire for the GRN and would like to ensure that the questions I ask are relevant and provide me with the data required.

I have read a number of your papers on clinical nurse leadership and used them as a basis for writing some of my questions. However, it would be preferable to use questions that have already been used in a study on congruent leadership if this is possible.

I would be very grateful if I am able to see and use the questions you have formulated and used for your studies.

If not, thanks for your excellent work over the years, and contribution to clinical leadership. Very much appreciated.

Kind regards,

Tracey Coventry

Tracey Coventry
20 Drayton Green Way
Kingsley
WA 6026

Appendix C: Email Invitation to GRN Questionnaire

Qualtrics Survey Information for GRN Participants

Email invitation and first page of survey

Dear Participant,

You are invited to participate in this survey as part of the research project titled:

The impact of the supernumerary staff development nurse on patient outcomes specifically related to graduate nurses.

Researcher

My name is Tracey Coventry and I am a Registered Nurse conducting this project as part of the requirements for the award of PhD at Edith Cowan University (ECU). My supervisors are Dr Gilly Smith and Dr Deborah Sundin from the School of Nursing and Midwifery at ECU.

What is the project about?

The aim of my project is to investigate if the supernumerary staff development nurse (SDN) on the ward has a positive effect on the patient outcomes of newly qualified graduate registered nurses (GRNs). The project will look at the perspectives of the GRN and SDN on the SDN role related to GRN patient outcomes and data from incident information management systems.

The goal is to show how the supernumerary SDN supports nurses in the clinical environment to maintain patient safety by developing skills and competencies; promoting critical thinking and reflective practice; and furthering education on disease processes, new products and technology. The GRN group has been chosen because the SDN is involved in many aspects of the new graduate nurses' development and adjustment to the clinical environment. The results will have significance for the development of the SDN role, leadership in the clinical environment, and the progression and delivery of safe healthcare to patients.

Why have I been asked to be involved in this project?

You have been invited to participate in this project because you are a GRN or have recently completed a graduate nurse programme and provide patient care for inpatients in an acute care setting.

Do I have to participate in this study?

Your participation is voluntary and, if you decide to take part, you may stop at any time without explanation or penalty.

You will be asked at the beginning of the survey for your consent to participate.

Are there any risks associated with participating in this project?

You may feel concern about reliving or retelling incidents that have occurred on the wards during your participation in this project. Professional, confidential and free counselling is available to you through the Employee Assistance Program should you wish further discussion and support.

What are the benefits of being part of this project?

Your involvement in this project is an opportunity to share experiences of the GRN graduate year and the supernumerary SDN role in relation to patient care. You will also help to increase the understanding related to positive patient outcomes and the effect of the supernumerary SDN role on patient safety and quality of care in the acute hospital environment.

What are the costs to me?

There are no costs to you in participating in this project.

Will my part in this project be kept confidential?

All information collected for this project will be kept private and confidential. The survey information will be de-identified and stored securely, and will only be available to the authorised persons, such as the researcher, supervisors and an independent reviewer, who will maintain the confidentiality of participants and their information.

The results of this project are expected to be published in peer-reviewed journals. The journal articles and any conference papers can be made available to participants when they become available. There may be some feedback on the findings given to the hospitals involved in the project.

Who do I contact if I have questions about the project?

If you have any questions or require any further information about the research project, please contact Tracey Coventry on 0423 122 582 or tcovent2@our.ecu.edu.au.

If you prefer, you may contact my supervisors at the School of Nursing and Midwifery ECU: Dr Gilly Smith, Senior Lecturer, on 6304 3490 and Dr Deborah Sundin, Senior Lecturer, on 6304 3488.

This project has been approved by the ECU Human Research Ethics Committee. If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

> Research Ethics Officer
> Edith Cowan University
> 270 Joondalup Drive
> JOONDALUP WA 6027
> Phone: (08) 6304 2170
> Email: research.ethics@ecu.edu.au

The ethical aspects of this study have been approved by the Joondalup Health Campus Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the Committee through the Executive Office—phone 9400 9404.

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

Link to the Qualtrics survey

Click on the following link to take you to the survey (not required on Qualtrics page):

LINK TO THE QUALTRICS SURVEY

Yours sincerely,

Tracey Coventry

Appendix D: Qualtrics Questionnaire

Qualtrics Questionnaire

First question of questionnaire

Question 1

Your participation is voluntary; however, as this survey is anonymous, your contribution cannot be withdrawn once complete as the researcher will be unable to identify your survey submission.

Do you understand that by continuing with this survey you have given consent to participate?

Yes   No

- The Yes choice will allow participants to complete the survey.
- The No choice will terminate the survey.

Information about you

1.   What is your gender?   M/F

2.   How old are you?   21–25, 26–30, 31–35, 36–40, 41–45, 46–50, 51–55, 56–60

3.   Are you currently in a Graduate Registered Nurse (GRN) program?   Y/N

4.   Have you finished your GRN program?   Y/N

      Completion date _____

5.   At which hospital did you or are you doing your graduate programme in?

      Joondalup Health Campus ☐   Peel Health Campus ☐

      Hollywood Private Hospital ☐

The Staff Development Nurse (SDN) or Ward Clinical Support Nurse (WCSN) is senior registered nurse who is supernumerary (has no patient allocation) and is responsible for nursing staff education and development in the clinical wards. The SDN and WCSN may be known by other names such as Nurse Educator or Staff Educator, and may be employed in a part time or full time capacity.

Thinking about the SDN or WCSN on your ward during your time as a GRN, please answer the following questions:

6.   How often do you meet with the SDN or WCSN? For example to talk about your progress or concerns about your patients or the graduate programme?

      Never, Rarely, Sometimes, Most of the time, Always

7.   If you meet with your SDN or WCSN, how often do you meet?

Less than once a month, once a month, 2-3 times a month, once a week, 2-3 times a week, daily, other _____

8.   Is the SDN or WCSN available to assist you when you need help—i.e. can you ask questions or request help with patient care during work time?

Never, Rarely, Sometimes, Most of the time, Always

9.   If the SDN or WCSN is not always available to you when you need help with patient care during work time, why do you think this might be? You can choose more than one answer.

1. SDN/WCSN not on duty

2. SDN/WCSN busy with other staff

3. SDN/WCSN busy with education

4. SDN/WCSN working clinical shift

5. SDN/WCSN on leave

6. Other_____

10.   Of the following nursing staff on the ward who would you go to for help with a patient problem? Rank in order of preference where 1 is the most likely person you would go to for help with a patient problem and 6 is the least likely person you would go to for help. Drag the item on the left up or down to rank from 1 – 6.

1. Preceptor

2. Team nursing member

3. Coordinator of the shift

4. SDN

5. Clinical Nurse Manager

6. Other _____

11.   The role of the SDN in the ward during your graduate year is important

Strongly agree, Agree, Neither Agree nor Disagree, Disagree, Strongly disagree

12.   Is the SDN/WCSN role positive? Expand on your answer

Y/N _____

Write the ways here …

13. Do GRNs need a supernumerary SDN/WCSN for support with patient care during their first year? Expand on your answer

    Y/N _____

14. Have you experienced working on the ward when the SDN/WCSN was not available? For example, when the SDN/WCSN has their own patient load or on leave?

    Y/N

15. When SDN/WCSN was not available, did this affect your patient care?

    How? _____

16. In your personal opinion, what are the benefits of having a supernumerary SDN/WCSN?

    Write the benefits here_____

17. In your personal opinion, are there any advantages to having a supernumerary SDN/WCSN?

    Write the disadvantages here_____

18. Having a supernumerary SDN/WCSN on the ward reduces the risk of patient errors?

    Y/N _____

19. Please expand on why you think the SDN/WCSN on the ward reduces the risk of patient errors.

    Write here _____

20. Please expand on why you do not think the SDN/WCSN on the ward reduces the risk of patient errors.

    Write here _____

21. If you make a patient error who would be the person you would inform? Rank the following people in order of preference where 1 is the most likely person you would inform and 8 would be the least likely person you would inform. Drag the item on the left up or down to rank from 1 – 8.

    1. Preceptor

    2. Graduate Programme Coordinator

    3. Clinical Nurse Manager

    4. Team nursing member

5. Coordinator of the shift

6. SDN

7. Patient

8. Doctor

22. If you make a patient error and feel stressed, who would you go to and discuss the incident with? Rank the following people in order of preference where 1 is the most likely person you would discuss the incident with and 10 would be the least likely person you would discuss the incident with. Drag the item on the left up or down to rank from 1 - 10.

1. Clinical Nurse Manager

2. Team nursing member

3. Coordinator of the shift

4. SDN

5. Preceptor

6. Graduate Programme Coordinator

7. Counsellor

8. Pastoral Care

9. HR

10. Other, please specify _____

23. To what extent do you agree that the SDN/WCSN needs to have leadership qualities to be able to help other nurses give safe and quality patient care?

Strongly agree, Agree, Neither Agree nor Disagree, Disagree, Strongly disagree

24/25. Please put a tick ✓ next to the qualities/characteristics listed below that you would MOST identify with the SDN clinical leadership and a × next to the qualities/characteristics you would LEAST identify with the SDN/WCSN clinical leadership. Consider each quality/characteristic carefully and, if you can't decide, leave the space blank.

The SDN/WCSN					
Copes well with change		Is a motivator		Deals with routine	
Sets direction (planning)		Is controlling		Is consistent	
Considers relationships valuable		Has management experience		Copes well with complexity	

Is flexible		Is a teacher		Is visible in practice	
Is a guide		Is a mentor		Is a visionary	
Sets goals and targets		Is a negotiator		Directs and helps people	
Has integrity and is honest		Is responsible for others' duty/ responsibilities		Deals with reward/ punishment	
Is inspirational		Takes calculated risks		Aligns people	
Is a critical thinker		Is a regulator		Counts on trust	
Is creative/ innovative		Is analytical		Deals with resources allocation	
Is clinically competent		Is an administrator		Maintains relationships	
Is artistic/ imaginative		Is conservative		Inspires confidence	
Is supportive		Is an advocate		Is articulate	
Is a change agent		Is approachable		Is just/fair	
Can be a decision maker		Is a coach		Manages staff	
Has a healthy sense of humour		Is caring/ compassionate		Is an effective communicator	
Evaluates the performance of staff		Is a role model for others in practice		Resolves conflict	
Works alone		Must have relevant postgraduate training		Is courageous	

26. Are there any other qualities or characteristics that are not on the list above that you would identify with the SDN clinical leadership in your GRN role?

   Write here_____

27. Does the SDN/WCSN share their values, beliefs and principles with you?

   Never, Rarely, Sometimes, Most of the time, Always

28. Does the SDN/WCSN encourage positive cultural change in your ward area?

   Never, Rarely, Sometimes, Most of the time, Always

29. Does the SDN/WCSN promote themselves as a leader in your ward?

   Never, Rarely, Sometimes, Most of the time, Always

30. Is the SDN/WCSN guided by concern and compassion?

   Never, Rarely, Sometimes, Most of the time, Always

31. Do you think your SDN/WCSN has an influential leadership role in the ward?

Never, Rarely, Sometimes, Most of the time, Always

32.   Do you think your SDN/WCSN has an influential leadership role in the hospital?

Never, Rarely, Sometimes, Most of the time, Always

33.   Please feel free to add any other comments related to your experience and understanding of the SDN/WCSN role in the GRN program and on the ward.

Write here.

_____

_____

_____

Thank you for your consideration and participation in this survey. Are you interested in participating in an interview where you can have the opportunity to share one to one with the researcher about the SDN/WCSN role? The anticipated interview time is from 30 minutes to 1 hour at your convenience. If you are interested please choose yes and you will be directed to contact information.

Appendix E: Email Invitation to Interview Participants

Interview Information Email for Participants

Dear Participant,

You are invited to participate in the research project titled:

The impact of the supernumerary staff development nurse on patient outcomes specifically related to graduate nurses.

Researcher

My name is Tracey Coventry and I am a Registered Nurse conducting this project as part of the requirements for the award of PhD at Edith Cowan University (ECU). My supervisors are Dr Gilly Smith and Dr Debra Sundin from the School of Nursing and Midwifery at ECU.

What is the project about?

The aim of my project is to investigate if the supernumerary staff development nurse (SDN) on the ward has a positive effect on the patient outcomes of newly qualified graduate registered nurses (GRNs). The project will look at the perspectives of the GRN, SDN and CNM on the SDN role related to GRN patient outcomes.

The goal is to show how the supernumerary SDN supports nurses in the clinical environment to maintain patient safety by developing skills and competencies; promoting critical thinking and reflective practice; and furthering education on disease processes, new products and technology. The GRN group has been chosen because the SDN is involved in many aspects of the new graduate nurses' development and adjustment to the clinical environment. The results will have significance for the development of the SDN role in the clinical environment and for the progression and delivery of safe healthcare to patients.

Why have I been asked to be involved in this project?

You have been invited to participate in this project because you are a GRN and have recently completed a graduate nurse programme and provide patient care for inpatients in an acute care setting, or you are an SDN or CNM working in the acute care setting.

If you decide to participate, you will be interviewed at a time and location convenient to you.

The interview will be recorded and will focus on your thoughts and views on the SDN role and GRN patient care. When the findings of this project are being collated, you may be contacted and invited to review and comment on the transcriptions.

Do I have to participate in this study?

Your participation is voluntary and, if you decide to take part, you may stop at any time without explanation or penalty.

Are there any risks associated with participating in this project?

You may find that being interviewed is an uncomfortable experience and you may feel some concern when reliving or retelling incidents that have occurred on the wards. Professional, confidential and free counselling is available to you through the Employee Assistance Program should you wish further discussion and support.

At any time, you may terminate, suspend or postpose the interview, at which time the recorder will be turned off and the interview stopped immediately. You can then choose to restart or abandon the interview. The recording of the interview will be erased if you choose to withdraw from the project.

What are the benefits of being part of this project?

Your involvement in this project is an opportunity to share experiences of the GRN graduate year and the supernumerary SDN role in relation to patient care. You will also help to increase the understanding related to positive patient outcomes and the effect of the supernumerary SDN role on patient safety and quality of care in the acute hospital environment.

What are the costs to me?

There are no costs to you in participating in this project.

Will my part in this project be kept confidential?

All information collected for this project will be kept private and confidential. The information will be de-identified and stored securely and will only be available to the authorised persons, such as the researcher, supervisors, transcriber and an independent reviewer, who will maintain the confidentiality of participants and their information. The audio tapes will be destroyed following transcription. The project records will be kept by the researcher in a secure computer database and locked archive for a period of five years, after which they may be disposed confidentially.

The results of this project are expected to be published in peer-reviewed journals. The journal articles and any conference papers can be made available to participants when they become available. There may be some feedback on the findings given to the hospitals involved in the project.

In accordance with the relevant Australian privacy legislation, you have the right to request access to the information about you or any information with which you do not agree to be correct.

What do I do next if I wish to be part of the project?

If you are interested in participating in the interviews, please contact Tracey Coventry through email at tcovent2@our.ecu.edu.au or by phone on 0423 122 582, and an appointment will be made for the interview at your convenience.

Who do I contact if I have questions about the project?

If you have any questions or require any further information about the research project, please contact Tracey Coventry on 0423 122 582 or tcovent2@our.ecu.edu.au.

If you prefer, you may contact my supervisors at the School of Nursing and Midwifery ECU: Dr Gilly Smith, Senior Lecturer, on 6304 3490 and Dr Deborah Sundin, Senior Lecturer, on 6304 3488.

This project has been approved by the ECU Human Research Ethics Committee. If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

> Research Ethics Officer
>
> Edith Cowan University
>
> 270 Joondalup Drive
>
> JOONDALUP WA 6027
>
> Phone: (08) 6304 2170
>
> Email: research.ethics@ecu.edu.au

The ethical aspects of this study have been approved by the Joondalup Health Campus (JHC), Peel Health Campus and Hollywood Private Hospital Human Research Ethics Committee. If you have any complaints or reservations about any ethical aspect of your participation in this research, you may contact the JHC Committee through the Executive Office—phone 9400 9404.

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

Yours sincerely,

Tracey Coventry

Interview Topic Guide

Graduate Registered Nurse/Clinical Nurse Educator/Clinical Nurse Manager

GRN   **CNE**   **CNM**   **Date:**

Introduction Welcome to this study and thanks for agreeing to participate.

Information	Agreement	Comments
Study information sheet read and understood (copies available)		
Voice recording explained and explanation of purpose and process of member checking interview transcript		
Ensure understanding of research, participant involvement and answer any questions		
Give overview of process to maintain anonymity		
How to withdraw if necessary		
Consent to participation given verbally		
Explanation of Research/CPD points		

Demographic information

How long have you been a registered nurse (years/months)?

How long have you been a GRN/CNE/CNM (years/months)?

What is your specialty in nursing?

Do you have any postgraduate qualifications?

GRN/CNE/CNM—How many hours per fortnight do you work in your role?

CNE—How many hours per fortnight week do you work in a non-CNE role?

Questions

1. What do you think about the role of the supernumerary CNE on the ward? **Can you elaborate?**

2. How do you think the supernumerary CNEs help the GRNs with patient care in your ward? **Do you have any examples that you can share?**

3. Do you think the GRNs need a supernumerary CNE for support with patient care during their first year? **Can you give some examples?**

4. Do you think the GRNs miss the supernumerary CNE when they are not available on the wards? **Can you share any examples of times when the CNEs were wanted by the GRN, but not available?**

5. Do you think you influence in any way the safety and quality of care the GRNs give to their patients? **Can you elaborate?**

6. If the CNE is on the ward, does the GRN ask for help with the decision-making process related to areas of potential patient errors? **For example, administering medication?**

7. If the CNE is not on the ward, who does the GRN go to for help? **Can you share some examples of any patient errors that the CNE might have helped prevent?**

8. If the GRN does makes an error with patient care (e.g. medication, documentation), who do you think the GRN informs and why?

9. Do you think that GRNs' patient errors are always reported through the RiskMan system? **Can you tell me why you think this?**

10. In what way, if any, does the GRN see the supernumerary CNE as a leader in the ward? **Can you give me an example?**

11. Do you think the CNEs see themselves as leaders in the ward? **Can you elaborate?**

12. Do you think that leadership is part of the CNE role? **Can you tell me why?**

13. What do you think prevents the supernumerary CNE from fulfilling their role on the ward? **Can you give some examples?**

Appendix G: HREC Approval University

Dear Tracey

Project Number: 11766 COVENTRY

Project Name: The impact of the supernumerary staff development nurse on patient outcomes specifically related to graduate nurses.

Student Number: 10171434

The ECU Human Research Ethics Committee (HREC) has reviewed your application and has granted ethics approval for your research project. In granting approval, the HREC has determined that the research project meets the requirements of the *National Statement on Ethical Conduct in Human Research*.

The approval period is from 25 September 2014 to 1 October 2017.

The Research Assessments Team has been informed and they will issue formal notification of approval. Please note that the submission and approval of your research proposal is a separate process to obtaining ethics approval and that no recruitment of participants and/or data collection can commence until formal notification of both ethics approval and approval of your research proposal has been received.

All research projects are approved subject to general conditions of approval. Please see the attached document for details of these conditions, which include monitoring requirements, changes to the project and extension of ethics approval.

Please feel free to contact me if you require any further information.

Regards

Kim

Kim Gifkins, Research Ethics Officer, Office of Research & Innovation, Edith Cowan University, 270 Joondalup Drive, Joondalup, WA 6027

Email: **research.ethics@ecu.edu.au** Tel: +61 08 6304 2170 **|** Fax: +61 08 6304 5044 **|** CRICOS IPC 00279B

Appendix H: HREC Approvals from Participating Hospitals

Note: HREC approval for JHC includes PHC.

JOONDALUP
HEALTH CAMPUS

2 October 2014

Joondalup Hospital Pty Ltd trading as
Joondalup Health Campus
ABN 61 106 723 193
Cnr Grand Blvd & Shenton Ave
Joondalup WA 6027
PO Box 242
Joondalup WA 6919
Telephone: 08 9400 9400
Facsimile: 08 9400 9054
Web: www.ramsayhealth.com.au

Mrs Tracey Coventry
20 Drayton Green Way
KINGSLEY   WA   6026

Dear Mrs Coventry *Tracey*

RE: The impact of the supernumerary staff development nurse on patient outcomes specifically related to graduate nurses (1436)

The Human Research Ethics Committee of Joondalup Health Campus is pleased to notify you that your proposal to undertake research on this campus has been approved, including endorsement from the Hospital Executive. As the Committee is bound by NHMRC Guidelines, the following conditions apply:

- That the Committee be notified immediately of any substantial changes in the design, methodology, time line or intended subjects of the project,

- That the Committee be notified immediately of any unforeseen complications of the project,

- That the Committee be notified if the project does not commence within six months of approval,

- That the Committee receive annual/final reports on the study (you will receive a pro forma from the Committee in twelve months), and

- That the Committee be informed of any other matters which arise during the course of the project which may have ethical implications.

Your approval is initially for four years; after this period you may be asked to re-apply. You are also required to notify the Committee promptly of any changes in your contact details.

Our best wishes for a successful implementation of your research project.

Yours sincerely

Ann Y Hammer
Executive Officer, JHC HREC

ec   Drs G Smith/D Sundin, ECU

Tracey Coventry
Edith Cowan University
20 Drayton Green Way
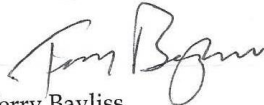Kingsley WA 6026

18th December 2014

Dear Tracey,

HPH400: The impact of the supernumerary staff development nurse on patient outcomes specifically related to graduate nurses.

The above study was reviewed at the Hollywood Private Hospital Research Ethics Committee (HPHREC) meeting held on Tuesday 2 December 2014. The REC approved this study in full. No clarifications/amendments are required.

Your application and documents have been sent to RHC legal counsel for approval. This is a requirement as part of our research governance procedure. Once we have received a reply from RHC legal counsel a final ethics approval letter will then be sent to you.

If you have any queries, please don't hesitate to contact me.

Kind regards,

Terry Bayliss
Chair
Hollywood Private Hospital Research Ethics Committee

cc: Dr Gilly Smith – *g.smith@ecu.edu.au*
    Dr Deb Sundin – *d.sundin@ecu.edu.au*

RAMSAY
HEALTH CARE

Appendix I: PhD Candidature Acceptance Letter from University

Note: I began my PhD journey at Edith Cowan University, where I had candidature in the Master of Research (Nursing) and was working towards upgrading to a PhD. Unfortunately, during this period, two of my principal supervisors left university employment and did not have adjunct status. The subsequent allocations of supervisors were not specialists in my field. After consideration and discussion with colleagues, I had the opportunity to move to the University of Notre Dame Australia, under the supervision of supervisors with the requisite knowledge and experience. I am grateful for all the help and support from both university supervisors, without whom I would not have completed this thesis.

THE UNIVERSITY OF
NOTRE DAME
AUSTRALIA

CELEBRATING
25 YEARS
1989 - 2014

19 Mouat St (PO Box 1225) Fremantle WA 6959
+61 8 **9433 0555** | enquiries@nd.edu.au

22 December 2015

Tracey Coventry
20 Drayton Green Way
KINGSLEY 6026

Dear Tracey,

I am pleased to advise you that your application to enrol in the Doctor of Philosophy degree at the University of Notre Dame Australia has been approved.

Your course code is 6800; your discipline code is 060399 within the School of Nursing & Midwifery, Fremantle Campus. Your Principal Supervisor will be Dr Kylie Russell and Co-Supervisor will be Dr Caroline Bulsara from the School of Nursing & Midwifery. Your registered enrolment load for Semester 1, 2016 will be 0.5 load (part-time). The course regulations for the Doctor of Philosophy degree are enclosed for your information.

I can advise that in 2016 the University is able to meet the tuition fees of higher degree by research students under the guidelines of the Commonwealth Research Training Scheme (RTS). The situation in relation to fees is reviewed annually, as research income is determined each year by Department of Education. Thus, the University cannot guarantee fee exemption for the duration of the degree.

I can also confirm that as of the 21st of December, 2015 you have consumed 620 days of your RTS allocation. This equates, at a part-time (0.5) load, to an expected thesis submission date of the 27th of July, 2018.

To confirm your place in the course, please complete the enclosed coloured copy of the acceptance and enrolment form and return both forms to the Research Office, University of Notre Dame Australia, PO Box 1225, Fremantle WA 6959. If you do not accept this offer within 14 days of the date of this letter, this offer will lapse.

I hope that your time with Notre Dame will be challenging and enjoyable. Please feel free to contact the Research Office on 9433 0943 or by email to research@nd.edu.au if you require any assistance.

Yours sincerely,

Professor Peta Sanderson
Pro Vice Chancellor International and Research

cc. Prof Elaine Pavlos, Dean, School of Nursing & Midwifery
     Dr Kylie Russell, Principal Supervisor
     Dr Caroline Bulsara, Co-Supervisor
     Anita Zele, Senior Administrative Officer, School of Health Sciences
     Dr Kate Howell, HDR Education Coordinator, Research Office
     Lorraine Mayhew, Senior Administrative Officer, Research Office
     Admissions

Enc: Acceptance form: Research Degree
      Unit enrolment form
      Doctor of Philosophy course regulations

Broome Campus 88 Guy St (PO Box 2287) Broome WA 6725
Sydney Campus 140 Broadway (PO Box 944) NSW 2007

Fremantle Broome Sydney

ABN 69 330 643 210 | CRICOS Provider Code: 01032F

nd.edu.au

Appendix J: Conference Presentations of Study

University of Notre Dame Australia, Institute for Health Research, Health Research Symposium, 8 December 2017:

- Presentation—The impact of the supernumerary clinical nurse educator role on advancing the graduate nurse's quality of patient care: A mixed method study within a private Western Australian health service.

Accepted submissions to the Australian and New Zealand Association for Health Professional Educators Conference, Adelaide South Australia 11 to 14 July 2017:

- The clinical nurse educator—A congruent clinical leader
- Clinical nurse educator role and leadership influence on the graduate registered nurse's transition to practice.

Accepted submissions to the Sigma Theta Tau International 44th Biennial Convention, Indianapolis, USA 28 October to 1 November 2017:

- The impact of the supernumerary clinical nurse educator on graduate nurse patient outcomes
- The influence of clinical nurse educator leadership on graduate registered nurses' first year of nursing.

Accepted submissions to the Nursing and Midwifery Leadership Conference 2017, Perth Western Australia, 30 November to 1 December 2017:

- Clinical Nurse Educators and optimising as leadership process
- The influence of clinical nurse educator role on advancing graduate registered nurses' quality of care.