BEST PRACTICE GUIDELINE FOR THE TRANSITION OF FINAL YEAR
NURSING STUDENTS TO PROFESSIONAL NURSES IN THE MILITARY HEALTH
SERVICE IN SOUTH AFRICA

by

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DECLARATION

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DECLARATION:

In accordance with Rule G4.6.3, I hereby declare that the above-mentioned treatise/dissertation/thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

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DATE: 05 January 2015
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I would like to thank God the Almighty for anchoring me throughout this trying time.

To my husband Xoli, thank you for being my pillar of strength. You are the best.

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ABSTRACT

The transition period from student nurses to professional nurses has been acknowledged as being very stressful, particularly in the military health service due to the dual transition. The phase is marked as final year nursing students try to consolidate the experience and knowledge gained during their four year training period with clinical decision making and problem solving skills being applied in the work environment. The students require support and guidance to effect a successful transition from being a student to being a professional nurse. The transition of students in the military health setting might be experienced differently due to the context that is vastly different from the other health care settings (Moore, 2006:541).

The aim of the research was to explore the experiences of role transition of final year nursing students, particularly their preparedness to take up the role of a professional nurse in the military health setting in order to assist managers and educators to support and facilitate this professional adjustment appropriately. A qualitative, descriptive, contextual design was employed for the study and followed a three-phase approach. Phase one comprised a qualitative approach, where semi-structured and focus group interviews were conducted to gather the data. Nurse managers, nurse educators, final year nursing students and novice professional nurses formed part of the population for the study. Creswell’s method of data analysis was employed in analysing the data. The second phase dealt with the integrative review of literature on the transition of final year nursing students into professional nurses. Data extracted from the guidelines formed themes that were triangulated to form phase three of the study. Lastly, a best practice guideline was developed to facilitate the transition period of final year nursing students to professional nurses.

Principles of trustworthiness were adhered to, participants were treated in a fair manner and confidential information was not divulged without the consent of the participants. Participants were asked to take part voluntarily and without coercion. Ethical approval was requested to give consent for the study to be undertaken and
ethical principles were adhered to throughout the study. Findings were then disseminated after the conclusion of the study.

Key words: Transition; student nurse; professional nurse; military health service; best practice guideline
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CHAPTER 1

OVERVIEW OF THE STUDY

Chapter 1 serves as a prelude for the study where literature pertaining to the transition of nursing students to professional nurses is thoroughly discussed. The outline of the problem that led to the realization of the study is also deliberated upon. A brief introduction to the research methodology is given. Elements of trustworthiness were also highlighted.

1.1 INTRODUCTION

Holt (2008:118), Lofmark, Smide and Wikblad (2006:722) tried to ascertain whether the transition period from a student to a professional nurse is a successful one. The transition was intricate as the students did not possess the full range of necessary skills to allow them complete autonomy. According to Goh and Watt (2003:14), Kilstoff and Rochester (2004:13), Broad, Walker, Boden and Barnes (2011:1299), the period of transition from student to professional nurse can be quite an achievement but also a daunting period. It is therefore imperative that education and practice collaborate in designing and implementing programmes to foster the successful transition from student nurse to professional nurse.

Wieland, Altmiller and Wolf (2007:316) view the clinical transition of nursing students as a rite of passage consisting of three phases: the separation phase, transition and the incorporation phase. The separation phase is characterised by parting from a student to being a mature clinical practitioner, while transition is movement into the new roles and responsibilities. Incorporation relates to assimilation into the field of experts with knowledge and skills. Hayman-White, Hapell, Charleston and Ryan (2007:186) define transition as a period of learning and adjustment to the requirements of nursing in which the graduate acquires the skills, knowledge and values to take up the role of becoming an efficient member of the nursing staff.

Patricia Benner’s model (1984:21-27), from novice to expert, provides a theory of skill acquisition to examine the transition of a novice nurse, who offers task-oriented nursing care, to the expert nurse who is competent in providing high quality care. Benner (1984:21-27) highlights the five phases in the development of expertise in
nursing practice: Novice, advanced beginner, competent, proficient and expert. The novice is task-oriented, rule-governed and focused on goal attainment. Over time, the novice acquires the characteristics of the advanced beginner, including the ability to formulate and act on principles. With more experience she becomes increasingly skilled and demonstrates proficiency, autonomy and competency that finally depict expert practice. The student nurse moves from being reliant on abstract principles to the use of concrete experience as a professional nurse. These abstract principles are refined and expanded by experience as the student gains clinical expertise.

According to Carlson, Kotze and Van Rooyen (2005:45), clinical expertise is revealed in the concept of self-management, which is illuminated as a student being aware of her own responsibilities and accountability for the actions taken in a particular situation. The expertise becomes evident as the student reaches independence in practice. During the period of socialization, the student attains expertise in the new profession and particularly in the new organization which enhances the adaptation process (Chen, 2005:110; Newton and McKenna, 2007:1233). In the event that transition did not take effect successfully, student nurses present with role performance stress, discouragement and disillusionment during the initial months of their introduction to the profession (Duscher, 2008:448; Chang and Hancock 2003:156; Ross and Clifford, 2002:545).

Duscher (2001:427) and O'Shea and Kelly (2007:1534) assert that this role performance stress and anxiety is primarily related to the multi-dimensional responsibilities associated with the new role and the lack of preparedness for the role (Le Maistre and Pare, 2004:44; Solowiej, Upton and Upton, 2010:494). Leong and Crossman (2009:29) pronounce that student nurses during training have minimal clinical responsibilities, hence qualifying as a professional nurse requires major role changes and adjustment, which culminates in transition shock.

The term transition shock emanates from “Reality shock” which was first reported by Kramer (1974), and defines it as “the reactions of new workers when they find themselves in a work situation for which they have spent several years preparing, for which they thought they were going to be prepared, and then suddenly find they are not”. Newton, Cross, White, Ockerby and Billet (2011:120) cites this lack of preparedness as contributing to the high attrition rate amongst newly qualified
professional nurses (Lauder, Watson and Topping, 2008:1860). According to Burns (2009:20), newly qualified nurses find the move to professional nurse difficult, unless they have been adequately prepared to transfer the knowledge gained during training to the clinical area. Holton, Bates, Bookter and Yamkevenko (2007:389) relate to the transfer of learning to the work environment by explicating that the student should be in a position to generalise the concepts learned during training and apply them to the real-life work situations, beyond the training period.

According to Mooney (2007:1611), the clinical learning area should be a powerful catalyst that influences students’ learning and should prepare them for the transition to becoming professional nurses. However, studies attest to nurses feeling inadequately prepared for the responsibilities and the role of a professional nurse and therefore not fit or competent for practice. Goodwin-Esola, Deely and Powell (2009:412) posit that the new graduate needs more time and transition resources to meet the expectations of the new role of a professional nurse. Cowin and Hangstberger-Sims (2005:57) share the same sentiments as they caution that it is unrealistic to expect a new graduate to demonstrate complete competency as it takes six months or longer to adapt to clinical practice, develop competencies and begin to apply independently what was learned throughout training.

Transition periods are extremely challenging for the nursing students in the military health service as they have to be military trained to ensure combat readiness as well as adhere to nursing practice demands to take up the new role of being a nursing officer in the South African Military Health Services (SAMHS). Firstly, students in the military are training under the rank of candidate officers (CO) in preparation for becoming officers. Before commencement of the four year nursing training, student nurses are required to undergo military training for six months, termed the officer’s forming course, and to execute this training throughout the four years as soldiers and nurses. During this time they are taught about basic military training, combat readiness, the military officer’s roles and military procedures and protocols. The military training teaches them how to be soldiers in addition to being professionals, whereas the nursing training prepares them solely to be professional nurses.

Secondly, students are trained as nurses predominantly in the public health setting to boost exposure as there are few speciality wards in the military hospitals.
Students are allocated to the public hospitals for Psychiatric, Midwifery and Community nursing to meet the demands and objectives of the students’ learning programme as these units are not available in the military. Adjustment to the two environments, namely the military health service and the public health care environments, and the dichotomy in the roles is what characterises the military nurse’s transition as unique and distinctive. The dichotomy arises in the sense that they could be called on to fulfil the roles of being nursing officers having to care for patients in the clinical or field setting and being deployed as platoon commanders in charge of the troops on the battle field. The military, though, does not have programmes or guidelines in place to ease this challenging transition period from nursing student into the challenging role of being a professional nurse and officer. Students are however expected to be competent after qualifying to render services in the military setting.

It is alleged by Hillman and Foster (2011:51) that additional clinical competencies and skills beyond those obtained during training are needed for a new graduate to successfully transition to the professional nurse’s role. One of the competencies required according to Burns and Poster (2008:68) is critical thinking. According to Tanner (2005:46), the nurse needs skills and performance in differentiating and identifying patient problems, applying corrective measures in a timely manner and relaying the needed information to the physician concerned.

Melrose and Gordon (2008:3) state that competencies related to leadership, research utilization and resource management need to be demonstrated by professional nurses. These functions are over and above the expected roles of nurses such as clinical practice, decision making and critical thinking. According to Benner, Hooper-Kyriakidis and Stannard (1999:17), nursing practice needs good clinical judgement whereas developing expertise in nursing practice requires experiential learning and thinking-in-action.

On qualifying from the four year diploma programme, student nurses are expected to demonstrate a high degree of knowledge, understanding and skill implementation related to patient care and ward management. Burton and Ormrod (2008:2) presuppose that these skills should have been acquired during the training period to render the new graduates competent. Clarke and Homes (2007:1) contest that
though newly qualified nurses are expected to be competent and able to practice independently without direct supervision the reality is that, for most, their training has not equipped them with the knowledge, skills or confidence necessary for independent practice.

Frenk, Chen, Bhutta, Cohen, Crisp, Evans, Fineberg, Garcia, Ke, Kelly, Kistnasamy, Meleis, Naylor, Pablos-Mendez, Reddy, Scrimshaw, Sepulveda, Serwadda and Zurayk (2010:1923) allege that professional education is not keeping abreast with the new developments and challenges, citing outdated and static curricula as a reason for the production of ill-equipped graduates. Cross (2009: 55) alludes to the fact that student nurses post-qualification are not work ready. The interpretation being that these nurses are unable to meet the demands of the workplace and to “hit the ground running”. Novice professional nurses are expected to perform equally to their experienced counterparts and be experts instantaneously after they qualify, while simultaneously learning the policies and protocols of the organization (Axford, 2005:89).

Spoelstra and Robbins (2010:1) suggest that transition should be initiated within the six months prior to qualification, as this will foster a foundation for awareness and expectations. The authors further elucidate that the learning environments that support critical thinking and amalgamation of information with a learner-centred approach are known to facilitate role transition. These are basically the environments that are learner-oriented and not task-oriented and can be advanced through the use of preceptorship and mentorship programmes.

There is a plethora of literature attesting to the diverse strategies available to enhance the transition of final year nursing students to professional nurses including transition programmes (Rapley, Nathan and Davidson (2006:363); Lea (2013:56); Edwards, Hawker, Rees and Bennet (2009:2)) and preceptorship programmes (Jebb (2008:28); Livsey (2009:3)). Numerous studies support preceptorship and mentorship programmes for the successful transition of newly qualified nurses, and models to this effect have been developed to expressly support the transition of final year nursing students into the workplace. The preceptorship and mentorship programmes focus more on the issue of retention of newly qualified professional nurses in the workplace (Almada, Carafoli, Flattery, French and McNamara,
2004:268; Nash, Lemcke and Sacre, 2009:50; Van Eps, Cooke, Creedy and Walker 2006:520). Strauss (2009:217) suggested a classroom component to support role development of the newly qualified nurse. These authors reported that this classroom component proved to be beneficial as time is allotted during every class session of orientation for giving and receiving peer support for newly qualified nurses. Levett-Jones and Fitzgerald (2005:40) argue that the effectiveness of programmes designed to ease the transition period can enhance retention in the profession if used successfully.

Transition programmes are aimed at: developing competent and confident registered nurses, facilitating professional adjustment and developing a commitment to a career in nursing. McDonald (2007:253) alludes to the fact that in reality the classroom, laboratory and clinical experiences should be integrated, not only to provide the student with realistic opportunities but also to better develop novice nurse practitioners.

In a study done by Frotjold, Hardy and Butler (2007:9), final year nursing students were taken for short visits to their departments of choice. The goal was to prepare them prior to commencement of their duties as professional nurses by exposing them to a setting similar to the real clinical setting. Ramsey, Merriman, Blowers, Grooms and Sullivan (2004:32) suggested designing regular seminars for students and professionals to enhance the transition role from student to professional nurse.

Clare, Brown, Edwards and Van Loon (2003:26) advocate that the transition of student nurses to professional nurses should include a dedicated learning environment and the use of preceptors and mentors while Mannix, Wilkes and Luck (2009:62) propose that, for the employer to receive a newly-qualified nurse who can “hit the ground running”, a collective effort from all stakeholders should ensue. Not only should the education institutions be preparing the students for the new role by ensuring competency, but clinical areas and the health professionals should also buy into the idea of facilitating a smooth transition (Hollywood, 2011:661). The military, because of its uniqueness and the dual roles played by the students, requires specially designed guidelines to manage the two transitional processes for students, namely the professional transition and the officer’s transition.
Cleary, Matheson and Happell (2008:845) affirm that a positive transition experience leads to opportunities for nurses to exercise autonomy and control over their professional practice. Subsequently, quality transitional programmes may encourage nurses’ preparedness and motivation to remain in the profession (West, 2004:346).

This study is about developing a guideline that will facilitate the transition of final year nursing students to professional nurses in the South African Military Health Service.

1.2 PROBLEM STATEMENT

The problem to be addressed in this study is linked to how well prepared the final year nursing students are to take up the role of being professional nurses in the South African Military Health Services (SAMHS). Student nurses should be adequately prepared for the assumption of the professional nurses’ roles after completion of their training. Preparation for a successful transition from student nurse to professional nurse should have been accomplished during the four year training period. However this is not always the case.

Final year nursing students alluded to the fact that they felt unprepared for the role of the professional nurse citing their inadequate clinical skills. Novice professional nurses on the other hand, were observed not to have adequate clinical skills, particularly psychomotor skills, where they will be unable to insert an intravenous infusion successfully without supervision. Delegation skills and planning of the daily roster was a challenge. Unit managers mentioned the lack of their ability to take decisions on behalf of the patient. Their level of functioning was likened to that of a first year student nurse by unit managers as the novice professional nurses could not even conduct the doctors’ rounds. Nurse educators concurred that the preparation, particularly clinically, was inadequate due to scarce clinical placement areas in the military health service.

Currently the military health service does not have guidelines or programmes for transitioning final year student nurses into practice. The military needs contextualized guidelines for the military to address its unique challenges. Based on the researcher’s observations as well as the discussion with relevant stakeholders,
novice professional nurses in the military health service are not sufficiently prepared for the role of professional nurse.

The relevance of the need to explore the preparedness of the role transition of final year nursing students to professional nurse in the SAMHS has therefore been identified. It is evident that the development of a best practice guideline to facilitate the transitioning from student nurse to professional nurse is needed in the Military Health Service to assist nurse educators and nurse managers to prepare student nurses adequately to take on the role of professional nurses. The question would therefore be, how prepared are the final year nursing students to take up the role of being professional nurses in the SAMHS and how can this process be facilitated?

1.3 PURPOSE AND OBJECTIVES

The purpose of the study is to:

Explore and describe the experiences of health practitioners regarding the role transition of final year nursing students, in order to develop a best practice guideline to facilitate a successful transition period from student nurse to professional nurse.

The objectives of the study are to:

- Explore and describe the experiences of final year nursing students, novice professional nurses, unit managers and nurse educators with regard to the transition of final year nursing students into professional nurses.
- Explore and describe the literature with regard to the transition of final year nursing students into the professional nurses.
- Develop a best practice guideline to facilitate the transition of final year nursing students to professional nurses in SAMHS.
1.4 THEORETICAL FRAMEWORK

A theoretical framework consists of concepts, together with their definitions, and existing theory/theories that are used for the particular study. The theoretical framework must demonstrate an understanding of theories and concepts that are relevant to the topic of the research paper and that will relate it to the broader fields of knowledge in the class one is taking (Swanson, 2013:114)

The theoretical framework strengthens the study in the following ways.

1. An explicit statement of theoretical assumptions permits the reader to evaluate them critically.
2. The theoretical framework connects the researcher to existing knowledge. Guided by a relevant theory, you are given a basis for your hypotheses and choice of research methods.
3. Articulating the theoretical assumptions of a research study forces the researcher to address questions of “why” and “how”. It permits a researcher to move from simply describing an observed phenomenon to generalising about various aspects of that phenomenon.
4. Having a theory helps one to identify the limits to those generalizations. A theoretical framework specifies which key variables influence a phenomenon of interest. It alerts the researcher to examine how those key variables might differ and under what circumstances.

To give a more detailed illumination of the study, Meleis’ Situation-specific theory will be used as it is deemed the most appropriate to channel the study. Meleis, (2007:420) states that unhealthy or ineffective transitions might lead to role insufficiency for the newly-qualified professional nurses. She describes role insufficiency as any difficulty in the cognizance and/or performance of a role. It is alleged that the goal of a healthy transition is competency and the achievement of mastery associated with new roles, through a non-problematic process. The author in this theory offers a corrective focus that can enrich our understanding of development, formation as well as stressful responses to both predictable and unpredictable changes in human life. The theory is applied particularly in this study for the development of best practice guidelines to help final year student nurses
come to terms with new situations, demands, the use of acquired knowledge and skills leading to competency in their new roles as professional nurses.

Meleis (2007:420) suggests that the properties of transition experience include:

a) Awareness: The awareness is defined as perception, knowledge and recognition of a transition experience. The nursing students have perceptions and knowledge about the challenges inherent in the transition process. The awareness is reflected in the degree of congruency between what they have observed happening and what they anticipate.

b) Engagement: Engagement refers to the degree to which a person demonstrates involvement in the process inherent in the transition. The nursing students have to be involved in the transition period as they need this period to be as stress free and successful as practicable.

c) Changes and differences are a property of transitions. Changes related to identities, roles, relationships, abilities and patterns of behaviour. Students are changing from the identity of being students to that of becoming a professional nurse. The roles are changing to assuming more responsibility and gaining the ability and the competency to view the world and the profession in a different light.

d) Time span: Transition is viewed as a span of time with an identifiable starting point to an ending with a new beginning or a period of stability. The preparation of final year nursing students for transition to professional nurse status has to commence at a certain point and where it ends has to signify a new beginning for the new professional nurse. The end of the transition period has to denote a prelude of stability.

e) Critical points and events: Critical points and events are defined as markers. In this case the markers will be the challenges faced during the transition period, in the form of expectations with regard to role assumption from both the managers and the nursing students. What are the competencies and skills that should have been acquired that are still deficient?

Based on the theory of Meleis, the transition period is characterised by various stages that also relate to the transition of final year nursing students and novice professional nurses in the military health service. Final year nursing students
perceive the challenges they anticipate of becoming professional nurses due to the inadequate preparation received for the role. The time span was delayed as the final year nursing students’ preparation for the role only commences after qualification. As for the novice professional nurses, the expectations from unit managers are that the newly qualified professional nurses should play a more responsible role and should be competent in rendering nursing care.

1.5 DEFINITION OF KEY CONCEPTS

For the purpose of the study the researcher used the following terms as defined below.

1.5.1 Final year nursing student

A final year nursing student is a student nurse in basic training in his or her final year of study in the diploma programme (South African Nursing Council, 1992b 2.9(2). The student nurse needs guidance and support in order to have a successful transition period to becoming a professional nurse in SAMHS. For the purpose of this study, the final year student nurse will mean a person who is undergoing training in preparation to becoming a professional nurse and who is regarded as having accumulated a vast experience in the clinical setting with regard to clinical skills and experience.

1.5.2 Role transition

Hayman-White, et.al. (2007:186) define role transition as a period of learning and adjustment to the requirements of nursing in which the graduate acquires skills, knowledge and values to take up the role of becoming an efficient member of the nursing staff. The transition period should be a period to gently introduce the final year nursing student into the roles of a professional nurse.

1.5.3 Transition to practice

Transition to practice refers to the period when the nurse or midwife enters the practice area for the first time as a qualified professional nurse and commences the new role after completing the training programme (Department of Health and Human Services of Tasmania: 2011:2). The student nurse enters the practice for the first
time as a professional nurse with basic knowledge and skills to take up the role of a professional nurse in practice. Support and guidance is required in order for the new professional nurse to be competent and to reach the level of an expert. The transition of students to professional nurses in practice will be explored in this study.

1.5.4 A best practice guideline

A best practice guideline is a statement that has been empirically proven to yield excellent results to accomplish a stated objective. Thus, deriving a best practice requires studying the work of others and selecting those techniques that are most successful (Tobey, 2012:2). A best practice guideline will be developed to facilitate the transition of final year student nurses to professional nurses in SAMHS.

1.5.5 SAMHS

The South African Military Health Service is the branch of the South African Defence Force responsible for health care delivery, training and deployment of all medical personnel within the force (Defence Act, 42 of 2002). The study will be conducted in the military health service, which is a very specific context.

1.6 RESEARCH DESIGN

The research design guides the researcher in planning and implementing the study in such a way that the projected outcome of the study is achieved (Burns and Grove, 2009:232). A more detailed explanation of the research design will be given in chapter 2.

The study will follow a three-phase approach, of which the first phase will be qualitative, explorative, descriptive and contextual in nature. Phase 2 will concentrate on an integrative literature review on the transition of final year nursing students into professional nurses, and phase 3 will embark on the development of a best practice guideline for the transition of final year nursing students into professional nurses by integrating the data obtained in phases 1 and 2. The detail for each phase will be given in chapter 2.

Qualitative research is based on a particular set of assumptions about how knowledge is produced and the nature of reality itself. It is used to discover and
interpret meanings and perceptions (Burns and Grove, 2009:24). A qualitative design will be appropriate for this study as the researcher needs an understanding of the transition period from student nurse to professional nurse.

1.7 RESEARCH METHOD

Research methods refer to the techniques the researcher uses to organize and structure a study in a systematic manner (Polit and Beck, 2012:120). The research methods that will be applied in this study are described in terms of the population, sampling, data collection, data analysis and the incorporation of literature. The research process will be conducted in three phases as elucidated earlier.

1.7.1 Population

Population is defined by Polit and Beck (2012:126) as the totality of those individuals conforming to a set of specifications. Final year nursing students, novice professional nurses, nurse educators and unit managers will form part of the population.

Sampling involves the selection of participants, events or other elements for the purpose of conducting the study (Burns and Grove, 2009:341) and a sample should closely reflect or represent the population being studied (Katzenellenbogen, Joubert, and Abdool-Karim, 2007:74).

1.7.2 Sampling

A purposive sampling method will be used. According to Brink (2006:132), purposive sampling is also called judgmental sampling as it is based on the judgment of the researcher regarding the participants to be selected who will be representative of the study, or who are knowledgeable about the phenomena to be studied.

1.7.3 Inclusion Criteria

The following represent the inclusion criteria for the participants:

- Student nurses in their final year of study;
- Novice professional nurses;
• All unit managers in the two selected hospitals because of their involvement with students and novice professional nurses;
• All nurse educators in the two military nursing colleges due to their experience in the nursing college.

For the sake of simplicity the groups will be termed as follows:

Group 1: Final year student nurses
Group 2: Novice professional nurses
Group 3: Nurse Educators
Group 4: Unit managers

1.7.4 Data Collection Method

Creswell (2014:189) suggests that the data collection method should best suit the aims and objectives of the researcher; whereas Flick (2006:21) notes that the collection and analysis of data can be performed by a whole range of methods in qualitative research.

The researcher will, however, make use of two methods of data collection during the various stages of the research, namely the focus group method and semi-structured individual interviews. A thorough explanation will be given to the participants with regard to the study. A request will be made to the nursing manager from the clinical areas for permission to access the participants who will be nominated and given a consent form to sign as an indication of voluntary participation in the study (see Annexure E).

1.7.4.1 Focus Groups

The researcher will conduct focus group interviews with the following groups: Groups 1, and 2 comprising final year nursing students and novice professional nurses. There is a desire for ideas to emerge from the different groups. A group possesses the capacity to generate more facts than individuals (Krueger and Casey, 2009:28). A more detailed explanation will be given in chapter 2.
1.7.4.2 Semi-Structured interviews with Unit Managers and Nurse Educators (Groups 3 and 4)

Semi-structured interviews possess high validity as the participants are able to talk about the topic in detail and in depth (Whiting, 2008:37). Semi structured interviews in the form of in-depth individual interviews will be conducted with unit managers and nurse educators. A more detailed explanation of the process will be given in chapter 2.

1.7.5 Data analysis

Data analysis involves reading through the data repeatedly and engaging in activities of breaking the data down and building it up again in novel ways (Terre Blanche, Durrheim and Painter, 2007:322). The data captured on audiotape during the interviews will be transcribed verbatim by the researcher. The transcription process implies converting the audiotape recordings or field notes into text data (Tesch, in Creswell, 2009:233).

1.8 STRATEGIES WITH WHICH TO ESTABLISH TRUSTWORTHINESS

The principles for trustworthiness will be applied as described by Lincoln and Guba (1985:290) and Polit and Beck (2012). Strategies to ensure trustworthiness will be deliberated upon in detail in chapter 2.

1.8.1 Credibility

Credibility refers to the assurance in the truth of the data and the analysis of that data (Polit and Beck, 2012:144). Credibility will be achieved through prolonged engagement, triangulation, and the authority of the researcher.

1.8.2 Dependability

Dependability confirms that the results are consistent and could be trusted as valid (Lincoln and Guba, 1985:290). Dependability will be reached through dense description and stepwise replication.
1.8.3 Confirmability

Confirmability refers to the comparison between at least two researchers regarding the accuracy, significance or meaning of the data. Data findings must describe the participants’ words and the setting of the study and not the researcher’s perceptions (Polit and Beck, 2012:145). Confirmability will be reached through an audit trail and reflexivity. A comprehensive account will be given in chapter 2.

1.8.4 Transferability

According to Lincoln and Guba (1985:290), transferability refers to the extent to which the results can be transferred or applied to other similar contexts or other participants. Transferability will be achieved through dense description.

Dense description: A thorough description of the research methodology will be given in chapter 2 as well as that of the background of the participants and the research context. Dense description will be done to enable interested researchers to make a transfer to other suitable studies (Krefting, 1991:216).

1.9 PHASE 2

According to Boote and Beile (2005:3), a literature review is an evaluative report of studies found in the literature related to the selected area. The review should describe, summarise, evaluate and clarify this literature, nursing science, inform research, practice and policy initiatives. The reasons for conducting the literature review are to explore the best, available evidence that will guide the development of a best practice guideline. A search strategy will be developed as part of the literature review process. A five stage approach towards reviewing literature will be discussed in chapter 2.

The following sites will be visited for review of literature.

- All databases will be searched including electronic, hand searched journals and using the identified keywords to become familiar with the contents in the titles, abstracts and subject descriptors
• The literature will be searched exhaustively and the search process will include articles found in databases, grey literature such as unpublished theses and dissertations related to the transition of student nurses to professional nurses.
• Reference lists and bibliographies of all papers will be searched for additional studies
• Various guidelines and articles on the transition of nursing students to professional nurses will be conducted. A wide variety of electronic databases including Google Scholar, CINHAL via EBSCO host and A-Z will be searched
• Critical appraisal will be done on the literature reviewed to determine the merit and readiness for use in clinical practice.

1.10 PHASE 3

On completion of phases 1 and 2 of the research process, the data from these phases will be synthesized to develop a best practice guideline for the transition of nursing students to professional nurses in the SAMHS. Graham, Harrison and Bouwers (2005:69) provide a 10 step process to guideline development. Not all the steps will be used due to the academic nature of the study. A thorough extrapolation of this 10-step process will be presented in chapter 5 and the rationale for not using steps 2, 6 and 9 will also be provided.

Step 1. Identify a clinical area to promote best practice: A gap in the transition process has been identified and a best practice guideline will be developed to make the transition period successful.

Step 2. Establish an interdisciplinary guideline evaluation group

Step 3. Establish a guideline appraisal process

Step 4. Search for and retrieve clinical guidelines

Step 5. Assess the guidelines

Step 6. Adopt or adapt guidelines for local use/ Develop new guideline

Step 7. Seek external review of the proposed guideline

Step 8. Finalize the guideline
Step 9. Obtain official endorsement and adoption of the guideline by the organization

Step 10. Schedule review and revision of the guideline

Once phases 1 and 2 are done, the best practice guideline will be developed using the relevant steps in the approach as indicated above.

1.11 ETHICAL CONSIDERATIONS

Ethics refers to the adherence to moral principles in the research, such as justice, the rights of the participants together with the rights of others who are in the setting (Burns and Grove, 2009:83). Due to the nature of the research that involves human participants the following ethical principles will be followed:

1.11.1 The right to self-determination

The right to self-determination is based on the principle that the participants are respected at all costs during the conducting of the study. Human beings are autonomous and should control their own lives as they please (Burns and Grove 2009:181). This principle endorses that the participants should be informed of their right to participate in the study and have the right to withdraw at any time of the study should they not feel comfortable to continue. The objectives of the study will be fully explained to the participants and their right to take part or not will also be highlighted. Explanations will be given that at any stage of the research, should they feel uncomfortable and wish to withdraw, they are free to do so.

1.11.2 The right to privacy

The participants have the right to give consent on when, how and under which circumstances the information could be divulged. They have the right to access the information they contributed to at any time of the study (Burns and Grove, 2009:186). The researcher will protect the privacy of the participants with regard to information contributed by them. Taped recordings will be kept locked to keep the information private/confidential and on completion of the study all tapes and information gathered will be destroyed.
1.11.3 The right to anonymity/confidentiality

Complete anonymity takes place where even the researcher will find it difficult to link the information with the participant (Burns and Grove 2009:188). The individual interviewees will enjoy the benefit of complete anonymity, whereas it will be difficult to achieve complete anonymity with the focus group interviews. The researcher will however make it a point that the names of the participants are deleted during analysis of data, consequently making it impossible to link the information to a particular person.

1.11.4 The right to fair treatment

The right to fair treatment is based on the principle of justice. The principle justifies that each individual should not be subjected to bias at any stage during the course of the study (Burns and Grove, 2009:189). All participants will be selected for the reasons directly related to the study and not because they are easily available or could be manipulated. The participants who will be selected for the study will not be selected based on race, social class or culture.

1.11.5 Plagiarism

Plagiarism is the practice of taking someone else’s work or ideas and passing them off as one’s own (Oxford Dictionary, 2007:442). Plagiarism is therefore viewed as an offence by law and is a punishable offence. Every author’s work deserves to be acknowledged as such when used by another person in their dissertation. The researcher will endeavour to recognize the various authors’ work that will be used in the study by appropriate citations.

1.11.6 Permission to conduct the study

Permission to conduct the study will be requested from the Officer Commanding of 3 Military Hospital, 1 Military Hospital, the General Officer Commanding Nursing College, and the Ethics committee of Nelson Mandela Metropolitan University, (see Annexures noted in chapter 2). Participants will be made aware that there would be no monetary benefit accompanying the study. Request for permission to conduct the study will be required and requests for permission and informed consent from the participants will also be sought.
Thorough explanations with regard to the study will be given to the participants. Their voluntary participation will be requested and, on agreeing, an informed consent will be given to them to complete. Further explanations will be given that at any time during the study should they feel uncomfortable, they would be permitted to withdraw without any penalty being imposed on them.

1.12 CHAPTER LAYOUT

The chapters will be outlined in the following sequence:

Chapter 1: Overview of the study

Chapter 2: Research design and method

Chapter 3: Data analysis and discussion of qualitative data

Chapter 4: Integrative literature review report

Chapter 5: Guideline development process

Chapter 6: Draft guideline and report from the expert panel of reviewers

Chapter 7: Conclusions, limitations and recommendations

1.13 CONCLUSION

Chapter 1 highlighted the overview of the study and introduced the reader to the study. The purpose of the study and the objectives thereof were explicitly discussed. Concepts inherent in the study were clearly defined. A preface to the research design to be followed in the study was given. The introduction extrapolated that the transition period for student nurses need not be a stressful period. It should be carefully planned in such a way that it becomes a smooth cross-over from student nurse to professional nurse. Hospital managers, employers and education institutions should collaborate in order to produce a work ready novice professional nurse who can hit the ground running. Roles should be outlined well in advance and strategies be implemented during the training period to meet the expectations of the employers and hospital managers.
CHAPTER 2
RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

Chapter one dealt with the introduction of the study. Chapter 2 will elaborate on the research methodology of the study including the research design, population, sampling, data collection, analysis, measures to ensure trustworthiness and ethical considerations. Research methodology is defined as a systematic way to solve a problem (Rajasekar, Philomenathan and Chinnathambi, 2013:5).

2.2 RESEARCH DESIGN

The research design refers to the overall strategy that was selected to integrate the different components of the study in a coherent and logical manner, thereby ensuring the research problem was effectively addressed; it constitutes the blueprint for the collection, measurement, and analysis of data (Kirshenblatt-Gimblett, 2006:1). The study followed a three-phase approach, of which the first phase was qualitative, explorative, descriptive and contextual in nature. The second phase consisted of an integrative literature review and the third phase comprised the development of a best practice guideline facilitating the transition of final year nursing students to professional nurse status. The first phase of the study will be detailed in the next section.

2.2.1 Qualitative Research

Qualitative research has come to be defined as research whose findings are not arrived at by statistical or other quantitative measures. It has the capacity to generate data that have richness, depth, nuance, context, multi-dimensionality and complexity (Flick, Von Kardorff and Steinke, 2004:5). The qualitative nature of research in this study began as do most other types of research, with a question the researcher wanted answered. From there, the researcher utilized a variety of techniques in order to gain understanding of how others viewed their experiences, including the different types of data collection methods to reach the intended answer on the research question (Merriam, 2009:5). According to Hancock, Ockleford and
Windridge (2009:7), qualitative research is concerned with developing explanations of social phenomena. This assisted the researcher to elicit meaning that helped in the understanding of the social world in which the participants live and why things are the way they are. Often qualitative research is described by the methods most associated with it, such as participant observation, in-depth interviews or the case study (Parkinson and Drislane, 2011:1). The researcher however only concentrated on the in-depth interviews as they were relevant to the study.

Two other goals attributed to qualitative research are: understanding a phenomenon from the perspective of the research participant and understanding the meanings people give to their experience (Fischer, 2005:xvii). The researcher gained an in-depth understanding of the informants’ views and entered the participants’ world without preconceived ideas about the phenomenon (Streubert, Speziale and Carpenter 2011:3). A qualitative design was appropriate for this study as the researcher needed an understanding of the transition period from student nurse to professional nurse and the meaning they attached to their experiences of the transition.

2.2.2 Exploratory research

Exploratory research is conducted classically to satisfy the researcher’s curiosity and desire for better understanding, to test the feasibility of undertaking a more extensive study and thirdly, to develop methods to be employed in any subsequent study (Babbie, 2010:88). Exploratory research was conducted about the research problem of transition in the SAMHS as there are no guidelines to refer to (Michael, 2002:79). The focus was on gaining insights and familiarity for later studies in the military setting.

The main rationale for using this design was to explore the transition from final year nursing students to professional nurses in the military health setting. It also allowed the researcher gain insight into the experiences of the participants with regard to role transition, particularly as there were no studies specifically conducted in the military with regard to the topic and, finally it allowed the researcher to develop a best practice guideline to facilitate the transition period.
2.2.3 Descriptive design

Descriptive designs help provide answers to the questions of who, what, when, where, and how associated with a particular research problem. A descriptive study cannot conclusively ascertain answers to why but they are the most widely used research designs (De Vaus, 2005:3). The researcher, with the assistance of the participants, attempted to answer the above-mentioned questions through the use of questionnaires in the form of in-depth individual interviews and focus groups. The purpose thereof was to describe the characteristics of final year nursing students, novice professional nurses, unit managers and nurse educators and to determine the challenges inherent in the transition period (Jackson, 2009:78). Descriptive designs aim to describe the essential findings in a rigorous manner that is free from distortion and bias (Brabury-Jones, Irvine and Sambrook, 2010:25). According to Brink (2006:132), the descriptive design in this study was heightened by the gathering of information from the representative sample of the population based on the assumption that:

- there is insufficient literature available to describe the phenomenon under study, particularly for the military context.
- the study can commence as a theoretical framework, but the researcher should provide the reason for the study and base this on a thorough literature review

The implication for the design was to describe the experiences of novice professional nurses and student nurses within the clinical setting and to highlight the factors that might impede successful transition. The study on transition in the military health setting is a completely new phenomenon, and the researcher utilised an extensive search of literature to support the study.

2.2.4 Context

Context is defined by Munhall (2012:39) as that which leads up to and follows and often specifies the meaning of a particular expression and the circumstances in which a particular event occurs. The contextual nature of this research tried to understand the participants in their own setting, which is the military health setting, using that understanding to develop good insight into the challenges of transition and applying
that insight to formulate a research problem (Holtzblatt and Beyer, 2013:2). The study focused on the final year nursing students’ transition to take on the role of professional nurse particularly within the SA military health context. The study was conducted only in the military health settings as the participants are trained and employed in the SA Military Health Service.

2.3 RESEARCH METHOD

The research method in this chapter included phase 1 of the study, which is data collection, and the strategies used to collect the data.

2.4 PHASE 1

Data was collected in phase 1 from all the participants, that is final year nursing students and novice professional nurses, using focus group interviews, and from unit managers and nurse educators using in-depth individual interviews.

2.4.1 Population

Yount (2006:447) refers to population as the number of persons or objects covered by the study or with which the study is concerned. Final year nursing students, novice professional nurses, nurse educators and unit managers formed part of the population. De Vos, Strydom, Fouche and Delport (2011:209) concur with the concept of a population as individuals in the universe who possess specific characteristics or a set of entities that represent all the measurements of interest to the researcher. All the four groups share the same characteristics as they need to collaborate in order to facilitate a successful transition from that of being a student nurse to being a professional nurse. The final year nursing students need preparation in order to adjust to the period of transition in the clinical environment. The nurse educators and unit managers should be navigating the implementation of the best practice guideline for transition to receive work ready novice professional nurses. The novice professional nurses are those professional nurses who have just completed their training and who need support and guidance from the unit managers to take up the role of being a professional nurse.
2.4.2 Sampling

Sampling can be defined as the selection of some part of an aggregate or totality on the basis of which a judgment or inference about the aggregate or totality is made (Bharat, 2011:39). It involves taking a representative selection of the population and using the data collected as research information (Latham, 2007:2).

A purposive sampling method was used for this study. The purposive sampling format is used in special situations where the sampling is done with a specific purpose in mind (Maree, Creswell, Ebersohn, Eloff, Ferreira, Ivankova, Jansen, Niewenhuis, Pietersen, Clark and van der Westhuizen, 2013:178). The participants selected were final year nursing students, novice professional nurses, unit managers and nurse educators. All participants are directly involved with the challenges brought about by transition from student nurse to professional nurse. Participants were identified from the two Military Nursing Colleges and the military hospitals and were recruited by the researcher. Participants were given a briefing into the study, its significance and the benefits. A brief meeting was held, where members were informed that all of them have the same opportunity to participate in the study. Unit managers, nurse educators, final year nursing students and novice professional nurses were afforded a chance to participate in the study. Written consent was sought voluntarily from the purposively identified participants.

2.4.3 Data collection

Data collection is defined by the World Health Organization as the ongoing systematic collection, analysis, and interpretation of health data necessary for designing, implementing, and evaluating public health prevention programmes, whereas Flick et al. (2004:21) notes that the collection and analysis of data can be performed by a whole range of methods in qualitative research. The researcher however made use of two methods of data collection during the various stages of phase 1 of the study, namely the focus group method and semi-structured individual interviews.

Open-ended questions were asked of individual unit managers as to what skills and competencies were expected from a novice professional nurse and what they as managers can do to ease the transition period in their respective departments.
Nurse educators were asked to highlight how the theoretical aspect of the programme could be improved to produce competent professional nurses. An interview guide with open-ended questions was designed to facilitate the discussions and data was collected until saturation was reached. Data saturation occurs when there is no more new data coming in.

2.4.3.1 Interview questions

The following interview questions were prepared for the 4 different groups of participants:

Table 2.1: Questions asked of participants during the interviews

<table>
<thead>
<tr>
<th>Groups 1 and 2</th>
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</thead>
<tbody>
<tr>
<td>CENTRAL QUESTION</td>
</tr>
<tr>
<td>Focus Group interview</td>
</tr>
</tbody>
</table>

**Group 1: Students**

**Main question**

- How prepared do you think you are to take up the role of being professional nurses?

**Sub-questions**

- What measures can be taken to prepare you to take up the role of the professional nurse efficiently after qualifying?
- What inputs can you give with regard to your need for preparation for the role of a professional nurse?

**Main question**

**Group 2: Novice Professional Nurses**

- What are your experiences of transition into the role of a professional nurse?
### Sub-questions

- How prepared were you when you took up the role of being professional nurses?
- How has the transition period affected your performance as a novice professional nurse?
- What measures can be put in place to ease the transition?
- What are the lessons learnt from your transition experiences?
- How do you think a best practice guideline can assist in facilitating the transition?

#### Groups 3 and 4

**Semi-structured individual interviews**

**Main question**

#### Group 3: Nurse Educators

- How prepared do you think the final year nursing students are to take up the role of being professional nurses?

**Sub-questions**

- What strategies can we use to better prepare them?
- How do you think a guideline can assist with this process?
- What skills and competencies can be enhanced in their preparation?

**Main question**

#### Group 4: Unit Managers

- How well prepared do you think the newly qualified professional nurses are?

**Sub-questions**

- What role can you as a manager play to facilitate a successful transition period?
• What skills and competencies are you expecting from a novice professional nurse?
• How can a guideline assist you as a manager to ease the transition?

Table 2.1 above depicts the questions that were asked by the researcher of the different groups of participants in the study.

2.4.3.2 Focus Groups (Groups 1 and 2)

Greeff (2005:300) defines a focus group as “a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment”. Kamberelis and Dimitriadis (2008:375) corroborate this by saying that focus groups are ‘collective conversations’ which can be small or large. In focus groups a group of people, four to six according to Creswell (2009:215) or 12-15 people according to Babbie (2010:308), is brought together to discuss a specific topic under the guidance of the researcher (see Table 3.1) for focus group members included for this study.

Focus groups comprising of 6 to 10 members were established for the purpose of collecting in-depth qualitative data about a group’s perceptions, attitudes and experiences on the transition topic. The researcher’s assumption was that the focus group strategy and interaction was going to be productive in widening the range of responses (Maree et al., 2013:91).

The researcher conducted focus group interviews with Group 1, comprising final year nursing students and group 2 comprising novice professional nurses, as there was a desire for ideas to emerge from the different groups. A group possesses the capacity to generate more facts than individuals (Krueger and Casey, 2009:28). For the purpose of this study, more information was sought from participants as a collective. In this way the researcher tried to elicit the experiences of final year nursing students and novice professional nurses with regard to the challenges of the transition of nursing students to professional nurses.
A particular process of conducting focus groups was followed which is clarified by Brink (2006:54) who phrases it as the *empirical phase*. This is the implementation phase where the researcher is actually going to put into action the planned process of the study.

*Clarification of purpose:*

The researcher clarified which issues to understand better and what information to obtain from the focus group discussion.

*Preparation of interview questions:*

A set of questions was prepared in order to guide the discussions. Open-ended questions, unbiased and focused only on the issue at hand were asked. The purpose of the questions was to stimulate the discussion (refer to table 2.1).

*Identifying and recruiting the participants:*

The participants were identified and contacted prior to data collection. The participants who were able to provide information and yield rich data for the study were selected. A thorough explanation regarding the study was provided to them. Participants were asked to sign an informed consent if they wished to participate in the study. A letter of invitation was written to the participants inviting them to attend the focus group meeting.

*Conducting the focus group interviews:*

A free and relaxed atmosphere was created by the researcher. The researcher facilitated the discussion and did not raise any of her own opinions with regard to the questions. Open-ended questions were asked. All members of the group were encouraged to participate. No one member was allowed to dominate the discussion. Data was recorded, using a tape recorder, while field notes were written and direct observations done throughout the session. Data was collected until there was no more new data emerging.
The *interpretive phase*, according to Brink (2006:55), is the stage where data is summarized and coded for analysis.

Data from the tapes and from the notes were summarized and transcribed verbatim omitting the names of the speakers. The discussion was typed and read again to check for key words that occurred frequently. Key words were then grouped into categories and were coded to form themes. These themes were then accurately reported. Creswell’s method of data analysis was used (Creswell, 2009:232).

2.4.3.3 **Semi-structured interviews (Groups 3 and 4)**

The interview method is said to be a conversation with a purpose (Woods, 2011:1). Harrell and Bradley (2009:7) concur that interviews are discussions, usually one-on-one, between the interviewer and the individual, meant to gather information on a specific set of topics. The semi-structured interviews were scheduled in advance and were organized around a set of pre-determined open-ended questions, with other questions emerging from the dialogue (Cicco-Bloom and Crabtree, 2006:315). Interviews are one of the most common forms of qualitative research methods (Silverman, 2004:140) and involve the construction or reconstruction of knowledge (Mason, 2002:63). The in-depth individual interviews were used in this study. The open-ended nature of the questions allowed for flexibility of responses from the participants. Utilizing this method, open-ended questions were posed to individual managers as to what skills and competencies were expected from a novice professional nurse and what can they as managers can do to ease the transition period in their respective departments. Clarification was sought from nurse educators as to how the theoretical aspect of the programme could be enhanced to produce competent professional nurses.

The researcher ensured that no leading questions were asked. The interviews took place during working hours to ensure that the participants did not utilise their own time. The respondents were interviewed whilst on duty and not expected to come on duty for interviews, consequently no extra costs were incurred by the participants. The researcher maintained absolute neutrality
throughout the study, by encouraging own expressions and not leading the participants towards expected responses.

*In-depth interview*

An in-depth interview merely extends and formalises conversations and is often characterized as a conversation with a goal (Guion, Diehl and McDonald, 2011:2). The in-depth interviews conducted in this study focused on the individuals and provided the opportunity for the unit managers and nurse educators to address the issues surrounding the transition of final year nursing students to professional nurses. The open-endedness of this method allowed the respondents to answer the questions applying their own frame of mind.

The key features of in-depth interviews are tabulated as follows:

**Table 2.2: Key features of in-depth interviews**

Adapted from Bodgan and Knopp Biklen, (2006); McMillan and Schumacher, (2001) and Ritchie and Lewis (2003). Table 2.1 below portrays the characteristic features of in-depth interviews.

<table>
<thead>
<tr>
<th>Features</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naturalistic</td>
<td>Interview data is captured in its natural form</td>
</tr>
<tr>
<td>Researcher</td>
<td>• Plays a key role in development of data and meaning&lt;br&gt;• More concerned with process than outcome&lt;br&gt;• Captures perceptions accurately</td>
</tr>
<tr>
<td>Data</td>
<td>• Data is descriptive in the form of words&lt;br&gt;• Includes field notes&lt;br&gt;• Theory is grounded in data&lt;br&gt;• Direction of research is determined after data is collected</td>
</tr>
<tr>
<td>Structure</td>
<td>• Makes use of different techniques, strategies and procedures</td>
</tr>
</tbody>
</table>
- Responses are probed and explored to achieve depth of answers in terms of penetration, exploration and explanation
- Researcher is responsive to relevant issues raised spontaneously
- Structure is flexible
- Interview guide/schedule sets out the key topics and issues to be covered

<table>
<thead>
<tr>
<th>Generative</th>
<th>• Creates new knowledge and stimulates coherent thinking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explanatory</td>
<td>• Explores respondents’ perspectives</td>
</tr>
</tbody>
</table>
| Analysis          | • The use of quotations helps to illustrate and substantiate analysis  
                   |   • Analyses data inductively                             |
| Aim               | • To achieve depth and coverage across key issues         |

In relation to table 2.2, the researcher played a prominent role in eliciting as much data as possible from the participants and captured the perceptions accurately. Field notes were handwritten and the participants gave their data in a verbal form. An interview guide (see interview questionnaire table 2.1) clearly explained the key points to be covered and open ended questions meant that participants were at ease to give an elaborative explanation. Data was captured through the use of audiotapes. The analysis of data was supported by quotations from the data collected from the participants.

2.5 PILOT STUDY

A pilot study was undertaken. The researcher practised listening, reflecting and paraphrasing throughout the pilot study. The researcher collected data with the assistance of a colleague who played a role of the assistant facilitator and gave support in the various stages of data collection. The researcher explained the purpose of the study to the different groups of participants and also explained the
process that the study will follow. A further clarification was given indicating that, on completion of the study, a guideline will be developed to ease the transition of final year nursing students to professional nurses.

Participants were assured of their anonymity and of the confidentiality of the study. This was done to allay anxiety as some participants became apprehensive because of the use of the tape recorder. A total of 5 unit managers and 4 nurse educators participated in the pilot study where data was collected through in-depth interviews whilst 6 novice professional nurses and 13 final year nursing students participated in focus group sessions. Questions that were not clear during the pilot study were adjusted for the main study and rephrased. Due to the changes and adjustments in the interview schedule, data from the pilot study was not included in the main study. Data was discarded subsequent to the collection of data for the main study, as the researcher needed to ensure that all the changes made were corrected for the main study.

2.6 FIELD NOTES

According to de Vos (2011:285), field notes encompass all the observations made during the process of data collection and entail all that the researcher sees and hears. The researcher enlisted the assistance of the field worker to write the field notes. Field notes contained a comprehensive account of the respondents themselves, the events that took place, the attitudes of the respondents, feelings and perceptions. Field notes were taken to capture the perceptions of nursing students, novice professional nurses, unit managers and nurse educators during data collection and were used during the data analysis process of the study.

A chronological account of what happened was given and a day-to-day report on what transpired in the setting was carefully documented on the notes, although taking of notes might lead to the researcher missing out on important observations during the interview. The tension the participants experienced when some questions arose, the ease with which they answered the questions and their happiness or sadness to divulge other information formed part of the collected data.
2.7 SETTING

The setting, according to Burns and Grove (2009:306), is the location where research is conducted. These might be natural locations that are highly or partially controlled by the researcher. The setting chosen for this study was 1 Military Hospital, which is a tertiary military hospital, 3 Military Hospital, which is a provincial military hospital as well as the two SAMHS Nursing Colleges. These institutions were selected based on the fact that they provide education and training for student nurses and afford placement for both nursing students and novice professional nurses. The other reason was that of accessibility and cost saving. Interviews were held in English as this is the medium of instruction in the military health service. Focus group interviews were held in the hospital conference room whereas individual interviews were held in the participants’ offices to afford them privacy and comfort of their own space.

2.8 DATA ANALYSIS

Qualitative data analysis ideally occurs concurrently with data collection so that investigators can generate an emerging understanding about the research questions (DiCicco-Bloom and Crabtree, 2006:317). Creswell (2009:232) is in accord that data analysis commences simultaneously with data collection in qualitative studies.

Data analysis in this study involved reading through the data repeatedly and engaging in activities of breaking the data down and building it up again in novel ways (TerreBlanche, Durrheim and Painter, 2007:322). The data captured on audiotape during the interviews was transcribed verbatim by the researcher. The transcription process implied converting audiotape recordings and field notes into text data (Creswell, 2009:233). Creswell’s (2009:233) method of data analysis was employed for the study. The method took a four step process indicated below.

**Step 1: Transcribing interviews**

Taped interviews were listened to as soon as the interviews were completed and were proofed against recorded interviews. Verbatim transcription was done, and the text data from the field notes was also incorporated. The tone of voice and pauses were carefully listened to and recorded as these might be an indication of the
participant’s emotions during data collection. Tapes were re-listened to, to ensure that all valuable data had been captured.

**Step 2: Organizing data**

The transcribed data was organized, identified by number and the audio-tapes labelled to make data easily retrievable. Data from both the individual interviews and the focus group discussion were cross-checked to ensure that all the collected data was attended to. A search for similarities, differences, categories and themes was done. The analysis commenced with reading all the data and dividing it into small meaningful units. The transcribed data was organized according to the similarities and coded. The codes were close to the words that the participants used. Follow-up meetings between the researcher and co-coder were conducted to ascertain whether the analysed data gave a true reflection of the experiences shared by the participants during data collection.

**Step 3: Reducing data**

After data was organized, it was categorized into patterns and themes. The process of reading the transcribed data was repeated and sometimes re-organized for a better fit. The researcher worked with these categories by comparing the data collected from one participant to another to identify those that were most prevalent or of greatest priority to the participants so that the final theme could be determined; thus data was reduced to four (4) themes and twelve (12) related sub-themes.

**Step 4: Description of data**

According to Creswell (2009:238), the description of qualitative data is a detailed rendering of people, places or events within a specific setting (context). In this study the description of data was done together with an exploration of existing literature. The data was related to the findings of studies published in literature, described and illustrated with direct quotations from the transcribed data and condensed in a conclusive statement for each theme. Subsequent to transcribing, organizing, reducing and describing the data, a comprehensive discussion of the analysed data
supported by the participants’ direct responses and literature will be reported on in chapter 3.

2.9 STRATEGIES WITH WHICH TO ESTABLISH TRUSTWORTHINESS

In order to achieve trustworthiness of the research, the researcher applied the criteria listed below to ensure accuracy of the findings.

2.9.1 Credibility

According to Moule and Goodman (2009:193), the readers of the research must be totally convinced that the information illustrated is a true reflection of the experiences, views or beliefs of the participants. Streubert-Speziale and Carpenter (2011:37) suggested a set of activities that would enhance the credibility of the research. These included data triangulation, researcher’s authority and prolonged engagement. To attain these, the researcher reviewed the relevant literature and grouped and interviewed different groups of participants.

Semi-structured interviews were used to collect data from nurse educators and unit managers whereas focus group discussions were employed for obtaining data from final year nursing students, and novice professional nurses. Field notes were also written from all the groups of participants.

Adequate time was spent with the final year nursing students in order to build rapport. The researcher underwent training for data collection, particularly for the focus group method, and is justifiably competent in collecting data.

2.9.2 Dependability

Qualitative data cannot be seen as credible unless its dependability is known, its ability to stand the test of time (Moule and Goodman, 2009:194). Establishing dependability can be seen as a parallel process to that of confirming reliability in quantitative research. Lincoln and Guba (1985:290) recommended an audit trail, thick description and stepwise replication to assist with the establishment of dependability.
To ensure a dense description, the exact method of data collection and analysis in line with the parameters of qualitative research methodology were clearly defined. An independent co-coder was given unmarked copies of the data and together with the researcher compared the data results for analysis and reached consensus on the common themes that emerged throughout the discussion (Lincoln and Guba, 2000:290), the rationale was to prove the stepwise replication to ensure rigour. A further stepwise replication was done during the appraisal of the integrative literature review where the independent reviewer together with the researcher agreed on the literature to be included for appraisal and extraction of data.

2.9.3 Confirmability

Confirmability refers to the measure of objectivity of the data. To confirm objectivity the researcher presented an audit trail of methods, analytical processes followed to analyse the data and a presentation of the data through the discussion of the results obtained from the collected data. The recommendations made for the study were supported by the data collected from the participants and the results of the integrative literature review (Moule and Goodman, 2009:194). To attain reflexivity the systematic collection and documentation of data assisted the researcher to draw conclusions about the data, its truth-value and applicability (Lincoln and Guba, 1985:290).

According to Davey, Gugui and Coryn (2010:143), the actions and perceptions of participants in qualitative research are analysed for their expressions of meaning within a given context. Consistent with the practices of the selected qualitative methodology used, the researcher interpreted the participant expressions through a coding or meaning-making process. In this coding process, the researcher looked for themes that were consistent with the study. From these themes, the researcher was able to make recommendations about the context under study.

2.9.4 Transferability

The researcher needed to demonstrate the extent to which the research findings could be transferred from one context to another by providing a thick description of the data as well as identifying sampling and design details (Barnes, Conrad, Demont-Heinrich, Graziano, Kowalski, Neufeld, Zamora and Palmquist, 2012:6). A
thorough description of the research methodology was given, as well as that of the background of the participants and the research context. The process was done to enable interested researchers to make a transfer to other suitable studies (Krefting, 1991:216).

Transferability is the generalisation of the study findings to other situations and contexts. Although Brink, van der Walt and van Rensburg (2014:121 stated that the generalisation potential in qualitative research is limited, in this study the development of a best practice guideline could be transferred or utilised in other similar contexts to facilitate the transition of final year nursing students to professional nurses. The participants in this study should be presumed to share the same sentiments as the same category of participants in other hospitals and nursing colleges

2.10 PHASE 2

In this phase a review of literature was done to identify the available guidelines for the transition of final year nursing students to professional nurses. An integrative literature review approach was employed which is a form of research that reviews, critiques and synthesises representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated (Toracco, 2005:356). Russell (2011:1) views an integrative literature review as a five stage process comprising the following:

- Problem formulation
- Data collection or literature search
- Evaluation of data
- Data analysis
- Interpretation and presentation of results.

A comprehensive description of this process will be done in chapter 4 of this study. The following advantages of integrative literature review were listed by Crawford, Valdez and Morita (2010:7):

- Integrative review presents varied perspectives
• It combines diverse methodologies to create a more well-rounded evidence review
• Provides enhanced data collection strategies

The disadvantages, according to these authors, were that the combination of diverse methodologies may be a complex procedure that could contribute to a lack of rigour, to inaccuracy and to bias.

Stage 1. Problem formulation

Russell (2011:3) noted that the problem identified should include the development of conceptual and operational definitions of the variables to be studied. In this study the conceptual definition would include all aspects of transition i.e. competency on transition, transition shock and support during transition whereas the operational definition of transition would indicate the movement from the known to the unknown.

Stage 2. Data collection or literature search

All databases were searched including electronic, hand searched journals and books, published and unpublished theses and dissertations using the identified keywords (see Annexure O for the key words used for the search), to become familiar with the contents in the titles, abstracts and subject descriptors. Data bases included Google Scholar, CINHAL via EBSCO host; Pubmed and A-Z were searched.

Stage 3. Evaluation of data

The third stage in the integrative literature review is the evaluation phase. In this phase the researcher decided whether the articles collected or viewed are worthy to be included in the study. The researcher, together with the independent appraiser, evaluated the reliability of each guideline for inclusion in the study. All the best practice guidelines searched with regard to transition of students in the health sector were evaluated and the most appropriate ones were included for data extraction and analysis.
Stage 4. Data analysis

The data analysis stage is conjoined with the interpretation stage at this point. This stage however indicates reducing the separate data points collected by the reviewer and merging them into one statement about the research problem. Depending on the goal of the integrative review, analysis may include statistical tests. The goal in this study does not need statistical measures as the aim is to develop guidelines for the successful transition of final year nursing students into professional nurses.

Stage 5. Interpretation and presentation of results.

The interpretation phase is the last and final phase of the integrative literature review. Dissemination of results in every study is paramount to that study as it increases the knowledge base in that field. With the dissemination of the entire results of the study, the inclusive integrative literature review will play a role as a basis for other studies. The developed guideline however will not be disseminated as this is not within the scope of this study.

According to IEEE (Institute of Electrical and Electronics Engineers Transactions on Professional Communication (2013), integrative literature reviews are an empirical research report that systematically collects, classifies, and analyses a body of literature on a topic. As part of the research report, authors of integrative literature reviews describe the methodology used to search, choose and code studies, and focus on providing a critique or interpretation rather than just reporting data. The AGREE II Instrument was utilized to assess the draft guideline. (Refer to chapter 6 of the study).

The AGREE II instrument consists of 23 items organized within six domains, followed by two global rating items for an overall assessment. Each domain captures a specific aspect of the guideline quality.

**Domain 1: Scope and Purpose**—overall aim of the guideline, target group

**Domain 2: Stakeholder Involvement**—extent to which appropriate stakeholders were involved in developing the guideline and represents the views of its intended users
Domain 3: Rigour of Development—process of gathering and summarizing the evidence, methods used to develop recommendations

Domain 4: Clarity of Presentation—language, structure, format of guideline

Domain 5: Applicability—potential barriers and facilitators to implementation, strategies to improve uptake, resources needed to implement the guideline

Domain 6: Editorial Independence—biases due to competing interests

Determining the validity of a guideline involves 3 separate but related steps: appraising the quality of the guideline as a whole, determining the currency of the guideline (ie. are the recommendations up to date?), and assessing the content of the recommendations (Graham, Harrison and Brouwers, 2005:70). The three steps are explained below and applied in the study.

a. Assess the quality of the guideline as a whole

The quality of the guidelines retrieved was determined by using the AGREE II instrument to establish the rigour of the guideline. Refer to chapter 4 for a thorough explanation on the assessment procedure.

b. Determine the currency of the guideline

Guidelines that meet minimum quality criteria must then be assessed to determine whether they are still current. Methods of checking the currency of guidelines include reviewing the date of release/publication, scanning the bibliography for the dates of the original studies cited; and checking with developers about whether they still consider the guideline to be current or have plans to update it.

c. Systematically assess the clinical content of guideline recommendations

Guideline appraisal instruments provide little detailed information on the actual recommendations being advanced in specific guidelines. Thus, if more than one guideline is being considered, the next step is to conduct a “content analysis” of the recommendations in each guideline. It is useful to have 1 or 2 clinicians with experience in the content area produce a table comparing each guideline in terms of
the specific recommendations made and the level of evidence supporting each recommendation. In this case only one guideline was developed for which all the recommendations were done by the expert panel. The members of the expert panel were experienced in guideline development and the broader health field. The final guideline developed for the study was based on the suggestions, comments and recommendations of the expert panel.

2.11 PHASE 3

On conclusion of phases 1 and 2 of the study, the data from those phases was blended to commence phase 3 which was the development of a best practice guideline. According to Kowalak, Hughes and Mills (2003:611), “best practice” refers to nursing practices that are based on the “best evidence” available from nursing research. The goal of “best practices” is to apply the most recent, relevant, and helpful nursing interventions, based on research, in real-life practice. A unique feature of best practices is that steps in the implementation are marked with icons that indicate the source of the evidence for this action. Graham, Harrison and Bouwers (2005:69) provide 10 steps to guideline development that was used for the purpose of the study. A comprehensive account of the process will be detailed in chapter 5 of the study.

Step 1. Identify a clinical area to promote best practice

The first step is to select an area in which to promote best practice. Reasons for selecting a particular area can include:

- the prevalence of the condition or its associated burden,
- concerns about large variations in practice or care gaps,
- costs associated with different practice options,
- the likelihood that a guideline will be effective in influencing practice,
- a desire to keep practice up to date or evidence-based,
- awareness of the existence of relevant evidence-based guidelines.

A gap was identified (refer to the problem statement) that existed where final year nursing students and novice professional nurse were not adequately prepared to
take up the role of being professional nurses and therefore the likelihood that a best practice guideline will be effective in facilitating the transition of final year nursing students to professional nurses.

**Step 2. Establish an interdisciplinary guideline evaluation group**

According to Graham, Harrison and Bouwers (2005:70), when an organisation or group is interested in providing best practice, a local interdisciplinary guideline evaluation group should be established comprising key stakeholders who will be affected by the selection of guideline recommendations. The advantages of using a group to evaluate guidelines include sharing of work among group members, reducing the potential for bias in the evaluation process, and increasing awareness of the guidelines and opportunities for group members to develop ownership of the resulting decisions. However, due to the academic nature of this study, no guideline development group was sought. The guideline was developed by the researcher under the leadership of two experienced promoters in the guideline development, as well as an experienced independent appraiser.

**Step 3. Establish a guideline appraisal process**

It is important to select a guideline appraisal process. Guideline appraisal instruments are intended to be used to systematically assess and compare guidelines using the same criteria. They typically consist of several quality criteria or items that assess the extent to which each guideline meets these criteria. For the purpose of this study, the criteria used were based on an AGREE II instrument. The guideline appraisal process will be dealt with in detail in chapter 4 of this study.

**Step 4. Search for and retrieve clinical guidelines**

The next step is to clarify the issues of particular interest. Based on the identified areas of interest, criteria for searching for and selecting guidelines for review were identified. Such criteria may include the language of publication. To ensure that high quality guidelines were not inadvertently missed, a systematic search for all relevant guidelines on the topic was done. A thorough integrative literature search was
conducted. All guidelines that met the inclusion criteria were retrieved and included in the study following the literature review.

**Step 5. Assess the guidelines**

Guidelines need to be assessed for quality and content to determine whether they fit the study. Only guidelines that responded to the review question and were deemed rigorous were recommended for inclusion in the study. This process of assessing guidelines will be discussed comprehensively in chapter 4 of the study.

**Step 6. Adopt or adapt guidelines for local use/ Develop a new guideline**

The choices at this step are to adopt or adapt existing guidelines. Adopting a guideline involves choosing the best guideline and accepting all recommendations as written. This may not be practical or feasible for many reasons, and the group may need to adapt or tailor a guideline to their needs. Selection of this option may be appropriate if the recommendations are not a good fit with the practice setting. Due to the context of the study and its uniqueness, a new guideline was developed for the purpose of this study for the military health service as there are no guidelines fitting adaptation or adoption in this context.

**Step 7. Seek external review of the proposed guideline**

When the guideline evaluation process is undertaken on behalf of a group, the resulting draft of local recommendations should be sent to local practitioners, other stakeholders and organisational policy makers for review and comment. The abovementioned step should be done even if a single guideline is adopted in its entirety. Seeking feedback on the proposed guideline ensures that those who need to use the guideline have an opportunity to review the document and identify potential difficulties for implementation before the guideline is finalized. The step allows policy makers to consider the organisational effects of implementing the recommendations and to begin preparing for its future adoption. It also serves as the first wave of dissemination of the guideline and provides the group with an opportunity to address issues raised by reviewers before finalizing the local guideline.
An expert committee, including representation from key stakeholder groups identified by the researcher as having relevant expertise in nurse education and training, was established and consulted via teleconference at two crucial points during the study. The expert committee comprised of three members from the academic spectrum, one member from the military nursing college, one member from SAMHS directorate and one member from a hospital in SAMHS. The first teleconference was held in February 2014, in the early stages of the study in order to inform the identified expert members of the study at hand. The expert panel was asked for their comments. Communication with the members of the committee was also maintained throughout the study via e-mail correspondence, and all members were invited to comment on the proposed draft guideline.

**Step 8. Finalise the guideline**

Once finalised, official endorsement of the guideline should be sought from policy makers in settings where implementation of the guideline is intended. The endorsement of the guideline will however not be sought due to the academic nature of the study. The guideline will also not be implemented as the scope of the research does not allow for this. Implementation of the guideline will have to be undertaken in another study.

**Step 9. Obtain official endorsement**

Once finalised, official endorsement of the guideline should be sought from policy makers in settings where the guideline is intended to be implemented. The above-mentioned step will however not take place as the guideline is developed for academic purposes.

**Step 10. Schedule review and revision of the local guideline**

The researcher needed to develop a plan for when and how the guideline would be reviewed and updated as is the norm with guidelines. The guideline review date will not be set as that is not within the scope of this study.
2.12 ETHICAL CONSIDERATIONS

Ethics refers to the norms for conduct in research that distinguishes between acceptable and unacceptable behaviour (Resnik, 2013:1). Due to the nature of the research that involves human participants the following ethical principles were followed:

2.12.1 The Principle of beneficence

The generic definition of beneficence is an act of charity, mercy and kindness. It denotes doing good to others and invokes a wide array of moral obligations. Beneficent acts can be performed from a position of obligation in what is owed and from a supererogatory perspective, meaning more than what is owed. An example of this is what has become known as a random act of kindness (Beauchamp and Childress, 2009:38). The researcher had the moral obligation of being true, honest and kind to the participants and to display the understanding of their circumstances through this testing period of transition.

2.12.2 Principle of Justice

The principle of justice could be described as the moral obligation to act on the basis of fair adjudication between competing claims. As such, it is linked to fairness, entitlement and equality. Butts and Rich (2009:48) describe two elements of the principle of justice, namely equality and equity. With regard to equality in the provision of care, some people are not treated with the same degree of respect as that accorded to others e.g. with indifference, unfriendliness, lack of concern or rudeness. Inequality and discrimination may also be based on structural violence such as racism, sexism and poverty (Mahajan, Sayles, Patel, Remien, Sawires, Ortiz, Szekeres and Coates, 2008:70) which they describe as a form of discrimination based on unequal power relations. The participants were at no stage discriminated against. The selection of members was equitable as every participant had a similar chance of being included in the study.
2.12.3 The right to autonomy

The word autonomy comes from the Greek *autos-nomos* meaning “self-rule” or “self-determination”. According to Kantian ethics, autonomy is based on the human capacity to direct one’s life according to rational principles. He states,

“*Everything in nature works in accordance with laws. Only a rational being has the capacity to act in accordance with the representation of laws, that is, in accordance with principles, or has a will. Since reason is required for the derivation of actions from laws, the will is nothing other than practical reason*” (Korsgaard, 2004:880).

Autonomous people are considered as being ends in themselves in that they have the capacity to determine their own destiny, and as such must be respected.

The principle of respect for autonomy is also invoked in discussions about confidentiality, fidelity, privacy and truth-telling, but is most strongly associated with the idea that patients should be allowed or enabled to make autonomous decisions about their health care (Entwistle, Carter, Crib and McCaffery, 2010:742). Participants were given the autonomy to decide whether they would like to be included in the study. They had the choice to withdraw at any stage of the study with no penalty being imposed on them. Their views on the topic were respected and accepted as the truth.

2.13 PERMISSION TO CONDUCT THE STUDY

Permission to conduct the study was requested from the Officer Commanding 3 Military Hospital, (Annexure A), 1 Military Hospital, (Annexure B), the General Officer Commanding Nursing College, (Annexure C), and the Ethics Committee of Nelson Mandela Metropolitan University, (Annexure H). Participants were made aware that there would be no monetary benefit accompanying the study. Request for permission to conduct the study was required (Annexure D) and request for permission and informed consent from the participants was also sought (Annexure E).

A thorough explanation regarding the study was given to the participants. Their voluntary participation was requested and, on their agreeing, an informed consent was given to them to complete. A further explanation was further given that at any
time during the study should they feel uncomfortable they would be permitted to withdraw without any penalty.

2.14 CONCLUSION

Chapter 2 discussed the research design of the study and described the research method. The qualitative data collection methods were detailed and the rationale for choosing the outlined research approach was accentuated. The data analysis method was highlighted as well as strategies to ensure trustworthiness. Ethical considerations were taken into account. An integrative literature review and the formulation of a guideline were briefly explained. The following chapter will deliberate on an all-inclusive depiction of the analysis and interpretation of the findings.
CHAPTER 3
DATA ANALYSIS AND DISCUSSIONS OF QUALITATIVE DATA

Chapter two highlighted the research design and method of the study. Chapter three will present the analysis of data collected from the different groups of participants and the discussions that emanated from the data collected supported by extensive literature.

3.1 INTRODUCTION

Focus groups were conducted with the novice professional nurses and student nurses and individual interviews with the unit managers and nurse educators. Rich data were extracted particularly from the focus group interviews as groups have the capability of generating more insights into the topic.

3.2 OPERATIONALIZING THE FIELD WORK

Prior to commencement of the data collection, the researcher once more explained the purpose of the study and its objectives to the participants. The researcher mentioned that the core of the study was with regard to the facilitation of the transition of final year nursing students to professional nurses, particularly with the aim of developing a best practice guideline that will ease this transition. An interview guide was used to facilitate the data collection and different groups of participants were asked different questions with the view of eliciting as diverse responses as possible. Participants were reminded that their participation was completely voluntary and should they wish to withdraw at any stage of the study no penalties will be incurred.

3.3 DATA ANALYSIS

Data analysis is the process of evaluating data to examine each component of the data provided. The analysis consists of the recommended steps that must be completed when conducting a research experiment. Data from various sources was gathered, reviewed, and then analysed to formulate a finding or conclusion (Bailey, 2008:127). Data analysis in qualitative research focuses more on qualities than on quantities.
The analytic challenge for the qualitative researcher is to reduce data, identify categories, develop themes and offer well-seasoned reflective conclusions. This is a process of tearing apart and rebuilding abstract conceptual linkages and finally documenting the process to enhance the credibility of findings (Hammersley, 2007:287). Data was collected from four groups of participants, namely: final year nursing students, novice professional nurses, unit managers and nurse educators. The researcher conducted the data analysis independently of the independent coder. Audiotapes were labelled before the commencement of the interviews, for accurate retrieval of information. After each interview session, tapes were listened to by the researcher to ensure familiarity with their content. All changes in voice tone and pauses were captured.

The emotions of the participants were carefully observed during the interviews. Notes were also handwritten during the course of the interviews. Subsequent to the interviews the data from the tapes and from the notes were transcribed verbatim. The researcher underlined words and phrases representative of participants’ transition experiences. The interviews were then typed and read again to check for key words that occurred frequently. Key words were then grouped into categories and were coded to form themes. Data was then further reduced into sub-themes to construct deeper levels of meaning. These themes and sub-themes were then accurately reported on (Cresswell, 2009:192).

3.4 DISCUSSION OF RESULTS

The findings obtained from the data collected from the focus groups with the novice professional nurses and students and the individual interviews with unit managers and nurse educators (tables 3.1 and 3.2) formed part of Phase 1 of the data collection and are portrayed in themes and sub-themes in this chapter. Four themes and twelve sub-themes relating to the transition of final year nursing students to professional nurses were identified subsequent to the analysis of data and are depicted in table 3.3.

Table 3.1 depicts the mean age of the participants who took part in the focus group interviews namely the final year nursing students and novice professional nurses.
Four focus group interviews were held with the final year nursing students and two focus groups with the novice professional nurses.

**Table 3.1:** Table depicting the mean age of participants in the focus group interviews

<table>
<thead>
<tr>
<th>Final Year Nursing Students (Focus group interviews)</th>
<th>Area</th>
<th>Mean Age</th>
<th>Total no of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Focus groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Focus groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 1: (10) participants</td>
<td>Pretoria Nursing College</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td>Group 2: (9) participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Focus groups</td>
<td>Bloemfontein Nursing College</td>
<td>47</td>
<td>9</td>
</tr>
<tr>
<td>Group 1: (5) participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2: (4) participants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Novice Professional Nurses (Focus Group interviews)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pretoria Hospital</td>
<td>28.5</td>
<td>7</td>
</tr>
<tr>
<td>1</td>
<td>Bloemfontein Hospital</td>
<td>27</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 3.2 on the following page portrays the mean age of the participants who took part in the in-depth interviews, namely the managers and nurse educators. Nine unit managers and nine nurse educators formed part of the in-depth interviews.
Table 3.2: Table depicting the mean age of participants for in-depth interviews

<table>
<thead>
<tr>
<th>Number of Participants</th>
<th>Area</th>
<th>Mean Age</th>
<th>Years of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Pretoria Hospital</td>
<td>36</td>
<td>10-18</td>
</tr>
<tr>
<td>5</td>
<td>Bloemfontein Hospital</td>
<td>45.8</td>
<td>12-23</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of participants</th>
<th>Area</th>
<th>Mean Age</th>
<th>Years of experience</th>
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<tbody>
<tr>
<td>6</td>
<td>Pretoria Nursing College</td>
<td>42.5</td>
<td>6-14</td>
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<tr>
<td>3</td>
<td>Bloemfontein Nursing College</td>
<td>39.5</td>
<td>4-11</td>
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</tbody>
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Table 3.3 on the following page outlines the themes and sub-themes that emerged from the data collected from the participants. There are four themes and twelve sub-themes that emerged and that will be discussed extensively in this chapter..
Table 3.3: Table outlining the themes and sub-themes from the analysis of data

<table>
<thead>
<tr>
<th>THEME</th>
<th>SUB-THEME</th>
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| THEME 1: Preparedness of final year nursing students and novice professional nurses to take up the role of being professional nurses | Sub-theme 1.1 Clinical exposure for nursing students  
Sub-theme 1.2 Transition shock from student to professional nurse  
Sub-theme 1.3 Lack of adequate clinical knowledge of novice professional nurses |
| THEME 2: Factors enhancing transition of final year nursing students to professional nurses. | Sub-theme 2.1 Clinical accompaniment for nursing students  
Sub-theme 2.2 The need for a best practice guideline by participants  
Sub-theme 2.3 Support for nursing students from stakeholders involved in the training of the students |
| THEME 3: Skills and competence needed to enhance clinical practice of novice professional nurses | Sub-theme 3.1 Communication skills needed by novice professional nurses for the role of the professional nurse  
Sub-theme 3.2 Clinical competence to provide quality nursing care  
Sub-theme 3.3 Responsibility and accountability to fulfil the role of the professional nurse |
| THEME 4: Factors impacting negatively on the transition process of students in to professional nurses | Sub-theme 4.1 Attitudes of health care professionals  
Sub-theme 4.2 Dual transition in SAMHS  
Sub-theme 4.3 Shortage of staff in SAMHS |
3.5 DISCUSSION OF THEMES

Data was collected from the different groups of participants through focus group interviews and face to face in-depth interviews. The researcher identified keywords that were synonymous as mentioned by the participants. Extraction and analysis of the keywords formed themes and sub-themes as mentioned earlier. Data will be presented as narrated by the participants by explicitly extracting their quotations which will then be supported by relevant literature. Themes and sub-themes will initially be presented schematically thereafter an elaborative discussion will be conducted.

Figure 3.1: An outline of theme 1 and the related sub-themes.

Figure 3.1 outlines the themes and sub-themes that emerged from phase 1 of the study. They will be discussed in detail in the following section.

Theme 1 Preparedness of final year nursing students and novice professional nurses to take up the role of being professional nurses

Viewing the period of transition from student to professional nurse through the eyes of preparedness, a few factors need mentioning as to what actually constitutes preparedness for the role. Milton-Wildey and Rochester (2012:20) outlined the
factors that could affect role transition and foster preparation for the role as inclusive of age, maturity, previous work experiences, motivation, aspirations and availability of personal support. However different factors emerged from this study as contributing to the preparedness of final year nursing students transitioning to professional nurses and will be debated throughout theme 1, with the researcher attaching relevant supporting literature backed by the data provided by the participants as to how and when the students need preparation for the role of the professional nurse. It is well documented in literature that frequently students underestimate the preparation required for their new role and need assistance to reduce stress and develop confidence (Newton and McKenna, 2007:10). Students need to be more prepared for the realities of being a nurse (Mooney, 2007:841). According to Doody, Tuohy and Deasy (2012:684), stress, anxiety and uncertainty may be attributed to not feeling prepared and lacking confidence on completion of the nursing programme. Both the four year nursing students and the novice professional nurses concurred to the feelings of anxiety and stress on taking up the role of being professional nurses due to deficient knowledge. They displayed low levels of confidence portrayed by the inability to delegate even the simplest duties to their juniors

‘I think practically the military hospitals, they just don’t prepare us because the practical things that you see here are just minor things, once in a while something major will come up and you don’t know how to manage it. We didn’t get enough exposure like with midwifery we were at least allowed to work in public hospitals.’ (focus group 2, novice professional nurses, (novice p/n) p54).

Subtheme 1.1 Clinical exposure for nursing students

Clinical exposure for military students is very limited as the defence force only caters for its employees and their family members. Wards are inadequate and there is a total absence of specialized areas, leading to students not acquiring sufficient exposure to diverse disciplines. Clinical exposure can be in the form of creating ample learning opportunities for students including allocating them in the surrounding public hospitals. The lack of adequate clinical exposure was cited as compromising the successful transition of final year nursing students to professional nurses as it limited the experience to be gained during clinical placement. The novice
professional nurses explained that as students they had insufficient exposure in the clinical area and they yearned to be placed more in the public hospitals to prepare them to be efficient professional nurses as the military lacked enough opportunities to prepare them for the role. They declared the lack of exposure as having contributed to them not being adequately prepared. On the contrary, the bridging programme students felt ready and prepared to take up the role of being professional nurses citing the many years of experience that they had accumulated as enrolled nurses. They accentuated the experience they gathered of assisting the professional nurses in the running of the wards, as having contributed to their readiness for the role. Moreover the readiness came due to the lengthy waiting period between the completion of their two year pupil nurse programme and the commencement of the bridging programme.

‘I will say eh, due to the experience I had the privilege of ordering drugs, and I also worked in high care, when I see what I have done what they have done I think I am prepared but that is practical, practical I am prepared, theoretical I have a lot to learn, because I nurse a patient I know what I must do but it is a little bit difficult on writing it down what I have done. So I think my theory I still have to work on it theory wise I am not ready’ (focus group 3, bridging students, p36).

The most important purpose of clinical exposure is to provide students with learning opportunities that will enable them to develop critical thinking skills so that they become competent, independent nurse practitioners (Kaphagawani and Useh, 2013:181). Due to the lower ranks occupied by the students in the military, they are not always afforded the opportunity to practice on real patients, particularly on high ranking members e.g. Colonels and Generals as these members tend to give orders as to who is deemed experienced enough to care for them.

The nurse educators reiterated their views as follows:

‘You know, my, my, I’m worried, my worry is that they are prepared let’s say theoretically, but my worry is practically, you know, it’s just now we’ve got problems with facilities like bo Jubilee for midwifery and psychiatry. I’m still worried that we do not have a slot at Wiskoppies for psychiatry where they are going to see psychiatric cases’. (individual interview nurse educator 2, P4)
According to Levett-Jones (2007:210), clinical exposure means the assignment of students to quality and enriching clinical learning areas that afford the students the opportunity to develop their performance and attain clinical skills. The lack of adequate clinical exposure was cited as compromising the successful transition of final year nursing students to professional nurses as it limited the experience gained during clinical placement. The nurse educators felt that if the clinical exposure could be improved for the students, then their transition could be enhanced.

‘They need exposure so much our institution is not giving them a challenge to be fully prepared and remember during strikes we are allocated outside in the public hospitals then they will be faced with the real situation. They need to see diverse cases of patients, different diagnosis and how to manage them, the military alone and the clinic is not enough’ (individual interview, nurse educator 6, p12).

According to Purdie (2008:315) the students need diversity during clinical placement, ensuring their exposure to a variety of health care experiences and equipping them to nurse holistically. On par with the aspirations of the nurse educators is the notion that exposure to quality clinical areas could boost the competency of students. The students’ outcomes could be reached through nursing diverse medical conditions under the guidance of a competent supervisor.

‘Yoh, let me say the issue of exposure in the form of learning opportunities. Learning opportunities have been a very serious problem until I think last year, cause our students were allocated to 1 Mil hospital and Far East and eh, just few hospital or areas, clinics and we never had agreements with areas like Kalafong and Jubilee, that are treating all the other disciplines’ (individual interview, nurse educator 1, p2).

One of the findings from Mabuda (2008:19), concurring with the findings of this study that impacted negatively on students’ learning experiences was the lack of learning opportunities. As stated by the nursing educators, learning opportunities have been a serious problem requiring urgent intervention.

The reason that bridging programme students feel more prepared practically is because they were assigned to different clinical learning areas over a period of years under guided supervision. They were able to nurse the different patients with
different medical conditions. Guided exposure to other departments is an important component of transition. Such exposure helps you understand the continuum of care for your patients, build skills that you may not be exposed to in your home unit, and develop relationships with other nursing personnel members. Their morale and confidence was actually boosted over the years of working in the clinical area.

‘The experience plays an important role in preparing us to be professional nurses, like I also had a lot of experience like she said, running the department doing the off duties, the ordering a lot of experience and a lot of opportunities we were given as well. So that experience makes me clinically ready for patient care, and to be a sister in the department’ (focus group 3, bridging students, p37).

‘We are very far behind practically from the public sector’s students, theoretically we might be on the same level, but practically like personally sometimes when I’m working in Far East, like I don’t even have to ask a listen like what going on, I know there’s a student who’s going to tell me. Like they’ll even show you how to do this, how to put up a drip, how to deliver this baby and whatever and whatever, and we are on the same level’ (focus group 1, students, 4yr, p31).

Clinically expert nurses are distinguished from their colleagues by their often intuitive ability to efficiently make critical clinical decisions while grasping the whole nature of a situation. Expertise influences nurses’ clinical judgment and quality of care and develops when a nurse tests and refines both theoretical and practical knowledge in actual clinical situations (Benner, Tanner and Chesla, 2012:137).

When student nurses are allocated in the outside institutions they are given the tasks befitting their level of expertise and guided throughout. They are given the benefit to make their own mistakes and are assisted in correcting them. There is enough trust from the professional nurses who prepare them, hence viewing students as being capable. On the contrary, the military is very rigid and students are not really trusted to do procedures that are deemed complicated or risky. For example, a fourth year nursing student will not be allowed to insert a drip but should rather do the vital signs and urine testing to be on the safe side. Once they have completed the programme they can then be given the opportunity to insert drips and to do the more challenging procedures.
'Like a patient if you are working in the surgical clinic, like they will never let you draw blood from them if you are a Candidate Officer. They will ask you, do you know what you are doing so that you can feel inferior' (focus group 1, students 4yr, p32).

Procter, Beutel, Deuter, Curren, de Crespiigny and Simon, (2011:254) concur that the fact that newly graduated nurses have limited opportunities to gain adequate experiential knowledge before their graduate year, significantly impacts on their preparedness for clinical practice. Learning in quality clinical placements is what experiential learning theory calls 'situated' – that is, it transforms theory into practice (Yardley, Teunissen and Dornan, 2012:102). Students must be accorded opportunities to transfer classroom learning to the context where this learning applies.

‘On what he said now, eh let me take the midwifery ward, outside we do everything, we call the sister if you really don’t know what to do, here we are not allowed to pv because the doctor must come and pv. So what is my role then?’ (focus group 1, students 4yr, p31).

Learners of different ages and experiences learn differently. Mature students have a preference for self-directed learning compared with younger students and as a result perform better in such tasks (Darcy Associates Consulting Services, 2009:15).

The novice professional nurses attributed their lack of experience to not being given tasks that promote their growth and maturity in the profession.

‘My colleagues who qualified the same as me who’s working in the public setting or private setting, have much more experience than me because they are exposed, you know the more you practice the more you gain experience’ (focus group 2, novice p/n, p54).

This is on par with the findings of Volschenk (2009:16) when the students in her study indicated feeling proud and privileged to study at the selected private hospital. They enjoyed working in the wards and also reported getting excellent clinical exposure, especially when compared with fellow students from smaller hospitals in their group.
Sub-theme 1.2: Transition shock from student to professional nurse

The participants were looking forward to the positive aspects of their new roles when qualified. These included the ability to care for patients independently, carrying out certain tasks and taking on the autonomous nurse role. Instead, they experienced transition stress as they used words like fear as they described the clinical area. According to Varner (2011:1), transition begins with the “doing” stage and orientation to the role. During this stage, graduate nurses may experience a wide range of emotions, including an initial elation over passing the final exams and acquiring a professional nurses position, as well as an unexpected grief due to losses associated with changes, such as the loss of contact with colleagues, familiar routines and faculty support while discovering the new practice environment as well as the nursing culture.

The inadequacy of the preparation of student nurses led them to the realization that they were not fully equipped for the role of being professional nurses. The anxiety and the confusion they felt during the transition period, mainly from the expectations of their seniors and juniors alike, made them doubt themselves. Taking up the role of being professional nurses proved to be more challenging than they thought.

The term reality shock was coined by Kramer (1974) when he described how nurses felt when they experienced the reality of practice. The author defined it as “the reactions of new workers when they find themselves in a work situation for which they have spent several years preparing, for which they thought they were going to be prepared, and then suddenly find they are not”.

Figure 3.2 reflects the transition shock that was experienced by the students when they first became professional nurses. They felt uncertain about their roles due to not receiving adequate guidance and support throughout their training. They lacked clinical knowledge and only possess limited clinical skills to demonstrate leadership.
On inquiring from the participants about their first experience of being professional nurses, the response was that they had feelings of disillusionment, anxiety, confusion, frustration, fear and stress. All of these feelings depict shock. The following excerpts portray their shock. It was very easy for the novice professional nurses to feel disillusioned, anxious and frustrated given the inadequate clinical knowledge they had acquired throughout their training. The minimal exposure and the denial of opportunities from the military side did not do them any favours.

‘Ok, it was then the interest in the books, then we came to the hospital after finishing my course, it was difficult as a newly qualified cause during your training you don't do the things the way that the hospital does’ (focus group 2, novice p/n p53).

‘You know we are having that bit of fear or something, you know I am gonna have a lot of responsibilities, that is not an easy thing. Sometimes you are going to deal with different people that have been in nursing for many years and telling you hey you have just arrived here, those kind of things also they contribute neh to the fear’ (focus group 2, novice p/n, p54).

Transition shock emerged as the experience of moving from the known role of a student nurse to the relatively less familiar role of the professionally practicing nurse (Duchscher 2009:1103). Novice professional nurses were forever afraid that
something might happen for which they were not prepared. This fear caused them to be self-conscious of what they do and ultimately led to the eroding of their self-esteem.

‘You constantly have this fear that something is gonna happen and you gonna flop or make a big mistake because you are never sure of what you are doing most of the time’ (focus group 2, novice p/n, p53).

In support of the above excerpt, Harwood (2011:1) stated that transition shock signifies the fear of making a mistake and feeling unsafe and that this could be crippling to a new graduate’s confidence and self-image.

**Sub-theme 1.3: Lack of adequate clinical knowledge**

Students only realize the inexperience in clinical knowledge that they possess to make clinical decisions on behalf of the patient and to solve problems on completion of their training. Their nursing care skills are still under scrutiny from their seniors due to their lack of adequate clinical knowledge. Clinical knowledge is classified in psychology as (1) declarative knowledge, awareness of factual information; (2) procedural knowledge, knowledge of how to perform a task (Dictionary of Sport and Exercise Science and Medicine, 2008). Due to the lack of adequate knowledge students, after completing their nursing training do not always know what to do; hence they cannot even guide their juniors or correct their mistakes. They experience feelings of embarrassment related to their lack of appropriate clinical knowledge. The unit managers can also clearly perceive the gap in their linking of theory and practice and tend to lack trust in them.

‘Clinically if it is a rescus, you don’t know what to do, we used to call the sisters with icu from the matrons and say come and help me if it’s a rescus’ (individual interview, unit manager 1, p12).

Nurses have a fundamental role in ensuring that patients receive safe, effective person-centred care, based on the best available evidence. The ability to apply a combination of technical expertise, clinical reasoning and evidence appropriate to a range of healthcare settings is crucial (Watts, 2011:37). Novice professional nurses
though, are always in a dilemma as to what to do in situations warranting expert clinical practice and this leads to frustration on the side of the managers who are expecting competency from a qualified nurse.

‘… they are still struggling in some things … ’ (individual interview, unit manager 2, p13).

‘To be honest, I don’t trust them too much to leave them with the unit’ (individual interview, unit manager 2, p14).

Nursing is not just a collection of tasks. To provide safe and effective care to the clients, nurses must integrate knowledge, skills and attitudes to make sound judgments and decisions (Carter, Bishop and Kravitis, 2008:290). Given the fact that student nurses were never permitted to making decisions for the patients during their training, it is rather unfair to expect them to make sound judgments and provide safe care for the patients, immediately after completion of the training programme.

‘You must start from zero, it’s like you are in a training institution, now you are introducing them to this field. It’s like they never saw this field before,’ (individual interview, unit manager 4, p16).

Students had to say this about the lack of adequate clinical knowledge:

‘… some of the things you don’t know yet like ordering of drugs you did them once and you don’t even have the idea how you did it …’ (focus group1, students 4yr p27).

Student nurses have to be exposed to information and to gain enough understanding with regard to patient care and to be innovative about their knowledge. Their desire is to bridge the gap between the knowledge gained in the theoretical setting and the implementation of this knowledge in real practice settings.

‘I have to acquire information, I have to acquire knowledge but at the end of the day I cannot implement the knowledge acquired from the theory’ (focus group1, students 4yr p27).

According to Moore and Leahy (2012:140), new nurses lack clear roles. They are
afraid of making mistakes, lack confidence and are fearful of new situations.

3.6 SUMMARY FOR THEME 1

Theme 1 addressed the transition challenges brought about by the lack of adequate clinical facilities in the military setting, particularly the lack of specialized clinical areas. The lack of diversity of clinical placement added strongly to insufficient exposure of the students, hence their feeling of inadequate preparation for the role of a professional nurse. Participants echoed the lack of clinical knowledge which causes uncertainty in taking up the role of being a professional nurse.

3.6.1 PREPAREDNESS OF FINAL YEAR NURSING STUDENTS TO TAKE UP THEIR ROLE AS PROFESSIONAL NURSE

The lack of preparedness for this role came out very strongly in different connotations and is indicative of shock and anxiety in taking up the role of a professional nurse. Without exception, the participants concurred that a significant crisis situation exists that leads to the students not being adequately prepared to transition successfully into the role of the professional nurse. The lack of adequate clinical exposure and insufficient clinical knowledge certainly did not help the situation. Student nurses in the four year programme appeared not to have adequate opportunities during their basic training to gain the necessary clinical competence expected at the end of the programme. Final year nursing students in the four year programme, novice professional nurses, unit managers and nurse educators all felt the unpreparedness of students to take up the role of being professional nurses, citing a few concerns mentioned previously. Only the bridging programme students alluded to their preparedness as positive, based on the experience they had as enrolled nurses and the readiness and anticipation they had to be professional nurses. Working extensively alongside the professional nurses for many years prepared them adequately for the role of being professional nurses. It is therefore strongly depicted, as reiterated by the participants, that experience, adequate exposure to diverse placements, alleviation of transition shock together with the acquisition of clinical knowledge play a pivotal role in the preparedness of nursing students to take up the role of being professional nurses.
Figure 3.3: An outline of theme 2 and the related sub-themes

Figure 3.3 outlines the themes and sub-themes related to the factors enhancing transition of final year nursing students to professional nurses.

**THEME 2: Factors enhancing the transition of final year nursing students to professional nurses**

The following factors were highlighted collectively by the participants as enhancing the students’ transition to the role of professional nurse. These factors were clinical accompaniment of students, the need for a best practice guideline by participants, availability of learning opportunities for nursing students and the support from stakeholders involved in the training of the students. All these factors will be dealt with independently to emphasise the value and significance of each in enhancing the transition process.

**Sub-theme 2.1 Clinical accompaniment for nursing students**

Clinical accompaniment plays a pivotal role in preparing the students in the clinical area for their much awaited competence. Clinical accompaniment should include and not be limited to mentoring, clinical teaching of students and supervising student nurses in the clinical arena. The clinical accompaniment could be done by a clinical facilitator or preceptor with clinical expertise thus allowing for teachable moments to be captured promptly.
According to SANC (2013:R169), clinical accompaniment means a structured process by a nursing education institution to facilitate assistance and support to the learner by the nurse educator at the clinical facility thus ensuring the achievement of the programme outcomes. Military students are rarely accompanied in the clinical setting and as a result they lose out on the most vital information that could have been imparted by their nurse educators in the clinical setting. The rationale cited for the absence of clinical accompaniment was the shortage of staff to undertake the task. The students are severely and unnecessarily disadvantaged owing to improper planning.

Students idle away most of the time as their time in the clinical setting is not effectively utilized due to the lack of clinical intervention. They wait hopefully for their nurse educators as they witness the other students from surrounding institutions being accompanied and supported. Clinical accompaniment was one of the factors that contributed to the lack of adequate clinical preparation. Students voiced out their concerns of not being accompanied when they are in the clinical setting. They feel their learning needs are compromised as nobody from the college comes to visit or guide them.

‘I think there’s a gap between nursing college and the clinical area that needs to be breached. When we’re at the college, the hospital doesn’t know what we are doing and when we’re at the hospital the college doesn’t know what we are doing. We need clinical tutors that will prepare us this side, that will know exactly what we are being taught’ (focus group 1, novice professional nurses, p47).

The student nurses are not really accompanied by their nurse educators, as a result the college is not sure as to what they are taught in the clinical learning area. There is a gap between the theory and practice due to the lack of clinical accompaniment. In a study done by Thrysoe, Hounsgaard, Dohn and Wagners (2011:18), students experienced being thrown in at the deep end, without feeling sufficiently prepared and not being supported by experienced colleagues. The same feeling applies to these participants as they expressed being unprepared, especially practically, to be professional nurses.

‘What needs to be done is like we are in the hospital there must be somebody who is
allocated specifically to address our issues. I am seeing a person delivering for the first time, but I will never see my lecturer visiting me, coming to show me how to do it, like maybe I will be told by the sister’ (focus group 1, students yr,p34).

Effective and efficient clinical accompaniment, also an important part of clinical education, can be regarded as the means of achieving the aim of integrating theory and practice. Part of theory-practice integration also encapsulates the facilitation and development of personal and professional values and of professionalism in nursing students as future health care professionals (Beukes, 2010:2).

‘And also from the college we don’t have that support we can say, the lecturer say ok we will be here for you. But we don’t have that thing that ok today the lecturer is coming we are going to do this and this or the lecturer is going to go with us to a specific patient and we are going to do this for that patient’ (focus group 1, students 4yr, p34).

A study done by Newton, Billet and Ockerby (2009:630) reported that the students lack support regarding their transition from both the clinical environment and the training institution and that the clinical environment poses little challenge as they are not effectively utilized.

‘It is very important to be accompanied, because you get this confidence to say you know what, I know what my lecturer said’ (focus group 1, students 4yr, p35).

Clinical supervision being a formal process where the clinical staff accompany and mentor students in achieving competency should be properly planned (Carver, Ashmore and Clibbens, 2006:768). The process of clinical accompaniment seeks to create an environment where students can develop clinical expertise (White and Roche 2006 209). According to the participants, the nurse educators do not make frequent visits for students nurses when they are allocated in the clinical setting. Clinical supervision afforded by the nurse educator seems to be insufficient to enhance clinical expertise. The nursing college also feels that the clinical area does not support them in preparing the students when the students feel abandoned by everybody concerned in their training. The only time when they feel like their training needs are taken into account is when they are allocated in the outside public
hospitals.

This is what an educator had to state:

‘You know theory is fine, anybody can sit in front of the students and give information, teach you know. I think clinically we need to show the students, demonstrate to them how procedures are done and it should be instilled in them and you know uh, they need supervision, frequent, constant supervision’ (individual interview, nurse educator 3, p5).

As the clinical accompaniment process prepares the student nurses for their clinical assessments. (Borrageiro, 2014:5) it also entails the support and guidance of student nurses based on the students’ specific clinical needs by creating clinical learning opportunities in order to develop a critical thinking nurse

‘When we are in the ward and we do clinical accompaniment we need to, not just stand there as outsider observing, we need to put down our books, nurse the patient with the student so that they can see the example that’s how I feel, because they know those are the kinds of skills …’ (individual interview, nurse educator 4, p9).

The unit managers were also distressed about the issue of not having educators around to support and accompany the students. They preferred the students to be mentored somehow when they are in the clinical setting. Mentoring, as mentioned earlier, is a critical part of clinical accompaniment and will also be addressed as it plays a crucial role in the early years of your career and later at key development and career path points. Mentoring can occur on a one-to-one basis or through small groups led by a professional mentor (Ulrich, Krozek and Reinsvold, 2009:27). Mentoring should be incorporated in clinical accompaniment in order to provide quality care, thus leading students to become confident and competent practitioners. Parsloe, (2013:1) defines mentoring as to support and encourage people to manage their own learning (Myall, Levett-Jones and Lathleen, 2008:1835) in order that they may maximize their potential, develop their skills, improve their performance and become the person they want to be. These authors further assert that mentoring is an effective way of assisting people to progress in their careers. The issue of mentoring is pivotal as it may be grossly neglected in the military setting. The
confidence and competency that could have been boosted is compromised hence after completion of nursing training, students lack the confidence even to tackle the simplest of tasks as the students went through the clinical placements with little, or at times, no mentoring at all.

‘I think having someone along-side just to make sure that whatever confidence they have to build up and to encourage them to make mistakes and like whenever you are with them to do whatever they think is right, to correct if it’s wrong immediately, if it’s good applaud and move forward’ (individual interview, unit manager 3, p18).

‘So they pair you, you don’t become an extra person, you be part of the team. So you work under supervision of this professional nurse as a team member of professional nurses’ (individual interview, unit manager 4, p20).

In the light of the comments made by the students, the importance of the role of the mentor and the quality of mentorship cannot be overemphasized. The mentor, as the key to supporting students in practice and ensuring that the nurses of the future are fit for practice, is deemed paramount (Abbott, Burke, Chapman and Dunham, 2008:11).

The students also had their views on the importance of mentoring in the clinical environment:

‘So what I was expecting here is that they can maybe because they are Candidate Officers maybe they can take us with COs and then say CO you can take them and show them, whatever they are doing administratively because now we are sort of, we are doing what we have been doing here, the vital signs’ (focus group 4, bridging students, p42).

In a study conducted by Myall, Levett-Jones and Lathleen (2008:1834) on the experiences of nursing students and practice mentors, the findings echo the importance of mentorship for pre-qualifying students and emphasize the need to provide mentors with adequate preparation and support.

‘So if they were doing that mentoring I think we should have learnt better but now is just that we are having our own experiences, so whatever they say no you must do
vital signs you care less mos you know what are your capabilities’ (focus group 4, bridging students, p42).

‘I think eh Major if they can eh, what they were doing I will always refer to the hospital that I trained at so at that time there was the general nursing it was three years and then they take a senior student maybe second year student from the general and then they will allocate you as a first year with this student and she must show you everything whatever she is doing you must be there and you must learn’ (focus group 4, bridging students, p42).

The nurse educators also pronounced on the issue of mentoring as follows:

‘Creating mentoring is one of those better ways of building a person to be skillful and you know to be prepared in all the areas, but half the time you find that a lecturer is supposed to be here, prepare for block and is expected that the following month she is supposed to follow up the students, whereas obviously you will find out that even the first years are still around and it’s not easy’ (individual interview, nurse educator 1, p2).

Mentoring in the clinical area requires committed time, purpose and dedication Nalliah (2012:4), for the personal and professional development of the mentee. The educators need to commit resources in order to mentor the students with time being one of the most crucial resources.

The other issue that came to the fore during the discussions about clinical accompaniment was clinical teaching. Burns, Beauchesne, Ryan-Krause,P and Sawin (2006: 172) as well as Croxon and Maginnis (2009:237) assert that clinical teaching forms a bridge between classroom teaching and practice-based teaching. It provides students with the opportunity to experience the real world of nursing through knowledge acquisition, problem solving and acculturation in the nursing profession. The following concerns were emphasized:

‘Instead of teaching the third year, they are only teaching those that are qualified as com-serve and then they forget about you, you are left behind. The groups are falling
Because nursing is a practical profession, what nurses and nursing students do in clinical practice is more vital than what happens in the classroom. Clinical teaching activities provide real-life experiences and opportunities to transfer knowledge to practical situations (Oerman and Gaberson, 2009:8).

‘Most of them don’t like teaching and obviously what we learn here it needs to be executed down there’ (focus group 1, students 4yr, p32).

‘You function from first year to fourth year, you are a student you’re gonna do vital signs nobody will teach you. Nobody will teach you how to do delegation or to order the drugs. Something like you learn them when you are an R/N already qualified, which is wrong cause you should be knowing them already’ (focus group 2, novice p/n, p55).

Professional nurses have a duty to teach as one of their paramount functions in the nursing profession. Students expressed the need to be taught while in the clinical area. They viewed clinical teaching as one of the factors that could assist to adequately prepare them for the role. Apparently the teaching is non-existent and this leads to them not properly integrating the theory and practice.

‘As a student you hide cause you are not sure of your story, and then the time comes when they say you are qualified, you come this side you are not sure, so you start afresh, so you only prepare yourself when you are qualified’ (focus group 1, p/n, p48)

‘Theoretical wise I’m in 4th year, I am ready to be a professional nurse, but practically I think I’m still a 2nd year or 3rd year cause we know nothing’ (focus group 1, students 4yr, p29)

Students should be allowed to learn and explore their skills under the guidance of a qualified person in all the clinical environments. It is in this way that they will gain the experience and later the expertise and the confidence to be efficient professional nurses. In a study done by Niederhauser, Schoesler, Gubrud-Howe, Magnussen and Codier, (2012:3) it was reported that students were denied participation in the
provision of nursing care to patients, yet students must have the experience of providing patient care to develop skills in technical care and clinical judgment which proved very unfair on the part of the students.

**Sub-theme 2.2 The need for a best practice guideline by participants**

Unit managers, novice professional nurses and nurse educators advocated the support for a best practice guideline to be developed for the military institutions. Participants were keen on acquiring a best practice guideline to direct them as they prepare the students to attain the best possible competency to becoming professional nurses. Important suggestions were made as to what should be incorporated in the best practice guideline to allow precise utilisation thereof. Clinical practice guidelines are statements that include recommendations intended to optimise patient care and are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options (Gronseth, Woodroffe and Getchius 2011:4).

The transition of final year nursing students in the military to professional nurses is not supported by any document. Novice professional nurses just fall in, join the rest of the staff and start working. There are no existing guidelines directing the unit managers as to what needs to be planned and prepared for these novice professional nurses. The expectations from the managers are that students underwent nursing training therefore they need to be ready for the role of being professional nurses. They soon became conscious that the novice professional nurses were not adequately prepared for the role. The need for a guideline was suggested as a vehicle that could facilitate the preparation of students in their final year of study and the reception of novice professional nurses.

The novice professional nurses voiced their views pertaining to guideline development as follows:

‘You know Major I think if we had clear guidelines on what to do and to expect when we start in the wards as professional nurses, it would make things very easy’ (focus group 2, novice p/n, p56)
Turner (2008:4) is in agreement with the above statement that the improvement of clinical practice and health outcomes is dependent on both well-developed practice guidelines and effective methods for their implementation.

‘It could really be easy for us if we come and we find some sort of direction you know, something that’s guiding us, rules like you know maybe a tool or something’ (focus group 2, novice p/n, p56).

The nurse educators also concurred on the need for a best practice guideline, with the optimism that it will bring some solutions.

‘Yah, like you talked about the development of best practice guidelines, I think if the college can have that for the hospitals during the last year of placement of the students it will actually also guide them on what to do and what to prepare for them’ (individual interview, nurse educator 1, p2)

Guidelines are viewed as tools that offer direction to the employers and registered nurses in the health care institutions on relevant and comprehensive programmes (Association of Registered Nurses of Newfoundland and Labrador, 2003:7). It is imperative for an organization to recognize the need for a good practice guideline to facilitate and support the transition period of the newly qualified nurses. Given the reality of today’s work environment there is a significant pressure from within the system for new nurses to quickly integrate into the organization.

‘It could really be nice if we could have this best practice guideline. This will work better as the clinical area that side will know exactly what our expectations and intentions are when the students are to be prepared in the clinical area. Besides the objectives they will understand as the guideline will take them step by step until the students are well prepared and ready, they will not be disappointed also at the product that they will get at the end of the day’ (individual interview, nurse educator 5, p11).

According to the National Institute for Health and Clinical Excellence (NICE), (2007) clinical guidelines are recommendations for the care of individuals by healthcare professionals, and can be used to develop standards to assess the practice of health
care, assist in the education and training of healthcare professionals and improve communication.

‘Yes the problem we have is that they don’t have guidelines to work as comserve after qualification as a result they let them work as staff nurses, they will tell you themselves cause they are the ones that are exposed to this thing’ (individual interview, unit manager 4, p20).

A standard guideline according to World Health Organization (2010) is produced in response to a request for guidance in relation to a change or improvement in practice. There is a dire need for the improvement in practice, particularly in the military health service, as the novice professional nurses are utilised as enrolled nurses due to the lack of a transition guideline.

‘Also I think the transition will be easy when we have guidelines, we can include things like mentoring in our guidelines, I don’t know if clinical department will be part of the guidelines, but something like that it can really ease the transition. We need a working instrument on how to prepare them then it’s sort of easy’ (individual interview, unit manager 4, p20).

**Sub-theme 2.3 Support for nursing students from stake holders involved in the training of the students**

It is widely recognized that support is critical to graduate nurse transition from novice to advanced beginner-level practitioner and to the integration of novice professional nurses into safe and effective organisational processes.

The belief is that the work environment should provide support and guidance to its junior members to create a sense of belonging. Newly qualified professional nurses seemed to enjoy the support particularly from the older professional nurses in the units, though it was stated categorically that the support was lacking throughout the training period. They appreciated receiving caring support from the staff members, principally regarding the recognition of their novice status. Dalton (2005:127) has described students’ learning experience as including appreciation and support from the clinical staff. The need for support for students and novice professional nurses
cannot be underestimated. Support in the clinical learning area from the colleagues and managers can bring out the best in students and novice professional nurses. It can enhance their self-esteem, the feeling of belonging and the increased commitment to the profession itself. Support denotes acceptance and a feeling of caring that induces confidence and competence in a particular being.

‘The support is not that good, at first, they are expecting you by that time, that you have studied and everything you are a sister and that you must be competent in every activity’ (focus group 2, novice p/n, p 58)

The Centre for Enhancement of Learning and Teaching (2008:1) posits that supportive learning environments can validate the presence of individuals and encourage participation and involvement. In a study done by Henning, Shulruf, Hawken and Pinnock, (2011:84) students reported the absence of psychological support to reduce the quality of life and increase the risk of compassion fatigue and explicit trauma, whereas placement experiences characterized by supportive relationships in positive learning environments have been shown to improve learning outcomes significantly (Hartigan-Rogers, Cobbett, Amirault, Muise-Davis, 2007:3; Morris 2007:213).

‘What I have realized in this institution is that our seniors just come without knowing what our needs are, so we just have to sacrifice whatever we have. They don’t give proper support’ (focus group 2, novice p/n, p56)

Magobe (2010:6) emphasized the need for a high level of support to successfully make the transition from graduate to competent and confident nurse. The author further accentuates that a good form of support boosts the morale of the students. A supportive clinical learning environment (CLE) is vital to the success of the teaching-learning process. Many nursing students perceive their clinical learning environment as anxiety and stress provoking (D’ Souza, Venkatesaperumal, Radhakrishnan and Balachandran, 2013:26). According to Jokelainen, Turunen, Tossavainen, Jamookeeh and Coco (2011:2860) one of the emphases placed on supporting nursing students in the clinical area was familiarising the student with placement as a working environment, including adjusting to the hospital, different units and the
student’s own ward and the culture of care and the climate in the ward. In addition, one action was enabling students’ equal participation in teamwork in placement.

On the positive side this is what the participants had to say.

‘They do support us, it’s like they know where they’ve wronged us, it’s like they know the position we are in, how it is. So they are, they do give support. ‘They do give you support but they don’t explain everything to you’ (focus group 1, novice p/n, p50).

‘The change is drastic, it’s like eh, last week I was a student, and I go a sister and I say sister ,eh my grandmother passed away I need to go to the funeral this Saturday. No, No, no you students are lying, what, what, what, what. Then the next week, I’m a professional nurse when I say that, it’s shame, I’m sorry about that. So I don’t know if they are trying to make up for the last time or, but they do support. (focus group 1, novice p/n, p50).

It is evident that a culture of support offers students the psychological safety necessary to ask and respond to questions, make and learn from mistakes, and initiate additional opportunities for learning (Plack, 2008:10).

3.7 SUMMARY FOR THEME 2

Clinical accompaniment was emphasized as one of the strategies that could enhance clinical teaching and bridge the gap between theory and practice. The participants clearly needed a best practice guideline that will assist stakeholders involved in the training of the students to facilitate a smooth transition period. Novice professional nurses highlighted the need to be mentored and supported after qualification.

3.7.1 FACTORS ENHANCING TRANSITION OF FINAL YEAR NURSING STUDENTS TO PROFESSIONAL NURSES

Different groups highlighted factors or strategies that could ease the transition to the role of being professional nurses. It is clear from the data analysis that transition remains very stressful for some newly qualified nurses and that the students experience the anxiety of being poorly prepared for the role. The participants suggested different ways to ensure better preparation and that could ease this
transition period. There is also evidence of positive aspects to the experience in the form of support that the novice professional nurses brought to the fore. The issue of clinical accompaniment that was hailed as pivotal to enhance the transition could not have been more accentuated.

Figure 3.4: An illustration of theme3 and the related sub-themes

Figure 3.4 illustrated the themes and sub-themes affecting skills and competence needed for the role of a professional nurse.

Nurses need diverse skills to enhance their clinical practice. Skills such as psychomotor where they are able to do procedures efficiently, cognitive skills for abstract and clinical thinking and affective skills to be more compassionate in rendering patient care. Nurses need specific competencies such as leadership, that is made up of knowledge, attitude and skills hence the usage of the two terms interchangeably. Competence of the novice professional nurses will not necessarily be observed but inferred through their elevated and skilled performance of tasks.

Sub-theme 3.1: Communication skills needed by novice professional nurses for the role of the professional nurse

Communication in nursing is critical as it is one method leading to the understanding of the core problem of the patient. Communication can be either verbal or non-verbal but the message will have the same impact on the patient. This section focuses on communication between the student, placement site, and academic institution as a precursor to adequate preparation for the placement experience. Nurses should
always strive to have a therapeutic communication with their patients and students should always be summoned to actively participate in therapeutic discussions with their patients. Communication is the sending and receiving of messages via symbols, words, signs, gestures or cues (Peate, 2006:17). The positive results of effective communication are essential in achieving amongst others, increased recovery rates, a sense of safety and protection, improved levels of patient satisfaction and greater adherence to treatment options (Wright, 2012:1).

‘Communication skills, decision making skills those can be emphasized, apart from the mere practical basic care nursing skills, that should also be included, especially now that If we say we cannot allocate this person who say according to the nursing council this person is competent is registered but still we cannot allocate or use this person as a registered nurse’ (individual interview, nurse educator 1, p2)

Bach and Grant (2009:9) speculate that there is evidence to suggest that, while qualified nurses often rate their own communication skills as high, patients report less satisfaction and maintain that communication could be improved. The dilemma with regard to the military concerning this issue is that even the qualified competent professional nurses will have to bear higher ranks to effect a comfortable communication across the board.

Proper nurse patient communication in the military setting is very limited, the source being the rank issue. This really causes a breach in communication lines. The lower ranking members, particularly the students, should always be mindful as to what they can or cannot communicate with their seniors. The lines should be clearly drawn and boundaries well observed though this could lead to missed opportunities for vital information. Effective interpersonal communication plays a pivotal role in the promotion of health and success in health maintenance, prevention of ill-health and promotion of wellness (Geyer, Mogotlane and Young, 2009:263).

‘The other thing is the communication skills, you know with communication a lot of problems can be solved. Remember we are working in a multidisciplinary institution; our nurses need to have good communication skills and be advocates for their patients’ (individual interview, nurse educator 6 p11).
In a study of paramedic students, McCall, Wray and Lord (2009:9) found students frustrated when supervising staff were unaware of their impending arrival, the student’s role and their learning requirements. For students to deem their placement satisfactory depends primarily on the open communication routes between the nursing training institution and the placement areas. Levett-Jones, Fahy, Parsons and Mitchell (2006:60) posited that nurse managers were concerned about the poor communication between them and universities. It was characterised by limited knowledge about what students had learned prior to placement, trouble contacting academic staff, untimely provision of information about placement details, unclear clinical objectives and the absence of orientation processes to clinical venues.

**Sub-theme 3.2: Clinical competence to provide quality nursing care**

Students need to develop some degree of clinical competence throughout their years of learning. They need to acquire skills that will be reinforced from time to time in order to maintain a particular level of competence. The students will need to attain new information and new skills in order to provide safe, high quality care. The Nursing Act, 33 of 2005, defines "competence" as the ability of a practitioner to integrate the professional attributes including, but not limited to, knowledge, skill, judgment, values and beliefs, required to perform as a professional nurse in all situations and practice settings. Competence has been interpreted in the literature as an assessment of performance and as an assessment of capability, while Rutowski (2007:35) defined competence as a generic quality referring to a person’s overall capacity and competency with reference to certain capabilities. Thus competence may represent the potential to perform. Fullerton, Johnson, Thompson and Vivio (2010:3) concurred that competence is the combination of knowledge, psychomotor, communication and decision making skills that enable a particular person to perform a specific task to a defined level of proficiency. Contrarily, Scott Tilley (2008: 61) pointed out in a review of the literature regarding the defining attributes of competence, “that only 22 of the 61 articles on the topic provided a definition of competence” rendering the term difficult to define. The educators had to say this about competency:
‘We are somewhere not planning our things very well, so somewhere we lack we try to push, the work to cover the periods without understanding and then you find that competency is lacking’ (individual interview, nurse educator 2, p3).

Competency may be perceived by self and others as demonstrating safe practice behaviour (Armstrong, Spencer and Lenberg, 2009:688). Students are still not trusted to practice safe care, and this should be a skill that is nurtured throughout their training, if they are to be competent at the end of their nursing training.

The unit managers reiterated the issue of competence as follows:

‘No they not are competent I don’t even think they are ready umh, they are still struggling in some things.’ (individual interview, unit manager 2p16).

Competency is not static, rather it is differently defined over an individual professional’s lifetime (World Health Organization, 2011). The newly qualified professional nurse will need to acquire new information and new skills in order to continue to provide safe, quality nursing care. Students had the feeling that they were recognised as not being competent enough to practice safe care. The College of Registered Nurses of British Columbia (2012:5) conceived that nursing education programmes must ensure that student practice learning experiences reflect national and jurisdictional expectations and prepare graduates to achieve the competencies. To fulfil the practice learning experience requirements, nursing education programmes and health care settings need to work in partnership to ensure that students have access to quality practice learning experiences.

According to Courtney-Pratt, Ford, Marsden and Marlow (2011:381), clinical experience is undisputed as a key to professional competence though it has been argued to be the most difficult to manage.

‘… they feel that we are not competent enough to do those things’ (focus group, students 4yr, p 28)

The description of competence by the Nursing and Midwifery Council (2009:2) as the combination of knowledge, skills, attitudes and values necessary for nurses and midwives to practice at a standard acceptable to clients and other professionals with
a similar background and experience tallies with the excerpts of the participants above. It goes without saying that students will practice to an acceptable standard if they are guided, supported and exposed to challenging clinical environments. Dyess (2009:404) agreed that newly qualified nurses, despite having achieved the requirements to function as professional nurses, still lack the clinical skills and judgment needed to provide safe, competent practice and therefore still need guidance and support to achieve clinical competency.

Sub-theme 3.3: Responsibility and accountability to fulfil the role of the professional nurse

Nurses and nursing staff take the responsibility for the care they provide and answer for their own judgments and actions. They carry out these actions in a way that is agreed with their patients and their families. According to the SANC Charter of Nursing Practice (2004:10-11), it is advocated that the relationship of trust between society and the nurse must be based on the nurse’s professional knowledge, competence and conduct characterised by a willingness to be accountable for his/her actions and a commitment to serve mankind. It should be further acknowledged that nurses are to be accountable and responsible for maintaining their professional conduct. Responsibility equates to the duty of care in law, whereas accountability is shown by measuring some degree of competence (Scrivener, Hand and Hooper, 2011: 26). A further statement implies that responsibility involves liability with the performance of duties in a specific role and that responsibility is a two-way process that is both allocated and accepted. Assistive personnel accept responsibility when they agree to perform an activity delegated to them. On the other hand accountability involves a retrospective review which includes critical thinking to determine if the action was appropriate and giving an answer for what has occurred. Nurses at different levels of practice demonstrate accountability when they answer both for themselves and for others regarding their actions. Professional nurses however assure appropriate accountability by verifying that the receiving person accepts the delegation and accompanying responsibility (Weydt, 2010:4).

In a study conducted by Whitehead and Holmes (2011:21), the increase in newly qualified nurses’ responsibilities and accountability was a major stressor in the transition period.
Final year nursing students at their level must be given some form of responsibility and accountability that equates to their level of competence in order to support them to mature professionally. The participants however craved from as early as third year to be given some form of responsibility to prepare them for the role of being professional nurses. It appears that they were not afforded these opportunities.

The novice professional nurses highlighted the need for exposure to responsibility at an early stage.

‘The thing is as well; eh when you finish your fourth year they must tell you the responsibility of you is 1,2,3,4 to manage the ward. So I feel when you enter the ward they must explain your responsibilities to you, this is your task you must do off-duties, you must do things that a registered nurse is supposed to do. They don’t explain it they think you must know them out of your head’ (focus group 1, novice p/n, p48).

In a study done by Carlson, Kotze and van Rooyen (2005:70), students felt that they were not adequately informed of the daily responsibilities required of them to develop nursing skills and practice. This also applies to these SAMHS students. Their responsibilities were not outlined therefore they did not know what their tasks were on entering the clinical practice.

‘I think you know hmm, giving more emphasis on what she said, they were supposed to give us more responsibility in 3rd year, that’s where we are actually gonna have a ground and be confident that we can do this and then continue with fourth year’ (focus group 1, novice p/n p49)

Booyens (2006:133) explained responsibility as the obligation or commitment of a manager or subordinate to carry out an assignment according to the received instructions. The feeling is supported where students feel the readiness to carry out the instructions and be responsible for the tasks allotted to them.

‘I cannot delegate this person cause she is older than me, ja the age wise also. So now even drawing the line between this people it takes times to get to that one believe you me. I ended up doing everything in the ward like as R/N and E/N
Delegation is a complex professional skill requiring sophisticated clinical judgment and final accountability for patient care. It is therefore imperative that educators and organizations provide clinical experiences for students to see delegation as a skill set that has to be practiced in order for it to be perfected (Weydt, 2009:8).

‘I can’t delegate I am frightened. There are people that really frighten me, that ’I feel threatened about that in the ward I can’t delegate because at the end of the day they are going to tell me whatever they are telling me’ (focus group 2, novice p/n, p53)

Responsibilities can be sub-divided into management, delegation, drug administration and prioritizing. Attributable to the issue of not affording the students ample opportunities to run the wards under supervision during their training, deprived them of the opportunity to develop their delegation skills. They feared challenge, even from their junior members, as they were unsure what the delegation entails. They find it difficult to allocate the tasks to the extent of doing everything themselves in fear of being ridiculed. Their responsibility and accountability level is very low as they continually function under direct supervision.

3.8 SUMMARY FOR THEME 3

Communication skills are an issue in the military setting as it cannot be initiated by a junior member in the lower rank like a nursing student. Permission has to be granted by a senior member, even if that member is a patient. The communication barrier leads to final year nursing students being threatened and diminishes their competence even after qualification. Participants recommended that they be afforded with the opportunity of some level of accountability and responsibility as these might improve their competency.

3.8.1 SKILLS AND COMPETENCE NEEDED TO ENHANCE CLINICAL PRACTICE OF NOVICE PROFESSIONAL NURSES

Regulations for nursing education assume that nurses, on completion of training, have reached a standard prepared for autonomous practice and for which they can be held accountable. There is a general understanding that competence is based on
a combination of components that reflect knowledge understanding and judgment, a range of skills and a range of personal attributes (Lofmark, Smide and Wikblad 2006:722). Evaluation of competence in the transition from student to professional nurse was highlighted by Kramer (1974) who extrapolated this period as shock-like reactions, portrayed in terms such as anxiety, depression and disillusionment regarding work situations for which the students thought they were prepared. The different groups of participants depicted the lack of needed skills and competence from the students for the role of the professional nurse. Novice professional nurses wished that they could have been exposed more to the responsibility and accountability of running the wards earlier in their training, suggesting that this could have strengthened their decision making and communication skills, rendering them more competent.

**Figure 3.5: An illustration of theme 4 and related sub-themes**

Figure 3.5 highlights the factors impacting negatively on the transition of final year nursing students to professional nurses in the military health setting.

There were factors that were labelled as impacting negatively on the transition process of students to professional nurses. These factors created a barrier to the smooth transition period. A thorough elucidation of these factors is stated below.
Sub-theme 4.1: Attitudes of health care professionals

A person’s attitude can either be positive or negative. Students experienced a negative attitude from the health care professionals in the military health care setting. A negative attitude can dampen the atmosphere of learning as it denotes rejection. Students should feel welcomed in the clinical learning area and to feel a sense of belonging as this will enhance their self-esteem and the openness to learning. A positive attitude can enhance the student’s freedom to interact leading to a successful transition. Attitude, according to the Oxford Dictionary, means a complex mental state involving beliefs, feelings, values and dispositions to act in certain ways, the way a person views something or tends to behave towards it, often in an evaluative way.

The students related their frustrations with reference to attitude as such:

‘Honestly we are not prepared and the other thing that contributes is the attitude of professional nurses. Just think when you are doing 2nd year and you ask me something or there’s a procedure going on in the ward I have not been exposed to that particular thing it is for sister for now to show me this is how it’s done but for someone to be saying now go and fetch sterile water and I ask what is sterile water and someone says ahh you guys you just useless. So now students tend to, they tend to stand back because they are afraid of being called useless and stupid you understand. Yes that's the other thing’ (focus group 2 students 4yr, p36).

Attitude plays a major role in guiding human behaviour toward achieving goals, awareness of its consequences and effective processing of complex information about the living environment. The negative attitude that students received from the clinical staff dampened the morale of the students. Low morale of the nursing students results in the lack of motivation and eventually dropping out of the programme in this field (Koushali, Hajiamini and Ebadi 2012:376).

‘I’ve had that bad experience and I never ever wanna work there that was in theatre and I felt so useless, indeed you feel useless, you understand. If somebody is asking you please pass me a pair of gloves and somebody says those ones are stupid and
useless they don’t even know what a pair of gloves is, you know even a first year student understands, that really …’ (focus group students 4yr , p36).

‘And one of the things that causes people to conserve and resign, is the attitude that they get from them. They don’t get an attitude of being welcomed as newly qualified. You are welcomed still as a student and they make you feel that you are a student. So how am I going to be confident?’ (focus group, students 4yr, 1 pg 27).

The above finding is confirmed by Duchscher and Myrick (2008:196) when they pointed out that the new nurses develop a growing resentment which they direct inwards towards themselves for failing to provide the kind of care for which they were educated to. However, attitude plays a major role in guiding human behaviour towards achieving goals, awareness of its consequences and effective processing of complex information about the living environment (Awuah-Peasah, Sarfo and Asamoah, 2013:23)

‘So it makes people to feel bitter and when a student comes, she is in 3rd year, he is in 3rd year and then it comes to their mind, who do you think you are and they have this negative attitude. It gives a negative impact towards students due [to] the way they are being managed’ (focus group 1, students 4yr, p33).

The unit managers had to say this about the attitudes:

‘The attitudes of the professional nurses, the attitudes of nurses that are working even not only the professional nurses even the other categories they need to change their attitudes towards students, the students must feel welcomed, they must feel that they are part of the team’ (individual interview, unit manager 3 p19).

Providing positive experiences for students in the practice setting is essential for learning to occur (Moscaritolo, 2009:17). The professional attitudes of nursing staff significantly influences student learning in the clinical environment. Poor treatment of nursing students is not uncommon in the workplace. This is often the result of:

- Increased workload;

- Lack of teaching skills;
- Staff shortages

- Staff feeling threatened by nursing students

If students do not feel supported in their environment, for example if they are treated with hostility and disrespect or even ignored completely, they are unable to participate in the necessary communication to further their learning activities (Twentyman and Eaton 2006:35). Healy (2012:29) stated that the importance of organisational culture was raised during a study and untoward attitudes of staff to new graduates were noted to be one of the key barriers to successful placement.

Sub-theme 4.2: Dual transition of the military health system

The novice professional nurses holds the rank of a candidate officer in the military setting. This is the lowest rank in the Defence Force. There is a need to transition from being a candidate officer to being an officer and obtaining a rank of a lieutenant. In the military the other transition, although not dependent on the previous one, entirely affects it. This means that the transition from a student to a professional nurse can be effected though not recognized until militarily completed. Novice professional nurses cannot be recognized militarily to command and control as they do not have the necessary rank to do that.

‘I encounter problems when I come to patients because since you qualify and you are having this lower rank, some patients they underestimate according to ranks. If you come in they are calling for assistance and you come in they will just look at you at the shoulders and say CO (candidate officer) no, no, no, I want the sister here who are you’

For professional nurses in the SAMHS to be in charge of a nursing unit they have to undergo the military transition first and become rank holding members. The process can take up to four years depending on the availability of slots to undergo the military formative course in order to complete the transition period. In the meantime, the newly qualified professional nurses experience difficulty as they are not recognized as having the authority to treat patients competently or even to give simple orders. Their competency is challenged leading them to not be assertive enough as
professional nurses, resulting in frustration on their side. The following excerpts denote their frustration:

‘This issue of ranks of being COs has a negative impact on them. It becomes difficult for them to recognize themselves as professionals’. (individual interview, unit manager 5, p23)

‘Like now neh, the bridging course started, we have warrant officers and we have staff sergeants those people are higher rank than me professionally I am more qualified than them, but now if you have to delegate somebody and he is a staff sergeant. I once had an experience just now a few months ago, this person refused, literally refused, to take orders from me you understand and I can’t say anything. Military wise even if we have to go to the military court he is going to win the case, he is a staff sergeant I am just a CO. Ja we are, we really get frustrated’. (focus group 2, novice p/n, p53-54)

The unit managers felt that nursing should be demilitarized so that professional nurses can claim their status immediately after qualification. They had this to say to show their discontentment.

‘The nursing in the military should be demilitarized. They should be given the epaulettes just like outside so that people can know that you are a registered nurse’ (individual interview, unit manager 6, pg 25).

‘If we start first by demilitarizing nursing so that when a patient comes in they can see that this is a sister … ’. (individual interview, unit manager 6, p25

Sub-theme 4.4: Shortage of staff in SAHMS

Having inadequate staff can decrease the level of quality performance applied to one’s tasks. For efficient and effective provision of service in all spheres, it is the obligation of the management concerned to provide satisfactory staff. Shortage of staff can lead to conflicts and role ambiguity amongst members. Staffing effectiveness is described by the Joint Commission (2007:2) as ensuring an appropriate skill mix and numbers of competent staff to meet patients’ needs. Dall, Chen, Seifert, Maddox and Hogan (2009:98) found economic advantages for
increasing nurse staffing levels including decreased length of stay in hospitals; hospital acquired conditions and reduced mortality. One of the major challenges facing the nursing profession that was deliberated upon at the National Nursing Summit in 2011 was the dire shortage of nursing personnel. The summit concluded that the shortage of human resources for health undermines the ability of the country to improve health outcomes and disadvantages the performance of health systems.

The issue of shortage of staff has ominous consequences for the students as their accompaniment needs cannot be met. They suffered in silence as they observed students from other colleges being mentored and accompanied by their nurse educators. They were unjustly left to fend for themselves. The educators complained that the shortage of staff makes their work more complex. They had this to say:

‘Half the time you find that a lecturer is supposed to be here, prepare for block and is expected that the following month she is supposed to follow up the students, whereas obviously you will find out that even the first years are still around and it’s not easy. The lecturer is still finalizing, doing whatever, tests marks at the same time maybe try to look into the issues of assignments and whatever’ (individual interview, nurse educator 1, p2).

Mabuda, Potgieter and Alberts (2008:23) agreed with this statement when they stated that nurse educators do not do follow up on students allocated in the clinical areas as there is less time available in many cases for work with student nurses in the clinical setting. Another important report influencing the discourse around shortages in the health sector in South Africa, as well as trying to quantify the needs in the sector, is the Department of Health (DoH), National Human Resources for Health Planning Framework 2006. The overall report clearly identifies a shortage of health personnel in both the public and private sectors as key challenges for the South African health sector.

‘Neh we are overworked we don’t do a lot of accompaniment. There is a eh, there is no support between the lecturers and the hospital whereby you know that if they are hospital somebody will take care of, because we do not have any clinical tutors in at the moment’ (individual interview, nurse educator 2, p3).
Traditionally, teaching responsibilities and support for student nurses in the clinical practice was shared between clinical staff, nurse educators and clinical educators (Broad, Walker, Boden and Barnes, 2011:1298). Apparently this is no longer the case due to staff shortages in all spheres of nursing practice. The sole responsibility of teaching has been abandoned to the nurse educators and not shared amongst the stakeholders involved in teaching of the students.

“We must also remember it is very difficult to do creative innovative teaching if you have 82 to 100 students in class. It’s easier if they 10 or 20’ (individual interview, nurse educator p10).

‘I know it is difficult especially with this shortage, but we have to get a way of doing it’ (individual interview, nurse educator 5, p11).

The Utilization Guide for the ANA (American Nurses Association) Principles for Nurse Staffing (2005b) offers evidence for application of the nine principles ANA suggests ensuring appropriate staffing whilst the Guide reaffirms the difficulties in staffing decisions and the need to identify tools and processes for better staffing. The guidelines suggest the use of patient classification systems; nursing judgment with regard to the individual needs of the patient population; integration of resources which support the scope and standards of nursing practice; involvement of the nurse in decisions regarding the tools and evaluation of products that may be used to assist in staffing decisions (ANA, 2005b). Fundamental prospects were lost where students could have benefited from important cases especially from the outside institutions where placement only comes seldom. The nursing college only concentrated on the theoretical portion of nursing and completely overlooked the most important element of nursing, namely the clinical part.

The students also had their views pertaining to shortages of staff:

‘We try at most in our wards, we try and allocate them to registered nurses’ tasks, eh sometimes due to staff shortage we do need them to work as staff nurses’ (individual interview, unit manager 3, p18)
Levett-Jones (2005:41) posited that the current nursing shortages and difficulties in working environments may have in fact exacerbated the tension between employers and nursing education institutions, at times placing the students in an untenable position. DENOSA also asserts that there is a shortage of nurses in the profession to deal with its health and educational needs (Denosa 24, October 2007) and further points out that this directly impacts on the ability of the health sector to deliver an efficient service.

3.9 SUMMARY FOR THEME 4

The military transition that is not on par with the professional transition poses many challenges for the newly qualified professional nurses as they are still ranked as juniors and can hardly take decisions on behalf of the patient. They have studied throughout the years but have to wait to complete the military officers’ forming course to be recognized as officers. The frustration is that they do not feel a sense of authority to manage the wards.

3.9.1 FACTORS IMPACTING NEGATIVELY ON THE TRANSITION PROCESS OF STUDENTS IN TO PROFESSIONAL NURSES

Theme four focused on the factors impacting negatively on the transition of final year nursing students to professional nurses as related by the different groups of participants. The general perception was that the transition could be easier and more manageable if the above-mentioned impediments could be dealt with. The student nurses felt they needed to be accepted and made to feel part of the team, but the negative attitude of the staff members made this impossible. The atmosphere was viewed as tense and hostile most of the time. The professional nurses in particular, did not trust the nursing skills of the students although they were also not willing or able to teach them to develop. The shortage of staff also contributed to the frustrations of professional nurses as it made it difficult to allocate their time to teach, supervise or mentor the students. On the other hand the novice professional nurses felt threatened to give orders and to allocate tasks to higher ranking members as they did not feel confident enough to do that, even though those members were their juniors professionally. They advocated for the use of professional epaulettes as those could boost their morale and give them more authority.
3.10 CONCLUSION

Chapter 3 embarked on the analysis of data derived from phase 1. Themes relating to the issues affecting the transition of final year nursing students to professional nurses were comprehensively outlined and discussed. Emphasis was put on the preparedness or unpreparedness of the students to take up the role of being professional nurses; the strategies that could facilitate or enhance transition, skills and competencies needed to be competent nurse practitioners and the factors impacting negatively on the transition. Successful transition programmes are said to encourage new nurses to remain in the workforce and maximize the community’s investment in education and training (Heath, Duncan, Lowe, Macri and Ramsay, 2002). The extent to which the results are achieved by existing graduate transition programmes remains debatable, hence the challenge undertaken to develop a best practice guideline for successful transition of final year nursing students to professional nurse. It is imperative though that student nurses be adequately prepared to be confident and competent professional nurses to deliver quality nursing care. Educational institutions should work hand in hand with practice situations on providing preparatory means for role transition of senior students. A seasoned mentoring programme could be advisable in effortlessly preparing the new graduates to embark on their new role.
CHAPTER 4

INTEGRATIVE LITERATURE REVIEW REPORT

Chapter 1 gave a prelude to the study, in chapter 2 the methodology structuring the study was outlined whilst chapter 3 discussed the amalgamation of the findings from the focus group discussions from both the final year nursing students and novice professionals and the in-depth interviews from unit managers and nurse educators. The narratives clearly designated the need for a best practice guideline to facilitate the smooth transition period of the final year nursing students. Chapter 4 will report on the synthesis of the integrative literature review related to the transition of final year nursing students to professional nurses.

4.1 INTRODUCTION

A literature report outlines systematically how the literature was searched, and the synthesis thereof that formulated the themes that were eventually part of the formation of a best practice guideline.

4.2 LITERATURE REVIEW

A literature review is a thorough summary and critical analysis of the relevant available studies found in the literature related to a topic being studied. The literature review goes beyond the search for information and includes the identification and articulation of relationships between the literature and the area of research (Boote and Beile, 2005:34). The terms integrative literature review, systematic review and meta-analysis are sometimes used interchangeably. Although there are similarities, the methodologies differ as they have distinctive procedures that ultimately lead to different objectives and results. According to Crossetti (2012:12), a systematic review is characterized by carefully summarized research evidence applied to answer questions focusing on clinical practice. It is exclusively conducted through a strict selection process and analysis of several publications on the problem under study. Meta-analysis on the other hand is a methodology that quantitatively integrates and verifies the association of results from multiple recent studies of a certain event in clinical practice.
An integrative literature review, however, is an explicit review process that summarizes past empirical or theoretical literature to provide a more comprehensive understanding of a particular phenomenon (Crawford, Valdez and Morita, 2010:23). An integrative review of literature was conducted to help inform the development of a best practice guideline for the transition of final year nursing students to professional nurses. The literature review was done on this topic of interest with the aim of contextualizing the study problem and the review examined evidence pertaining to the best practice guidelines available with regard to the transition of nursing students to professional nurses. There are different levels of evidence available, see table 4.1. Level One (1) evidence was used for the purpose of this study as the study sought to review literature on best practice guidelines based on systematic reviews of the area under study.

Literature dating from 2008 to 2014 was used due to new studies and methods that evolved in this period on the development of best practice guidelines. Once the best practice guidelines were retrieved, they were critically appraised using the Appraisal of Guidelines for Research and Evaluation (AGREE II) tool since this is the most relevant tool to appraise guidelines (see data extraction section for further elucidation on this process). The purpose of the tool is to provide a framework to assess the quality of the guidelines, provide a methodological strategy for the development of guidelines and to inform what information and how information ought to be reported in guidelines. Data was then extracted and synthesized from relevant guidelines.

LoBindo-Wood and Harber (2010:16) developed levels of evidence in a hierarchical order to rate evidence. Table 4.1 below illustrates the levels of evidence used to classify the studies selected for inclusion or exclusion in the research study.
Table 4.1: Levels of evidence hierarchy by LoBindo-Wood and Harber (2010:16)

<table>
<thead>
<tr>
<th>LEVEL OF EVIDENCE</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I:</td>
<td>Best (Clinical) practice guidelines based on systematic reviews.</td>
</tr>
<tr>
<td></td>
<td>Systematic reviews or meta-analysis</td>
</tr>
<tr>
<td>Level II</td>
<td>A well designed randomized controlled trial or randomized cross over studies</td>
</tr>
<tr>
<td>Level III</td>
<td>Controlled trial without randomization</td>
</tr>
<tr>
<td>Level IV</td>
<td>Single not-experimental study</td>
</tr>
<tr>
<td></td>
<td>* Descriptive, survey and/or observational</td>
</tr>
<tr>
<td></td>
<td>* Case reports</td>
</tr>
<tr>
<td></td>
<td>* Cohort, correlation, case control</td>
</tr>
<tr>
<td>Level V</td>
<td>Systematic reviews of descriptive and qualitative studies</td>
</tr>
<tr>
<td>Level VI</td>
<td>Single descriptive or qualitative study</td>
</tr>
<tr>
<td>Level VII</td>
<td>Opinion of experts and/or reports or expert committee/conference paper</td>
</tr>
</tbody>
</table>

For the purpose of this study Level I evidence was used where an integrative review on the best practice guidelines was conducted. The following steps of the integrative literature review was adopted from Russell (2011:1)

The following steps of the integrative literature review as employed in this study.

Step 1, Problem formulation and review question
Step 2, Literature searching process

Step 3, Data evaluation

Step 4, Data analysis

Step 5, Data extraction

Each step will be dealt with in more detail.

**Step 1: Problem formulation and review question**

The first step embarks on the formulation of the problem at hand and answers the review question. The problem must be explicit and clearly stated in order to outline the search for information. Cronin, Ryan and Coughlan (2008:38) advise that the research topic must be refined in such a way that it does not deviate from the initial information needed. According to the Curtin University Library, (2014), PICO (Population, Interest, Context and Outcome) is a useful tool for asking focused clinical questions. The library also affords the researchers the opportunity to use the PICo format. For the purpose of this study the PICo format will be used due to the calibre of the study which is qualitative, and no specific requirement for an outcome statement exists in qualitative reviews, therefore a comparator is not required. The PICo focuses only on the population, intervention and context.

**Table 4.2: Three components in the PICo format**

<table>
<thead>
<tr>
<th>P</th>
<th>I</th>
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<tbody>
<tr>
<td>Population</td>
<td>Interest</td>
<td>Context</td>
</tr>
<tr>
<td>The type of person involved: Final year nursing students, novice professional nurses, unit managers and nurse educators</td>
<td>The phenomenon of interest relates to a defined event, activity, experience or process: transition of final year nursing students to professional nurses.</td>
<td>This is the setting or distinct characteristics: South African Military Health Service</td>
</tr>
</tbody>
</table>
Table 4.2 above depicts the three components in the PICo format. The PICO is used to ensure that clinical questions are clearly answered and the focus is kept on the area of interest. Emphasis however will be placed on answering the review question as it represents the clinical question in this case, thereby utilizing the PICo as mentioned above.

The review question formulated would therefore be:

What is the best available evidence that will guide the development of a best practice guideline for the transition of final year nursing students to professional nurses in SAMHS?

**Step2: Literature searching process**

Once the question or topic was formulated the review of literature commenced. A systematic search of literature was conducted. The search for this topic included nursing and medical references and health related fields. The scoping review included articles found in databases and grey literature such as unpublished theses and dissertations responding to the transition of student nurses to professional nurses. The researcher however concentrated only on Level 1 evidence based best practice guidelines. Databases specialising in best practice guidelines (BPG) were thoroughly searched for BPGs (see annexure O for the databases related to search engines, key words used and types of literature searched).

Five more computerized databases were searched. A combination of key words; “transition”, “best practice guideline”, “student nurses”, “factors influencing transition,” professional nurses” and “healthcare” were used to enhance the search. All words were searched under full title and with full PDF. Abstracts were read in order to obtain a preview of the contents and to make decisions on whether to use the documents. The abovementioned strategy ensured that a comprehensive search was conducted and a full text provided a more elaborate comprehension of the topic under discussion. The following data bases were accessed and utilized: CINAHL, Ebscohost, A-Z, Pubmed and Science Direct. The guidelines that were retained were those that were most relevant or addressed the topic under study, while the ones not closely related to the study or not answering the review question were discarded, as
elaborated on in the data extraction phase. Literature searched and utilised for the purpose of this study represented the phenomenon under study. The main themes and ideas from the literature were identified as responding to the review question formulated for the literature search.

**Step 3: Data evaluation stage**

The third stage in the integrative review process is the data evaluation phase. During this phase, the reviewer critically judges whether the article comprises data that can be used in the study. The decision can be *a priori*, in which case the judgment to include or exclude certain articles is made before data collection, or *a posteriori*, in which case the decision is made to include all articles but less weight is then given to the weaker articles. In this study a decision to either include or exclude the guidelines was taken after data collection. A weight of 60% was allocated for the guidelines that were deemed suitable for inclusion in the study as this was considered an acceptable weighting to be included in the study.

### 4.2.1 Eligibility Criteria

The search process is based on the eligibility criteria that reviewers establish before they begin the process of identifying, locating and retrieving the research needed to address the problem of best practice guidelines. The eligibility criteria specify which studies will be included and which will be excluded from the review (Meline, 2006:21). Inclusion and exclusion criteria were used to determine a relevant primary search. Selection of studies to be included is an essential task as it is a critical indicator to assess the power of generalisation and reliability of the conclusions (Toracco, 2005:362).

### 4.2.2 Inclusion criteria

On completion of the above-mentioned 3 steps of the literature review, namely formulating the review question, literature search and data evaluation, the following inclusion criteria were devised for this study:

- All Level 1 evidence and BPGs focusing on guidelines on the transition
• Studies published in English as the researcher did not have the capability of reviewing documents in other languages due to translation costs
• Literature published between 2008 and 2014 as the researcher needed to concentrate on the most recent literature.

4.2.3 Exclusion criteria

The exclusion criteria will be based on the following:

• Literature on transitions other than health care professionals

4.2.4 Selection process for inclusion and exclusion.

All guidelines that fitted the criteria for the study i.e. answering the research question and were retrieved and classified correctly by the researcher and the independent coder. The studies that did not meet the required criteria after critical appraisal using the AGREE II instrument were excluded on the basis of rigour. The exclusion was done as the titles and contents clearly disqualified them by not responding to the review question since these studies either did not address the transition of students or were not health related. Abstracts were used in order to determine full inclusion of the study. The inclusion and exclusion criteria were applied by both the researcher and the independent reviewer. Eligible guidelines were presumed at this stage to be representative of the population of relevant guidelines and were then included in the study. Consensus following conscious deliberation was then reached between the two reviewers being the independent appraiser and the primary reviewer (researcher) as to which guidelines to include or exclude from the study.

Step 4: Data analysis

In this stage guidelines selected were critically analysed according to relevance of information pertinent to the study and representativeness. The analysis included verifying whether the data in the guidelines addressed the research question. After extensive reading of the guidelines, selected, valid data extraction tool was used to extract the data.
For the purpose of this study the AGREE II instrument was used as it is the most relevant for appraising best practice guidelines and serves to extract data from best practice guidelines selected. The guidelines searched were organized and categorized in chronological order as this assisted with the knowledge about historical evolution of the phenomenon under study. The AGREE II instrument was utilized as it served to extract and appraise best practice guidelines found. The AGREE II consists of 23 items organized within six domains, followed by two global rating items for an overall assessment. Each domain captures a specific aspect of guideline quality.

It is recommended that the tool be used by at least two independent appraisers as extrapolated earlier as this will enhance the reliability of the assessment (Brouwers, 2009:6). The independent appraiser chosen to appraise the selected guidelines is an experienced senior lecturer with vast knowledge in the field of health and nursing and in appraising and reviewing guidelines.

Figure 4.1

Rating scale for AGREE II according to (BROUWERS, 2009:8)

All AGREE II items are rated on a 7 point scale (1- strongly disagree to 7- strongly agree).

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Strongly agree</td>
</tr>
</tbody>
</table>

Score of 1: (Strongly disagree): A score of 1 should be given when there is no information that is relevant to the AGREE II item.

Score of 7: A score of 7 should be given if the quality of reporting is exceptional and where a full criterion has been met.
Scores of 2 to 6 should be assigned if the reporting of the AGREE II does not meet the full criteria. The score was assigned depending on the completeness and quality of reporting. For the purpose of this study a weight of 60% after the ratings and scores were assigned to the guidelines was deemed agreeable and was accepted for the appraisal. Guidelines with a weight of 60% were considered to be strong as they were deemed to have more rigour, and to contribute more weight to the discussion and recommendations derived from the review.

**Step 5: Data extraction process**

Data was extracted for Level 1 evidence, which is best practice guidelines based on systematic reviews. The data extraction particularly focused on whether the objective of the guideline was mentioned, the population had been clearly identified, the guideline development group included individuals from all relevant professional groups, systematic methods were used to search for evidence, the criteria for selecting evidence were clearly defined and the methods for formulating the recommendations were clearly described, the recommendations were specific and unambiguous and lastly the views of the funding body had not influenced the content of the guideline. Data was then summarized using the different headings as stated in the AGREE appraisal tool. The AGREE II appraisal tool was used as there was no other structured data extraction tool available.

To ensure trustworthiness and rigour during data extraction and synthesis a 4 step systematic process was followed. Firstly, a scoping review was done where all guidelines pertaining to the topic on transition were searched using a standard format, (authors, title, and topic, date of publication, design recommendations and findings). Secondly, only best practice guidelines were sifted from the rest of the raw data and considered for inclusion (see Annexure L). Data from each guideline was appraised through the use of the AGREE II instrument due to the unavailability of another developed data extraction tool as indicated earlier, and the fact that data from guidelines is extracted efficiently and effectively using the AGREE II instrument. Each study was read carefully in order to capture the most relevant data needed for the study. The extracted information was compared and patterns recorded as they became apparent. The results of this process were further scrutinized, where groupings of similar data and the identification of key themes was realized. Four
themes were then identified that will be discussed later. The same process was undertaken by the independent appraiser to promote the trustworthiness of the study. Each guideline was assigned marks in percentages for inclusion into the study to ensure its rigour.

All guidelines that were deemed relevant with regard to the established criteria were included in the study. A table was formulated detailing information about each article included in the study (see Annexure L).

4.3 DESCRIPTION OF THE EVIDENCE

A total of twenty-four (24) guidelines on transition were searched. Of the 24 guidelines eight (8) were not considered for the study (see annexure P) while sixteen (16) guidelines were identified for possible inclusion in the integrative literature review. After the critical appraisal, nine (9) guidelines were found to not be relevant for the study and were therefore eliminated (see Annexure M for exclusion reasons). After the appraisal seven (7) guidelines were included for data extraction and synthesis in the integrative review and themes were subsequently formulated.

Figure 4.1: A summary of the best practice guidelines used for the integrative literature review
The above schematic representation denotes the guidelines that were retrieved, guidelines that did not meet the criteria for inclusion, those that were not fully considered and **lastly the guidelines that were included and used in the study.**

4.4 **RESULTS**

The following section deliberates on the results of the integrative literature review. Four themes came out strongly in support of the transition of final year nursing students to professional nurses that were identified for discussion after the appraisal and extraction of the data from the guidelines. Since there is no specific tool for the appraisal of guidelines, the results will be based on the elements of the AGREE II tool (see Annexure I). All guidelines appraised were allocated a score above 60% to obtain the best available evidence. The researcher as well as the second appraiser allocated the scores independently for all the relevant sixteen guidelines initially selected as eight of the 24 original guidelines were not considered since they did not meet the inclusion criteria. A score of less than 60% indicated a guideline considered too weak to be able to contribute to the discussion. Five telephonic discussions were held where the results from both the independent appraiser and the researcher were discussed until consensus was reached on which guidelines were deemed fit for inclusion in the synthesis. Only seven guidelines were then considered for the synthesis and development of themes. The themes included the following: support for new graduates; the need for socialization and belonging; the need for a positive clinical learning environment and improved retention. These themes were considered as they emerged from about 80% of the guidelines which is about six of the seven guidelines. Themes that only emerged once or twice were not considered as strong themes for discussion and were excluded from the discussion.

All of the seven (7) appraised guidelines addressed the support for new graduates. Five (5) guidelines addressed the need for socialization and belonging, whilst the need for a positive clinical environment was addressed by all seven (7) appraised guidelines and lastly improved retention was addressed in six (6) of the appraised guidelines.
4.4.1 Support for final year nursing students and new graduates

A guideline developed by the Nurses Association of New Brunswick (2012:6), suggested that nursing graduates enter the profession without a transition phase, and indicated that newly qualified professional nurses needed support to effectively integrate and safely transfer the competencies they have acquired. The guideline further emphasised that the professional nurses should mentor, encourage and support new graduates as these are especially vital activities to the new graduate. New graduates should therefore be provided with mentors to give support beyond the preceptored period of transition. Further, there should be the assurance of new opportunities for the newly graduated nurses to connect with other new graduate nurses so they can provide each other with support.

Additionally, the American Organization of Nurse Executives (AONE) (2010:1) recommended a wide variety of support requirements for newly qualified nurses that are necessary from all levels throughout the organisation. On evaluation of the guideline, it came to the fore that new graduates experienced some form of reality shock and required some form of support for longer than six (6) months post-appointment to address this transitional period. It was further stressed that post-transition support programmes should be in place to aid in the retention of the newly qualified nurse.

Further, Rush, Adamack and Gordon’s guideline (2013:15) recommended that, during the transition period, formal supports should continue to be available for at least six to nine months post-hiring. Preceptors working with new graduates should have the required preceptor education. The uniqueness of this guideline is the emphasis placed on the positive impact supportive unit staff had on the new graduate’s transition experience. The more helpful new graduate nurses found their unit staff in supporting their transition, the more positive their transition experiences became.

A form of support could be information transmission by the senior nursing staff to the graduates, as mentioned by Klomp (2009:5). This author suggested that graduates needed not only the information concerning the protocols of the organization, but they also needed support from ward or unit staff to integrate the learned theory into
practice. It was further highlighted that programmes should encourage peer support where support groups can be internet-based or face to face. Besides peer support for theory transmission, the rationale for the groups was to provide an opportunity for debriefing and to provide useful psychosocial support. Adequate support was proven to ease anxiety for early graduate nurses and to enhance job satisfaction. According to Klomp (2009:5), other studies have proven that support is critical to transition and integration into the hospital and this support is best when provided in the first four weeks of the programme and again with any ward rotation. Further input revealed that supportive environments are equally important in assisting the new graduate to transition and to function as part of the team (Klomp, 2009:4). Klomp (2009:6) further asserted that there is evidence to suggest the nurse unit managers are viewed as leaders by new graduates and are very influential in setting the tone of that supportive work environment and culture. Supportive culture in this case was described as:

- nurturing for new graduates
- allowing students time to learn
- giving clear objectives for both students and newly qualified professional nurses
- providing feedback on performance
- assigning peer and mentor support

A guideline synthesis by the Medical Radiation Technologists (2013:12) concurred when stating that there are many scenarios within the clinical environment where individuals who are engaged in transition would benefit from having a role model to guide and support them. A good orientation, welcoming the learner and creating a positive environment was deemed very supportive to the learner.

According to Hayes (2014:3-4), mentoring and support should be provided throughout the curriculum. Healy and Howe (2012:29) reiterated that it is widely recognized that support is critical to the graduate nurse/midwife transition from novice to advanced beginner-level practitioner and to the integration of new practitioners safely and effectively into organisational processes. Importantly, support must be appropriate to the stage of the nurses’ transition. Overall, it was
noted that support should focus on work competency but it must also recognise the importance of new graduates developing a sense of belonging and building positive relationships. While some have contended that a supportive organisational culture could be as effective as a structured graduate nurse/midwife programmeme, most literature recognised the need for a specific programmeme to support the transition into nursing/midwifery practice within the context of a supportive organisational culture. According to Healy (2012:27), this ‘supportive culture’ referred not only to the resources provided to implement the graduate programmeme but more broadly, the value the organisation places on learning.

The issue of support was reported as pivotal for the transition period as it improved learning and developed competency for nursing students and newly qualified professional nurses. Dyess, (2009:406) concurred that new graduates must be supported throughout their first year of entering clinical practice as they will benefit from longer term support in order to build their clinical judgment and improve their clinical skills.

4.4.2 The need for socialization and belonging

For students to socialize and belong in the world of nursing, they need to feel accepted and approved of by the staff members as this indicates a feeling of belonging. Most of all students need to be made to feel like part of the team and not be isolated. In a guideline by Rush (2013:16) the outcomes of the study were that new graduates remarked on this as well, but indicated that they often felt alone in the unit, trying to coordinate many things without support. There was a strong subjective feedback from new graduates that revealed a lack of acceptance and respect, and an insensitivity of experienced nurses to the new graduate’s needs for continued development in time management skills.

In a guideline by Klomp (2009:3) it is reiterated that treating early graduates as part of the team and assisting them to develop an identity and feeling part of the organisation assists their career and commitment. A welcoming environment with a well-planned orientation programme designed specifically for early graduates made the graduates feel valued. Further work revealed that supportive environments are equally important in assisting the graduate to transition and to function as part of the
The author further proposed that development of an identity and feeling part of the organisation can assist the career commitment of the new graduate (Klomp, 2009:5).

According to AONE (2010:1) one of the guiding principles defined in this document was the issue of socialisation. When these guiding principles were effectively implemented they would ensure the successful transition of the novice nurses into their professional role and create a professional bond between the newly qualified nurse and the organisation.

A guideline by the Nurses Association of New Brunswick (2012:6) stated that when the newly qualified professional nurses felt they were perceived as valued team members and had a sense of belonging, they were willing and capable of accepting responsibility and demonstrating accountability for their practice by recognising their limitations, asking questions, exercising professional judgment and determining when consultation was required.

According to a guideline by Healy (2012:13), the issue of transitioning from student status to professional status presented challenges in many disciplines. One of the challenges faced by recent nursing and midwifery graduates was working and being accepted as part of a multidisciplinary team, including effectively communicating with medical practitioners, understanding the role of the nurse/midwife within the team and having the confidence to contribute to decisions. Frequent rotations were also thought to interrupt the process of professional socialisation, which was considered critical in the initial months of professional practice (Healy, 2012:35).

Healy (2012:17) further explained that socialisation and the development of a sense of belonging to both the organisation and the profession should be fostered. Not feeling accepted, not fitting in and a lack of confidence depletes the morale and confidence of the new graduate. Nursing students’ educational experiences involved more than acquiring a body of scientific knowledge and patient care skills. Nursing students learned how to relate to patients and themselves as nurses, that is, to construct their professional identities. Thus, while the occurrence of the socialization process generated benefits, its non-occurrence entailed severe consequences including a feeling of alienation and non-belonging.
4.4.3 Positive clinical learning environment

A positive clinical environment is a significant factor potentially impacting new graduate’s transition. A guideline by Rush, Adamack and Gordon (2013:47) demonstrated that “healthy” workplace environments reduced transition shock and promoted transition. A further remark in the guideline of the Canadian Association of Medical Radiation Technologists (2013:3) stated that it was during the clinical practicum that the student developed the skills and attitudes necessary to become a competent practitioner. Those responsible for assigning students to practical settings must look very closely at the environment in which the practicum occurs. It was further cited that students training in a clinical environment in which they receive guidance, instruction and have a positive experience will derive a great deal of satisfaction and reward during their training. Students were likely to develop a positive attitude towards their chosen profession and would commit to and value life-long learning. Such an environment suggested a positive atmosphere that all those who interacted with the students would also find rewarding.

Another guideline by Hayes (2012:28) stated that the acquisition of knowledge and skills happened best when learning is planned, conscious, deliberate, efficient, and organized both in the academic and practice settings. The promotion of clinical learning, assimilation of knowledge, and evaluation of goal achievement both by the individual newly qualified professional nurse and the employer were critical factors for successful transition to employment and to ongoing professional practice. A guideline by Klomp (2009:5) stated that a positive learning environment has a number of characteristics, including valuing educators and learners. A clinical environment should be a safe and supportive work environment that is welcoming with a well-planned orientation programme that enables new graduates to feel valued. She further emphasised that positive interpersonal and professional interactions correlated well with positive learning environments.

On evaluating a guideline by the Nurses Association of New Brunswick (2012:7), the opinion was that the organisation should provide initial work experiences in the same practice environment and with similar client populations to facilitate consolidation of knowledge. Healy (2012:28) identified key elements of best practice clinical learning
environments which underpinned a high quality educational environment, irrespective of discipline or setting. These were:

- An organisational culture that valued learning
- Availability of best clinical practice guidelines
- A positive learning environment
- A supportive health service-training provider relationship
- Effective communication processes

These key elements should be considered to facilitate a smooth transition from novice to professional nurse. Furthermore, the guideline developed by AONE (2010:1) stated that operating under the premise that the preparation for the transition of the newly qualified nurse cannot on its own meet the requirements for practice and produce confident and competent professional nurses, challenges the nursing profession along with health care organisations to define and implement strategies to create a positive learning and supportive professional environment that will position the new graduate nurse for success.

The general consensus under this topic is that the clinical environment should be welcoming and safe for practice for newly qualified professional nurses and students. That is, it should build competence through the development of clinical knowledge and clinical skills. According to Henderson, Briggs, Schoonbeek and Paterson (2011:198), a positive clinical learning environment should be fostered as it improves the learning and builds self confidence in the new graduate. It further declared that a positive learning environment offers the opportunity for safe practice which improves learning development of the newly graduated nurse.

4.4.4 Improved retention

A consistent theme throughout the literature was that formal transition programmes improve retention. A guideline by Healy (2012:33) noted that one of the benefits commonly cited in the use of transition programmes included improved retention rates.
Klomp (2009:3) suggested that the organisations that provide career assistance and foster skill development can assist employees to focus on career development and can bind them more closely to the organisation, thereby increasing the retention rates.

Medical Radiation Technologists (2013:4) asserted that transition programmes provide the opportunity to develop and practice clinical skills with a clinical expert on a one-to-one basis, which leads to increased confidence thus increasing satisfaction and retention of the professional and new graduates. Hayes (2014:3) furthermore indicated that one of the factors promoting new nurse retention is aligning the students with the desired employer and work setting. The author further indicated that numerous other studies reported that transition programmes promoted job satisfaction and reduced staff-turnover (Hayes, 2014:3).

Based on the guiding principles suggested by AONE (2010:1), effective implementation of the guideline regarding the retention of new graduates would ensure effective role modelling of the professional culture required for sustaining nurses within the profession. Outcomes of transition programmes included improved retention and high engagement of new graduates within the profession, organization and area of practice. It is further emphasized that post-transition support programmes should be in place to aid in the retention of the newly qualified nurses (AONE 2010:2).

In a guideline by Rush et al. (2013:15), evidence showed that within the transition programme longer orientations that met the new graduate’s needs resulted in better satisfaction and retention. Also, strong evidence within the literature demonstrated retention was higher and turnover was lower when new graduates were involved in a transition programme. It was further argued that improved retention had a direct impact on cost saving for the organization and these costs are further ploughed back into the implementation of the transition programmes (Rush, et al., 2013:50).

Retention of newly qualified professional nurses has been based on several factors including low salaries, attitudes of personnel in the clinical area and the unfavourable work conditions. According to Frost, Nickolai, Desir and Fairchild (2013:3) it is implied that retention rates are low for new nurse graduates as a result of stressful
work environments, coupled with inadequate support during the transition from student to professional practice. The authors suggest that mentors can assist the new graduate by increasing their self-confidence, improving their professionalism and self-worth, which will in turn improve the retention rates.

4.5 CONCLUSION

Chapter 4 illustrated the integrative literature review and particularly concentrated on the synthesis of the guidelines based on transition of final year nursing students to professional nurses. Data was extracted using the AGREE II instrument for those guidelines that fitted the phenomenon under study. Themes were then formulated and outlined from the synthesis of the guidelines. These themes were presented and thoroughly discussed. A draft guideline was subsequently developed and will be presented in chapter 5 of the study.
CHAPTER 5

GUIDELINE DEVELOPMENT PROCESS

Chapter 1 discussed the overview and introduction to the study. Chapter 2 dealt with the methodology and explicitly stated the steps that underpinned this research. Data was collected and analysed in chapter 3 where themes and subthemes emerged based on the information provided by the different participants and concluded phase 1 of the study. Chapter 4 embarked on the integrative literature review which formed part of phase 2 of the study. Chapter 5 will then triangulate the data from phases 1 and 2 to form new themes that will contribute to the development of a best practice guideline. The guideline development process will also be discussed in this chapter.

5.1 INTRODUCTION

The transition period of student nurses to professional nurses has been acknowledged as being very stressful. The reason for this is that final year nursing students are trying to consolidate the experience and knowledge gained during their four year training period into clinical decision making and problem solving skills to apply in the working environment (Broad, Walker, Boden and Barnes, 2011:1299). The students require support and guidance to effect a successful transition from being a student to being a professional nurse. The transition of students in the military health setting might be experienced differently due to the context that is vastly different from the other health care settings (Moore, 2006: 541).

Phase 1 of the study discussed the qualitative approach employed to form the basis of the study, which was contextual in nature. A rigorous research methodology was discussed. In Phase two an integrative literature review was done on available guidelines for the transition of final year nursing students to professional nurses. Data was extracted for Level 1 evidence or best practice guidelines. The data was then summarized using the different headings as stated in the AGREE 11 appraisal tool. An integrative literature review report was then compiled. Four themes emerged from phase two of the study and the two phases were amalgamated to form phase 3, namely to develop a best practice guideline for the transition of final year nursing students to professional nurses in SAMHS. A discussion of triangulated themes will follow.
Table 5.1: Synthesis of Phase 1 and Phase 2 and triangulation of the two phases

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**PHASE 1: Summary of the qualitative findings related to the transition of final year nursing students to professional nurses in SAMHS**

- Quality nursing care
- Responsibility and accountability to fulfil the role of the professional nurse

**Factors impacting negatively on the transition process of students into professional nurses**

- Attitude of healthcare professionals
- Dual transition in the military health system
- Shortage of staff in SAMHS

**PHASE 2: Integrative review of guidelines for the transition of final year nursing students to professional nurses**

**Triangulation of phase 1 and 2**
Table 5.1 above depicts the themes that emerged from the triangulation of data from phases 1 and 2. A draft guideline will be presented in chapter 6 and will provide direction to the users on how to utilise the guideline.

5.2 TRIANGULATION OF THE THEMES

The four themes that emerged following triangulation of data from phase 1 and 2 will now be discussed.

5.2.1 Support to prepare final year nursing students and new graduates to take up the role of being professional nurses

It was evident from the data collected in phase one of the study that newly qualified professional nurses and final year nursing students require support to assist them as they embark on their new journey of transition from final year students to professional nurses. The study found that the lack of clinical exposure experienced by final students was mainly due to the structural arrangements and the unique military context within the defence force (South African Defence Force). Inadequate wards and the lack of specialised areas for clinical learning opportunities available to students were some of reasons that contributed to the inadequate transition of students from final year students to professionals. The lack of diversity in terms of exposure to an array of diverse patient conditions and situations contributed to the challenges experienced during the transition of final year students.

Furthermore the rigid military ranking structure added to the diminished opportunities for final year nursing students, who were regarded as lower ranks, to practice in the military clinical areas. High ranking members, even though they are patients, can give an order as to who is entitled to treat them and that would definitely not be a nursing student, but a rank carrying member. These factors impact on the transition of these final year nursing students. Final year nursing students and new graduates need support from all levels in the organisation as they need the preparation to be the future backbones of the health institution. It is therefore essential that despite the rankings in a rigid military environment these students are supported as much possible.
It was further evident from the data analysed in phase one that final students experienced transition shock which was evident in experiencing anxiety, confusion, reality shock, uncertainty and the fear of the unknown. Furthermore, the issue that was highlighted in terms of support in phase 1 of the study was that a good orientation programme would assist the final year nursing students and novice professional nurses to function effectively in the unit.

From the literature as explored in phase two of the study, it was found that a supportive military culture was deemed necessary as this will allow opportunities for final year nursing students to gain experience and later the expertise to provide safe, quality patient care. Banks, Roxburgh, Kaane, Lauder, Jones, Kydd and Atkinson, (2012:2) concurred, stating that the new graduates are expected to be allocated a mentor during clinical placement to provide support to access protected learning time. Importantly, this support must be appropriate to the stage of the nurses’ transition. The supportive culture should allow for nurturing of the final year students, allowing them time to learn and build positive relations of a sense of belonging. Support from all levels in the organisation would be essential to consider, where final year students are mentored, encouraged and supported by their peers. The participants advocated for a support and mentoring programme of at least six months post-qualification. The transition from final year to professional nurse would be enhanced by having a supportive culture and providing effective support to the students.

5.2.2 The need for socialisation and belonging to enhance the transition of final year nursing students

For transition to be effective and successful, students should have a feeling of belonging to the group and being part of the team. Levett-Jones and Lathlean (2008:103), define belongingness as “… a deeply personal and contextually mediated experience that evolves in response to the degree to which an individual feels secure, accepted, included, valued and respected by a defined group”.

The final year nursing students interviewed in phase one of the study highlighted the fact that they would feel more at ease if they were accompanied in the clinical area by their nurse educators. The clinical accompaniment should be structured and
planned to include clinical teaching so that each student could benefit from each clinical placement, as this will boost their morale and enhance their clinical skills. The newly qualified professional nurses emphasised the need for a best practice guideline to guide them on effective transition for the final year students. Furthermore, the study findings showed that support from the stakeholders, particularly management, was essential to support the transition process. The idea of a supportive environment to ease the transition period was emphasized in the analysis of phase one of the study.

As derived from data synthesis in phase two of the study, the need for socialisation and belonging was confirmed. According to Kelly and Ahern (2008:911), the emphasis is placed on the role of socialisation for new graduates in transition to their new roles to make them feel part of the team. Firstly, student nurses and new graduates are socialised into the military environment, where the military protocols such as payment of compliments and the laws of war are inculcated in them. They are socialised into knowing that they are 'soldiers first before nurses' and to tell them otherwise is wasting time. Final year nursing students need to be reminded by their nurse educators that they are nurses within the military environment and their nursing obligations towards their patients must take precedence.

During clinical accompaniment, the nurse educators should work hand in hand with the students to accentuate their nursing roles within the military health service. From the findings it was evident that students need to be treated as part of the multi-disciplinary team. The clinical practice area should be welcoming and a well-planned orientation programme would assist in the transition from final year to professional nurses. Furthermore, it was highlighted that frequent rotation and peer mentoring should be considered as strategies to enhance and support the transition period for final year students.

5.2.3 Positive clinical learning environment to enhance the skills and competence of novice professional nurses

A positive clinical learning environment is realised through planned clinical accompaniment for students and an open communication system for both students and novice professional nurses to voice their concerns. A positive clinical
environment promotes clinical competence and knowledge gained in the clinical area that could be achieved through adequate clinical exposure for students during training.

The findings of phase one provided evidence that communication skills are essential in facilitating the effective transition of final year students to professional nurses. It was evident that the military setting was a barrier to this communication. Communication with regard to students, the clinical placement site and the academic institution was reported in the findings of the study. The lack of clinical competence was another factor that could hamper the positive clinical environment for the transition of students. Other findings related to the military context were highlighted in the study as factors that hamper the transition period of final year students. The military has always been a male-dominated fraternity which is also rank-oriented. One would assume that communication in any sphere would be simple, but this is not the case in the military setting. Communication trickles strictly from top to bottom and the rule is that an order is an order and needs to be carried out. Final year nursing students and novice professional nurses are also not new to receiving and carrying out orders. They need an order as to who they address and how they do this. No communication can be initiated by a low ranking member without first asking permission to communicate to the senior officers, irrespective of whether the senior officer is a patient or not. Military clinical placements are not exempted from promoting the military culture of subordination and restricted communication.

A positive clinical environment according to literature synthesised in phase 2 of the study is said to be a safe environment, but that is also not the case with the military environment. One is reminded on a daily basis that there is nothing safe about the military environment and as a worker you automatically relinquished the right to be safe as you signed a contract to work in a risky environment. You have no right to dignity nor any right to life as a soldier. Your safety and the safety of your patients in the clinical environment are not guaranteed. What a nurse can guarantee though is providing safe professional care to the patients i.e. administering treatment as prescribed and ensuring that the treatment is issued to the right patient by competent and experienced nurses.
According to Mckenna, McCall and Wray (2010:176), the clinical environment has been shown to have a direct impact on facilitating the grounding of the student's profession. In phase 1 of the study the novice professional nurses highlighted the fact that responsibility and accountability should be commenced at an earlier stage in their study period. They recommended that it would be easier if they could be given responsibilities of managing wards as early as their third year level, in that way managing the wards after completion and delegating duties to the subordinates would not pose such a challenge.

The challenge though is that all the members in the clinical area are rank carrying members, whereas both the final year nursing students and novice professional nurses do not have any military ranks. Militarily, they cannot delegate or in military language give orders, to any of the members in the clinical setting, including the staff nurses and assistant nurses who will be corporals, sergeants or staff sergeants. Members holding the latter ranks are senior to the newly qualified professional nurses until such time as they (newly qualified professional nurses) have attended an officer forming course to transition to lieutenant status, which could take up to 3 years.

The environment as stated above is both depressing and threatening to the final year nursing students and newly qualified professional nurses. According to literature in phase 2 of the study, the newly qualified professional nurses and students should be provided with a healthy and non-threatening work environment. In this case a positive clinical area could be achieved by establishing a system where newly qualified professional nurses are provided with civilian uniform after qualification until they have completed the necessary military courses for their promotion in the military ranks. This will boost their assertiveness and the feeling of authority in the clinical area.

For the sake of professional competency and skills achievement, unit rotations should be done at least on a 3 monthly basis as this affords the novice professional nurses the opportunity to settle in, learn the management of the ward and gain responsibility before being allocated/moved to a new department. A system where career prospects are evaluated on a regular basis for promotions into military ranks will be an added advantage to improve the positivity of the clinic environment. A
continuous system of performance, development and management should aim at giving feedback on both improved and lacking competencies by unit managers.

5.2.4 Recommendations to address organisational factors that impact negatively on transition

The deterring factors, as derived from data in phase one, to facilitate transition and enhance retention are the negative attitudes exhibited by the nursing personnel in the clinical areas, shortage of staff and the rigid military structure. The attitudes of nursing personnel were reported to not be welcoming and were often mentioned under factors impacting negatively on the transition process of students to professional nurses. The issue of shortage also played a role as final year nursing students lacked the mentoring that should be provided by the unit managers and the clinical accompaniment to be conducted by their nurse educators. The military ranking structure certainly hampered the development and negatively impacted on the retention rate as novice professional nurses remained without a military rank for up to 3 years following professional qualification.

In phase one of the study, retention in the military was discussed as posing a greater challenge than any other institution due to the strict military protocols. The dual transition in the military health system came under scrutiny as the newly qualified professional nurses lacked identity as they were deemed non-officers and consequently lacked a group with which to identify. A proper performance and appraisal system by the manager in the unit with benefits for the newly qualified professional nurse can enhance the speedy transition in the military ranking system to tally with the transition into the professional ranks hence improving the retention.

Wagner (2006:25) views retention of nurses as the responsibility of the manager who is entrusted with the task to motivate, develop and retain the nurses in the institution. Based on the synthesis of the literature review, it is clear that training and development of newly qualified professional nurses could enhance transition and improve retention. Furthermore, data from phase two of the study asserted that the retention rates of newly qualified professional nurses could be improved by alleviating stressful working conditions through acquiring adequate staff to meet the needs of the organization.
All these triangulated themes support each other in bringing out the challenges inherent in the transition from final year nursing student to professional nurse. A constellation of factors need to be taken into account in order to improve the situation and a best practice guideline was considered as a best method to facilitate this.

5.3 THE PURPOSE OF BEST PRACTICE GUIDELINES

According to Turner, Misso, Harris and Green (2008:47), best practice guidelines outline a plan of expected care, providing a guide to recommended practice and outlining the likely outcomes of care. They provide a guide to best practice, a framework within which clinical decisions can be made, and are used as a benchmark against which clinical practice can be evaluated. Historically, BPGs were often developed by consensus of a group of expert clinicians without explicit reference to research evidence.

5.4 STEPS IN THE GUIDELINE DEVELOPMENT PROCESS

The overarching goal of this phase is to develop a best practice guideline facilitating the transition of final year nursing students to professional nurses. The aim of this section is to outline the guideline development process and triangulation of data derived from phase 1 and 2. The development of a best practice guideline will be explicitly described in chapter 6. The draft guideline will also be presented in chapter 6 of this study. Best practice guidelines are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. They are intended to offer concise instructions on how to provide healthcare services. The most important benefit of best practice guidelines is their potential to improve both the quality and process of care and patient outcomes.

Harris, Green and Brouwers (2005: 1) outlined this 10 step process towards the development of a guideline.
Figure 5.1: Practice guidelines evaluation and adaptation cycle (Adapted from Graham and Harrison 2005).

The Practice Guidelines Evaluation and Adaptation Cycle is a framework for organizing and making decisions about which high quality guidelines to adopt (figure 5.1). Although the cycle was originally intended for use by organisations and groups wanting to implement best practice, most steps of the process are also helpful in guiding the evaluation of guidelines by individual clinicians.

**Step 1: Identify a clinical area to promote best practice**

The first step is to select an area in which to promote best practice. Reasons for selecting a particular area can include the prevalence of the condition or its associated burden, concerns about large variations in practice or care gaps, costs associated with different practice options, the likelihood that a guideline will be effective in influencing practice, a desire to keep practice up to date or evidence-based or awareness of the existence of relevant evidence-based guidelines. The guideline for this study will be developed to influence clinical practice.

The objective of this best practice guideline is to ensure a smooth facilitation of the transition process from student nurse to professional nurse in the South African
Military Health Service. The researcher observed that novice professional nurses were unable to delegate duties effectively as they were not sure how and when to delegate duties due to lack of adequate preparation for the role. There was a lack of role clarification that ended up in them (novice professional nurses) doing most of the work because of uncertainty. Transition shock took its toll on them as they were anxious most of the time. This is indicative of the need for support and mentoring.

Furthermore, final year nursing students were not allocated according to their academic level and expertise and ended up not being prepared for the role of the professional nurse. Responsibility and accountability was not given at the respective levels and that impeded their development in the profession. Since the SAMHS does not have any guidelines to prepare the students and novice professional nurses for the role of the professional, the need for a best practice guideline was identified.

**Step 2: Establish an interdisciplinary guideline evaluation group**

When an organisation or group is interested in providing best practice, a local interdisciplinary guideline evaluation group should be established comprising key stakeholders who will be affected by the selection of guideline recommendations, including patients or individuals from the community. The advantages of using a group to evaluate guidelines include sharing of work among group members, reduced potential for bias in the evaluation process and increased awareness of guidelines and opportunities for group members to develop ownership of the resulting decisions. Academic staff from different institutions will be sought as part of the evaluation group. Although the researcher was aware of the requirement for a guideline development group, due to the scope of the academic qualification under study the researcher, under the guidance of the two very experienced promoters, developed the guideline, while the expert panel group was consulted to review the draft guideline using a structured appraisal tool.

**Step 3: Establish a guideline appraisal process**

It is vital to select an appraisal process. Guideline appraisal instruments are intended to be used to systematically assess and compare guidelines using the same criteria. Guideline appraisal instruments typically consist of several quality criteria or items
that assess the extent to which each guideline meets the criteria. The Appraisal of Guidelines Research and Evaluation (AGREE II) Instrument was used to appraise the guidelines and only those guidelines that met the criteria stipulated were included for synthesis. The AGREE II is the only recommended tool to assess the quality of BPGs.

Step 4: Search for and retrieve guidelines

The next step is to clarify the issues of particular interest. The PICo approach involves considering the Population, Intervention, Control or context, and Outcomes of interest. Based on the identified areas of interest, criteria for searching for and selecting guidelines for review were identified. Such criteria may include language of publication (e.g. English only), or date of publication. The researcher however used the PICo approach which is population, interest and context given the qualitative nature of the study which does not require the outcomes statement. A best practice guideline is intended for use by the unit managers and lecturers in the military hospitals and nursing colleges to better prepare the students to take up the role of being professional nurses after completion of their training.

The guideline will be assisting the facilitation of the transition process from nursing students to professional nurses in the SAMHS. The population included final year nursing students, unit managers, novice professional nurses and nurse educators. To ensure that high quality guidelines were not inadvertently missed, a systematic search for all relevant guidelines was done on the topic. The researcher began by identifying guidelines that were familiar and scanned the bibliographies to identify additional guidelines. The search was restricted to the guidelines published in English, as the researcher did not have the capability of reviewing documents in other languages, and to restrict the search to documents published from 2008 to 2014.

Step 5: Assess the guidelines

Determining whether a guideline is valid involves 3 separate but related steps: appraising the quality of the guideline as a whole, determining the currency of the guideline (i.e. are the recommendations up to date?), and assessing the content of
the recommendations. One strategy that was used for quickly identifying the higher quality, best practice guidelines was to first screen the guidelines using the AGREE II’s “rigour of development” domain. The seven (7) items comprising this domain specifically focus on the degree to which the guideline development process was evidence-based and how evidence/research was incorporated into the recommendations. The researcher together with the independent appraiser identified the range of acceptable quality scores as only applicable to those guidelines scoring above 60%.

**Step 6: Adopt or adapt guidelines for local use**

The choices at this step are to adopt or adapt existing guidelines. Adopting a guideline involves choosing the best guideline and accepting all recommendations as written. For the benefit of this study a guideline was not adopted given the uniqueness of the military context. The researcher together with the two very competent supervisors developed a BPG, based on phase1 and 2 data and the integrative literature review that was conducted. The suggestions for a best practice guideline for the military are tabulated in Table 5.1.

**Step 7: Seek external review of the proposed guideline**

The draft guideline was then sent to the relevant stakeholders, that is the independent reviewers, for review and comments. Six members comprised the expert panel of reviewers. Three members were from different universities and experienced in reviewing guidelines, one member was from the nursing college and is responsible for quality assurance of the nursing college. Two members were from the clinical area where one member is head of the hospital and one in the nursing directorate. Three more members were sought to increase the rigour of the draft guideline. The researcher obtained feedback on the proposed guideline to ensure that those intended to use the guideline had an opportunity to review the document and identify potential difficulties for implementation before the guideline was finalized.
Step 8: Finalise the guideline

The researcher considered all feedback and, where necessary, modified the guideline suggestions to address the concerns. All changes made were documented in the final guideline as well as reasons for not making the suggested changes. Being explicit and transparent about the process increased the credibility of the process among potential guideline users.

Step 9: Obtain official endorsement and adoption of the guideline by the organisation

The guideline was to be submitted to the Director Nursing in SAMHS, for policy and planning as is the norm for guidelines. This will however not be considered as the guideline was developed for academic purposes. The above-mentioned administrative step provides the organization with a final opportunity to consider the effects of the proposed guideline on its functioning. The official endorsement of the guideline was done by the two promoters who are skilled in guideline development, and the expert panel of reviewers, who reviewed and scored the guideline. The formal decision making and procedural process required to endorse a guideline needs to be explicit and documented by the organisation, and this will take place during the post-doctoral component of the study. Once the organisation provides its “seal of approval,” the guideline will then be ready for dissemination. The dissemination of the guideline will not be undertaken due to the academic nature of this study. The guideline however was to be disseminated to the nursing colleges and military hospitals where students and novice professional nurses are allocated.

Step 10: Schedule review and revision of the guideline

All developed guidelines need to be reviewed and updated. The criteria for determining when a guideline needs updating include changes in evidence on existing benefits or harms associated with the recommendations, important outcomes, available interventions, evidence that current practice is optimal, values placed on outcomes, and resources available for health care. The researcher in this case, will not schedule the period for the update as this should be part of the
implementation which can only take place in another study. The expectation however is for the guideline to have at least a biannual review date.

5.5 CONCLUSION

Chapter 5 dealt with triangulation of data from phase 1 and 2 and the discussion thereof. A concise account on the guideline development process was provided. Chapter 6 will dwell on the development of a draft guideline and the recommendations from the expert panel of reviewers.
CHAPTER 6

DRAFT GUIDELINE AND REPORT FROM THE EXPERT PANEL OF REVIEWERS

Chapters 1 to 5 discussed the overview of the research, the research design and method, incorporating phase 1 and phase 2 of the process and the recommendations for the best practice guideline. The steps followed for the development of the guideline were comprehensively discussed in chapter 5. Phase 3 concentrated on the presentation of a draft guideline. A draft guideline will be outlined and the report from the independent reviewers will be discussed. The final guideline will then be developed contemplating the recommendations and comments of the independent reviewers.

6.1 INTRODUCTION

Best practice guidelines are recommendations for the care of individuals by health care professionals, based on the best available evidence. Guidelines are also important for health service managers and commissioners and can be used to develop standards to assess the practice of health care professionals, help in the education and training of health care professionals, help patients to make informed decisions and improve communication between patients and health care professionals (NICE, 2007:4).

According to the National Guideline Clearing house the following purposes are stated for best practice guidelines:

- To describe appropriate care based on the best available scientific evidence and broad consensus;
- To reduce inappropriate variation in practice;
- To provide a more rational basis for referral;
- To provide a focus for continuing education;
- To promote efficient use of resources;
- To act as focus for quality control, including audit;
- To highlight shortcomings of existing literature and suggest appropriate future research.
Guidelines can be developed for a wide range of reasons. Clinical areas can be concerned with conditions or procedures. Given the large number of potential areas, some priority setting is needed to select an area for guideline development. These areas may need clear guidelines as to how appropriate health care should be given and how patient outcomes can be improved (Clubb and Dahm, 2011:498). For the purpose of this study the area that was prioritized for guideline development was the nursing education spectrum, since there was uncertainty with regard to the transition of students to professional nurses.

According to Harrison, Siskin and Betz (2013:856), the content of a guideline is based on a systematic review of clinical evidence being the main source for evidence-based care. Based on this substantiation, the researcher consciously used an integrative literature review to select the guidelines that best responded to the study. It was decided for the scope of the study to rather follow an integrative literature review approach and not a systematic review. Four themes were identified after synthesis of the guidelines that were appraised. Triangulation of phases 1 and 2 then followed and the four final themes were conceptualized, namely: (1) support to prepare final year nursing students to take up the role of being professional nurses, (2) the need for socialization and belonging to enhance transition of final year nursing students, (3) positive clinical learning environment to enhance the skills and competence of novice professional nurses, and (4) recommendations to address organisational factors that impact negatively on transition. These themes formed the basis of the developed guideline.

6.2 AN OVERVIEW OF THE DRAFT GUIDELINE DEVELOPMENT PROCESS

An elaborative description of a process of guideline development was done in chapter 5 however this area will elaborate on the development of the draft guideline. On completion of the amalgamation of phases 1 and 2, a draft guideline was developed to support the successful transition of final year nursing students to professional nurses in SAMHS. An expert committee, including representation from key stakeholder groups, identified by the researcher as having the relevant expertise in nurse education and training, was established and consulted via teleconference during the period of the study. A thorough explanation into the process was given to the expert panel of reviewers, and consent was voluntarily sought from them to be
part of the panel. A participant information letter was issued to each member to give written authority of participation (see Annexure N). A draft guideline was developed on the facilitation of transition from final year nursing students to professional nurses in SAHMS based on the themes from the triangulated data. In order for the expert panel reviewers to assess the draft clinical guidelines, the researcher used a shortened version of the AGREE II appraisal instrument (see Annexure I). The expert panel members were asked to complete the AGREE II instrument and to make comments, suggestions and/or recommendations as required. A period of two weeks was granted for the expert reviewers to give feedback. Apart from the written feedback, discussion sessions on the feedback were held with each panel member. Only two members from the local University could be contacted for personal sessions, hence telephonic and e-mail communication was used. Feedback from each reviewer was then considered to prepare the final clinical guidelines.

To formulate the guideline, there were four themes that were used as the basis for the guideline content. The four themes were support for new graduates, the need for social belonging, positive clinical learning environment and improved retention. A summary of suggestions was tabulated in chapter 5 (see table 5.1).

6.3 FORMAT OF THE BEST PRACTICE GUIDELINES

According to Jesson and Lacey (2006:140), integrative literature reviews are an empirical research report that systematically collects, classifies and analyses a body of literature on a topic. As part of the research report, authors of integrative literature reviews described the methodology used to search, choose and code studies, and focused on providing a critique or interpretation rather than just reporting data. After the literature search was done the AGREE II Instrument was utilised to assist in the necessary inclusion and exclusion of the guidelines by assigning a recommended score for acceptance for inclusion in the study. The AGREE II Instrument consists of 23 items organized with six domains, followed by two global rating items for an overall assessment. Each domain captures a specific aspect of guideline quality.
Domain 1: Scope and Purpose—overall aim of the guideline, target group

Domain 2: Stakeholder Involvement—extent to which appropriate stakeholders were involved in developing the guideline and represents the views of its intended users

Domain 3: Rigour of Development—process of gathering and summarizing the evidence, methods used to develop recommendations

Domain 4: Clarity of Presentation—language, structure, format of guideline

Domain 5: Applicability—potential barriers and facilitators to implementation, strategies to improve uptake, resources needed to implement the guideline

Domain 6: Editorial Independence—biases due to competing interests

6.4 DRAFT GUIDELINE

A draft guideline resembles a pilot tool preceding the final guideline. The draft guideline was formulated following the triangulation of data derived from phases 1 and 2. It was then sent out to the expert panel of reviewers for review and, on completion of the reviews by the independent reviewers, a final guideline was developed based on the recommendations and comments stated by the independent reviewers.

6.4.1 DRAFT GUIDELINE SUMMARY

A summary of the draft guideline will be presented in this chapter on the transition of final year nursing students to professional nurses in the South African Military Health Service. A copy of the final guideline will however be available in Annexure K.

6.4.1.1 Guideline Title:

A best practice guideline facilitating the transition of final year nursing students to professional nurses in SAMHS
6.5.1.2 **Scope and Purpose**

This section will embark on the discussion of the objective of the guideline, the integrative review question and the target population.

6.4.1.3 **Objective:**

The objective of this best practice guideline was to make recommendations for a smooth facilitation of the transition process from final year nursing student to professional nurse in the South African Military Health Service.

6.4.1.4 **Review Question**

The integrative review question that was utilized to search for the best literature on the transition of final year nursing students to professional nurses was stated as follows:

> What is the best available evidence that will guide the development of a best practice guideline for the transition of final year nursing students to professional nurses in The South African Military Health Service (SAMHS)?

6.4.1.5 **Target Population:**

The guideline was intended for use by unit managers and nurse educators to better prepare final year nursing students and novice professional nurses to take up the role of professional nurses in the SAMHS.

6.4.1.6 **Stakeholder involvement:**

The guideline was not developed by a guideline development group as is the norm for guidelines. Due to the distinctiveness of the military milieu and for the scope of the study, the researcher and a team developed the guideline. The expert panel of reviewers was consulted to review the guideline as to whether it met the standard appropriate for use in the organisation. Initially six members comprised the expert panel of reviewers. Three members were from different universities and experienced in the review of guidelines, one member was from the nursing college and was responsible for quality assurance of the nursing college. Two members are from the clinical areas in SAMHS, where one member is head of the hospital and has a greater responsibility to ensure a successful transition of final year nursing students,
and one in the nursing directorate. Two members from the academic section hold a PhD degree in Nursing, and one member holds a Masters degree, a member from the nursing college holds a Master’s degree, one member from the clinical area holds a BA Nursing Education and Administration and one member from the nursing directorate has a Master of Business Administration degree.

The views of the students, unit managers, novice professional nurses and nurse educators during the phase 1 of the study and the findings of phase 2 of the study together with the results of the integrative literature review were all taken into account during the development of this guideline.

6.4.1.7  Rigour of development:

A best practice guideline was developed and supported by the data obtained from phase 1 and the integrative literature review that formed phase 2. The following sites were visited for review of literature. All databases were searched including electronic, hand searched journals using the identified keywords to become familiar with the contents in the titles, abstracts and subject descriptors. Reference lists and bibliographies of all papers were searched. Various guidelines and articles on the transition of nursing students to professional nurses were assessed. A wide variety of electronic databases including Google Scholar, CINHAL via EBSCO host and A-Z were searched.

A combination of key words; “transition”, “best practice guideline”, “student nurses”, “factors influencing transition”, “professional nurses” and “healthcare” were used to enhance the search in all the data bases. All words were searched under full title and with full PDF. The abstracts were also read for the purpose of a scoping review.

A comprehensive strategy was followed to ensure that a thorough search was conducted and a full text provided a more elaborate comprehension of the topic under discussion (see Annexure O). A total of twenty-four (24) guidelines on transition were searched. After the appraisal, seven (7) guidelines were included for data extraction and synthesis in the integrative review. An independent appraiser was used to appraise the guidelines and a consensus meeting saw agreement between the researcher and the independent appraiser. Data was synthesized by means of a thematic analysis.
A draft guideline was then formulated under the guidance of experienced supervisors and submitted to the expert panel of reviewers for their comments and/or recommendations. After effecting the changes, a final guideline was developed (see Annexure K).

### 6.4.1.8 Clarity and presentation of recommendations:

The suggestions based on the evidence from guidelines found and appraised are presented in this section. The four themes that formed the base line of the inputs for the guideline will be presented. The only language suitable for this study is English due to the overall familiarity of the researcher and the readers with the language.

**Theme 1: Support to prepare final year nursing students and new graduates to take up the role of being professional nurses**

The concept "support" implies to give strength to or encourage or to help (Wehmeier, 2005:1486). Student nurses and novice professional nurses need support and encouragement to be able to function competently and efficiently in their new roles as professional nurses. The following suggestions were derived from the integrative literature review and the data collected from the different groups of participants in order to achieve the support for final year nursing students and novice professional nurses. It was suggested that the unit managers should:

- Have an effective orientation and induction programme in their various units that will clearly guide both the students and the novice professional nurses on the tasks and responsibilities to be undertaken in the unit (Klomp, 2009:3)
- Ensure that the peer support groups are available to give the novice professional nurses the opportunity to obtain support from their peers (AONE, 2010:2)
- Ensure that the peer forums are viable and effectively utilized, so as to serve as the platform where students and novice professionals can be able to voice out their concerns without intimidation (Participants)
- Give feedback on a regular basis on the progress of students and novice professional nurses, as this will show that their efforts to learn are recognized (Klomp, 2009:5).
The nurse educators on the other hand are advised to do the following to achieve the support for the final year nursing students:

- Pay regular visitations in the form of clinical accompaniment to the students when allocated in the clinical area in order to support their learning (Medical Radiation Technologists 2013:4)
- Ensure that students have student forums where their challenges are voiced or communicated (Participants)
- Ensure clear objectives when students are allocated in the wards, in that way it will be clear as to what the expectations are for them (Participants).

**Theme 2: The need for socialisation and belonging to enhance transition of final year nursing students**

Professional socialisation can have a positive impact on the learner by developing their personality into that of a professional and fostering the caring role of nursing as a profession (Mackintosh, 2006:953). Caka (2013:8) discovered the impact of socialisation in nurse training as boosting confidence and enhancing a feeling of belonging in the profession, which could further advance the retention in the profession. For transitions to be effective and successful the students should have a feeling of belonging to the group and be part of the team.

The unit managers are advised to:

- Include the novice professional nurses in their team building sessions that will foster the feeling of belonging (Participants)
- Allocate a mentor for each student and novice professional nurse in the unit in order to socialize them in the routine of the department at a manageable pace (Klomp, 2009:4).
- Be observant to notice the signs of alienation from students and newly qualified professional nurses and to refer them to the relevant services if the need arises e.g. psychological or social services (Klomp, 2009:7).
The nurse educators are advised to:

- Establish a peer mentoring system for students allocated in different departments so as to socialise the new students in the units (Klomp, 2009:4)
- Plan and implement clinical accompaniment to boost the morale of the students and a sense of belonging (Medical Radiation Technologists, 2013:4).

**Theme 3: Positive clinical learning environment to enhance the skills and competence of novice professional nurses**

Healthy work environments were associated with less reality shock for novice professional nurses in the clinical area (Kramer, Brewer and Maguire, 2013:350).

The following suggestions were made to address the issue of creating a positive clinical environment following the suggestions based on Level 1 best practice guidelines evaluated and the data collected from the participants. It is suggested that the unit managers:

- Be approachable and open, in that way a non-threatening atmosphere will prevail so that students and novice professional nurses are able to learn in a more relaxed atmosphere to enhance their clinical skills (Rush, 2013:23)
- Advocate for the novice professional nurses to be provided with civilian uniform after qualification until they have completed the necessary military courses for their promotion in the ranks. This will give them assertiveness and a sense of authority which will develop their leadership skills and role competence (Participants)
- Establish open communication channels by having regular departmental meetings where students and novice professional nurses are able to communicate openly without fear (Hayes 2014:9)
- Evaluate the novice professional nurses’ clinical skills and performance on a regular basis and report to the management any prospects of the novice professional nurse being promoted to higher positions (Nurses Association of New Brunswick, 2012:7)
• Have regular in-service training sessions for students and novice professional nurse to learn in the clinical learning area and to continuously improve their competence and clinical skills (Medical radiation technologist, 2013:4).

The suggestions for the nurse educators are to:

• Advocate for a clinical department in the hospitals that will liaise with the nursing college and will in turn foster continuity of learning for the students to improve their clinical skills (Participants)

• Plan the allocation programme in such a way that unit rotations are done every six weeks instead of four weeks as this will afford the students the ability to settle in and learn more in the unit, before being allocated or moved to a new department. The lengthy stay in the unit can boost their competence in that field (Healy 2012:35).

Theme 3: Recommendations to address organizational factors that impact negatively on transition

Statistics from the South African Nursing Council show a 42% decline in the nurses who completed their training from 1996-2005. According to statistics in SAMHS for the period June 2010 to March 2012, the turnover of qualified nurses is 30% of which 25% have been lost to other organizations; the remaining 5% was divided between retirement and resignation out of the profession. Issues were raised by the participants during data collection that were more organisational and that impacted negatively on the transition of final year nursing students to professional nurses. One of those issues was shortage of staff. The shortage of staff both from the hospital and the nursing college in SAHMS is a reason for concern as it affects the time that should be spent with students in the clinical area and the mentoring of novice professional nurses.

The negative attitudes of the nursing personnel also did not ease the transition period as the students depend on the nursing personnel to assist them to master the clinical skills. A more open and accommodative approach could actually be of value to the students and novice professional nurses. The issue of transitioning from a student nurse to a professional nurse but not transitioning from a Candidate
Officer to an Officer proved to cause frustrations for the novice professional nurses as this is an indication that they still cannot give orders militarily. They need both transitions to be effected simultaneously.

The following suggestions were made based on the organisational factors that negatively affect the transition. The suggestions stemmed from the data collected from the participants and the synthesized guidelines. It is suggested that the unit managers should:

- Advice the management on the utilization of agency nurses to curb the shortage so that the permanent staff are able to give attention to the learning needs of the students and novice professional nurses as this could improve retention rates (Participants)
- Create personnel and development training programmes that will enhance retention and promote transition (Healy 2012:33)
- Give report on their monthly meetings to the management with regard to the need for novice professional nurses to attend the military courses promptly in order to allow them complete authority over their subordinates (Participants)
- Ensure that the attitudes of staff members are positive towards the nursing students and novice professional nurses by highlighting their present and future contribution to the organization (Participants).

The nurse educators on the other hand should:

- Facilitate regular meeting between the academic and the practice staff to ensure that a dialogue continuously exists to address preparation issues for transition of final year nursing students to professional nurses (AONE, 2010:3)

6.4.1.9 Applicability:

The barriers anticipated in this guideline were the military structure that is intertwined with the health fraternity in the Defence Force. The military practices and protocols always take precedence over the nursing practices. The issue of civilian uniform for newly qualified professional nurses will need approval from the military head, the Surgeon General, as the military uniform is the signature of the Defence Force and should always be adhered to no matter the circumstances. The approval thereof and
the career prospects for promotion into ranks could facilitate the retention of newly qualified professional nurses.

6.4.1.10 **Editorial independence:**

Data that was collected from the final year nursing students, unit managers, novice professional nurses and nurse educators, through focus group interviews and in-depth interviews directed the development of the guideline. The triangulation of the data received from the above-mentioned participants and the data from the integrative literature review together with the suggestions from the panel of expert reviewers, added to a more comprehensively structured guideline. The guideline is completely editorially independent as there was no funding received from any organisation. The institution where the study was undertaken assisted with funding in the final year of the study. No funding was obtained even from the military itself. Therefore no conflict of interest is applicable to the development of this guideline. The guideline will not be allocated a review date as is the norm for guidelines due to the academic nature of the study. A further study dealing uniquely with the guideline implementation will have to be undertaken and the review date stipulated.

6.5 **COMMENTS AND RECOMMENDATIONS FROM THE EXPERT PANEL REVIEWERS**

This section attends to the comments and suggestions of the expert panel of reviewers. A summary of the guideline will also be presented in this segment. The review of the guideline was done in two rounds. In the first round the six (6) members of the expert panel were given a draft guideline to score and the scores were obtained from all six of them together with their comments and recommendations. Three out of the six (6) members of the expert panel gave a score of between 61% and 67%, whereas the other members of the panel awarded scores of between 70% and 93%. Due to the variability of the scores obtained, which ranged between 61% and 93%, the second round was initiated in order to get consensus. The scores for the two rounds are tabulated in table 6.1. To avoid repetition, only the scores below 70% were assigned for a further review by the second panel of reviews. Three more members were requested to form part of the expert panel for the second round of the guideline review. The second panel of
expert reviewers comprised of two members from the academic field who are experienced in guideline development and who both hold a PhD in Nursing, and one member was from SAMHS who also holds a PhD in Nursing and is very instrumental in ensuring the effective use of the guideline. The comments and/or recommendations from the six reviewers are presented according to the headings used in the shortened version of the AGREE 11 instrument. The scores as rated by the reviewers were calculated for each domain and are discussed in this section. For the purpose of clarity, the calculation for the domain score is explained in the first section, but thereafter only the final score is stated. As for the second round of the guideline review, only the percentages are presented in table 6.1

6.5.1 Scope and purpose of the clinical guidelines

Four of the six expert panel reviewers either agreed or strongly agreed that the overall aim of the guideline, the question and the target population were clearly described. Two members either disagreed or strongly disagreed. The score for this domain was 61%.

The calculation of the domain scores for this section was as follows:

<table>
<thead>
<tr>
<th>Item 1</th>
<th>Item 2</th>
<th>Item 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewer 1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Reviewer 2</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Reviewer 3</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Reviewer 4</td>
<td>3</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Reviewer 5</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Reviewer 6</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>22</strong></td>
<td><strong>20</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

Maximum possible score = 4 x 3 items x 6 reviewers = 72
Minimum possible score = 2 x 3 items x 6 reviewers = 36

The scaled domain score will be:

Obtained score – Minimum possible score

Maximum possible score – minimum possible score

58-36/72-36 x 100 = 22/36 = 0.61111x100 = 61%

The higher the score rating that is obtained per domain, the greater the consensus, related to the domain assessed, thus validating the content of the clinical guideline.

6.5.2 Stakeholder involvement

There were different opinions in this domain as comments ranged from strongly agree to strongly disagree. Based on the comments the final guideline was adapted. The domain score for this section was 75%

6.5.3 Rigour of development

All the members of the panel commented that the systematic methods followed and the criteria for selecting the evidence were very well and explicitly explained. Based on the comments the guideline was adapted. The domain score for this section was 74%.

6.5.4 Clarity and presentation

All the members of the expert panel reviewers accepted this section well and indicated that the recommendations were clear, the structure and the format of the guideline is well presented. The score for this domain was 76%

6.5.5 Applicability

Four members of the expert panel commented positively on this section, though two members highlighted that the implications pertaining to the application of the guideline were not clearly set out. The score for this domain was 55.5% for the first round. After the re-administration and the consensus of the other two members, the score was re-calculated to 63%.
6.5.6 Editorial Independence

The members reciprocated a common positive understanding on this section except for one reviewer who interpreted it as not being clearly explained and understood. The score for this domain was 65%.

6.6 COMMENTS FROM INDIVIDUAL EXPERT PANEL REVIEWERS

Reviewer 1

Reviewer 1 commented that neither the health benefits nor risks were clearly stated for consideration during the formulation of the recommendations. The reviewer expressed though that the recommendations were easily identifiable and unambiguous. The overall guideline was rated 93%.

Reviewer 2

The reviewer suggested the following recommendations: the guideline should clearly define each user and why. The piloting of the guideline should be mentioned. The health benefits should clearly come out. The guideline should indicate that permission was obtained from Defence Intelligence. The cost implications of applying the guideline did not come out clearly. The guideline was rated 63%.

Reviewer 3

The reviewer mentioned that a background could be given to address the need for the guideline. A recommendation was made to make mention on how the guideline could be implemented. The reviewer rated the guideline 61%.

Reviewer 4

The reviewer commented that there was little supporting evidence for the recommendations. The guideline was allocated a score of 67%.
Reviewer 5

No recommendations or comments were made by the reviewer. The guideline was rated. The guideline was rated 83%.

Reviewer 6

The reviewer suggested that the stakeholder involvement should clearly state that the group comprised of nurses only. The guideline was rated 70%.

The table below signifies the scores that were allocated by the expert panel of reviewers for the two rounds of the guideline review. There was an evident improvement on the scores allocated for the draft guideline after the second round which signified the strength of the guideline for acceptance by the institution. The scores ranged between 70% and 90% and the final score for the draft guideline was 77.5% which is deemed an excellent score for a guideline.

Table 6.1: Table of Reviews from the expert panel for two rounds

<table>
<thead>
<tr>
<th>Reviewer(Round 1)</th>
<th>Score in %</th>
<th>Reviewer(Round 2)</th>
<th>Score in %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewer 1</td>
<td>93%</td>
<td>Reviewer 1</td>
<td>93%</td>
</tr>
<tr>
<td>Reviewer 2</td>
<td>63%</td>
<td>Reviewer 2</td>
<td>75%</td>
</tr>
<tr>
<td>Reviewer 3</td>
<td>61%</td>
<td>Reviewer 3</td>
<td>73%</td>
</tr>
<tr>
<td>Reviewer 4 (Round 1)</td>
<td>67%</td>
<td>Reviewer 4</td>
<td>71%</td>
</tr>
<tr>
<td>Reviewer 5 (Round 1)</td>
<td>83%</td>
<td>Reviewer 5</td>
<td>83%</td>
</tr>
<tr>
<td>Reviewer 6 (Round 1)</td>
<td>70%</td>
<td>Reviewer 6</td>
<td>70%</td>
</tr>
</tbody>
</table>

6.7 CONCLUSION

Chapter 6 handled the development of a draft guideline that was reviewed by six (6) expert panel members in the first round and three expert panel of reviewers in the second round. The draft guideline was administered in two parts due to the variability
of the scores obtained from different members of the review panel. Suggestions for the guideline were done following the data collected from the participants, the integrative literature review and the data extracted from the Level 1 evidence. The draft guideline was first assessed by supervisors who are experts in the development of guidelines before being released for review. The draft guideline was well rated and accepted by the two expert panels of reviewers. Differing views, comments and suggestions were received as feedback from the expert panel of reviewers and were essential in developing the final guideline. After a more consensual percentage was reached from all six and three members of the panel respectively, indicative of a more acceptable guideline, a final guideline comprising the comments and contributions of the members of the panel was drafted. The final guideline will be presented as Annexure K in the annexure section.
CHAPTER 7

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

Chapter one provided an overview of the study and chapter two introduced us to the research design and method. The data analysis comprised phase 1 of the study and was presented in chapter 3. A search and description of an integrative literature review, data appraisal and synthesis was presented in chapter 4, which comprised phase 2 of the study. Chapter 5 dealt with the process of a best practice guideline development and triangulation of data from phase 1 and phase 2. Lastly in chapter 6 a draft guideline was formulated, submitted to an expert panel of reviewers for review and deliberation on the comments and recommendations. Based on those comments and recommendations and the data from phases 1 and 2, a final guideline was developed. The final guideline will be presented as an annexure (see Annexure K). The aim of this chapter is to conclude the study by embarking on the conclusions, make recommendations and discuss the limitations inherent in the study.

7.1 INTRODUCTION

Best practice guidelines should formally grade the quality of the available evidence for a given clinical question and outline a formal process of how the recommendations were derived. The benefits and risks of the guideline should be clearly indicated during the guideline development process. The recommendations made should be practical and should address important clinical issues. Furthermore, their strength should be graded to reflect the underlying uncertainty about the evidence and the values applied in the guideline development process (Dahm, Yeung, Galluci and Schünemann, 2009:473).

According to Mash, Blitz, Kitshoff and Naude, (2011:365), a BPG is usually developed because the care of a specific condition within a medical community has been shown to exhibit one of the following patterns:

- Wide variation of practice
- Excessive cost
- Substandard outcomes
- New evidence that could have a significant impact on patient management.
The best practice guideline in this particular study was prompted by the observation of a sub-standard outcome for the military health service where the newly qualified professional nurses were exhibiting signs of unpreparedness for the role of being professional nurses.

7.2 CONCLUSIONS OF THE STUDY

Newly qualified professional nurses often describe the transition from being a nursing student to being a registered nurse as stressful and characterized by too heavy a workload and with too heavy a responsibility without sufficient peer and organisational support (Thrysoe, Hounsgaard, Dohn and Wagner, 2011:15). According to Procter (2011:255), central to many of these tensions is the fact that newly graduated professional nurses have limited opportunities to gain adequate experiential knowledge in the clinical areas before their graduate year, significantly impacting on their preparedness for clinical practice. Learning environments that support critical thinking and synthesis of information (Spoelstra, 2010:2), and that have a learner-centred approach to teaching are known to facilitate role transition.

Themes relating to the development of guidelines that could facilitate transition of final year nursing students to professional nurses were identified. These included, support to prepare final year nursing students and new graduates to take up the role of being professional nurses, the need for socialization and belonging to enhance transition of final year nursing students, positive clinical learning environment to enhance the skills and competence of novice professional nurses and recommendations to address organisational factors that impact negatively on the transition of final year nursing students to professional nurses.

A three phase approach was followed to reach the objectives for the study.

Phase 1 explored and described the experiences of final year nursing students, novice professional nurses, unit managers and nurse educators with regard to the transition of final year nursing students into the professional nurses. The objective was successfully reached by means of focus groups and face to face individual interviews from different participants. The findings were extrapolated in chapter 3.
Phase 2 aimed to explore and describe the literature with regard to the transition of students into the professional nurse’s role. A systematic search of literature was conducted. The search for this topic included nursing and medical references and health related fields. The literature was searched exhaustively and the search process included articles found in databases, grey literature, for instance unpublished theses and dissertations on guidelines relating to the transition of student nurses to professional nurses. Data extraction was done followed by synthesis which answered the third objective, namely the development of a best practice guideline to facilitate the transition of final year student nurses to professional nurses in SAMHS. This culminated in phase 3 of the study.

The findings of the researched study revealed that there is a gap in practice with regard to the preparedness of final year nursing students to take up the role of being a professional nurse in the SAMHS.

7.3 THEORETICAL FRAMEWORK

The foundation of the study was from Meleis (2007:416) who explicitly discussed the issue of transitions, particularly what he terms as situational transition. The situational transition is a form of transition where the person moves from the known role to the unknown, taking into account specifically the nursing student moving into the professional nurse’s role, a completely new role that requires preparedness.

Meleis (2007:416) identifies that transition is never a singular event, but rather an individualised process, occurring over an undetermined period of time. During this transition, the individual’s patterns of behaviour change in relation to abilities, identity, role, and relationships, and that the concept of transition demonstrates an acceptance of change. The theoretical framework is used as a basis for this study as final year nursing students are going through a changing phase with regard to the assumption of new roles, responsibilities and mostly the adjustment into the profession.

Awareness

Final year nursing students became aware of their limitations and inadequacies of adjusting to the new role of being a professional nurse. They lack experience with
regard to clinical skills and knowledge to be applied in the clinical area. Ultimately, however, there was an awareness of the need for a best practice guideline as extrapolated in the problem statement to guide a successful transition of final year nursing students to professional nurses in SAMHS.

**Engagement**

Engagement refers to the degree to which a person demonstrates involvement in the process inherent in the transition. All the participants in this study showed a great degree of involvement in making the transition for nursing students to professional nurses successful through the sharing of vital information and recommendations during data collection.

**Changes and differences are a property of transitions**

Recommendations for a best practice guideline included changes in the attitudes of staff members and the creation of a more positive environment to effect a more successful transition. Personal transitions that occur within the context of formal organisations are also shaped by the environment. The presence of a supportive environment, the need for a mentor or role model was identified as an important resource during phase one of the study.

**Time span**

Final year nursing students spent four years going through a nursing training programme. They spent from the 1st year to the 4th year preparing to become effective and efficient professional nurses at the end of their training. The data however collected from the final year nursing students and novice professional nurses showed gaps with regard to the inadequacies in their preparation for transition. Data was collected from the participants as a starting point towards developing the best practice guideline which did not at that stage exist. The end of the study after data extraction and synthesis culminated in the final product of a complete developed guideline to effect the successful transition of final year nursing students to professional nurses.
Critical points and events

Critical points and events are defined as markers. In this case the markers will be the expectations with regard to the effectiveness and efficiency of the developed guideline and as to whether it will serve the purpose intended namely that of facilitating transition. Transition is a process as extrapolated by Meleis that involves the stages through which the stakeholders involved should go. The starting point to ensure a successful transition was being aware of the limitations of a lack of guidelines to facilitate the transition. The end point was ensuring a development of a best practice guideline to facilitate the transition from final year nursing students to professional nurses, with all stakeholders engaged in the final product.

7.4 LIMITATIONS

- The study was only conducted in the two out of three SAMHS nursing colleges and hospitals as the third hospital was excluded due to cost containment.
- Members of the expert panel were selected from the Free State and the Gauteng provinces; consequently it became a challenge to hold frequent face to face meetings with the members particularly the ones in Gauteng province.
- Due to the unavailability of independent reviewers only one reviewer was available to do the critical appraisal.

7.5 RECOMMENDATIONS

Recommendations for the research study are made for nursing research, education and practice.

7.5.1 RECOMMENDATIONS FOR NURSING RESEARCH

- The study revealed the non-availability of a best practice guideline in SAMHS that could facilitate the transition of final year nursing students to professional nurses and the limited knowledge with regard to best practice guidelines. The significance of having a best practice guideline and its utilization in SAMHS could prove beneficial.
- Similar guidelines to facilitate transition in public hospitals and public nursing colleges could prove beneficial.
• Best practice guidelines have the potential to improve the process of care as well as patient outcome however their beneficial effects are contingent on successful implementation. Guidelines can be assessed and if rigorous can be implemented in other institutions.

• The other recommendation for research is that a post-doctoral study should be undertaken to ensure the implementation of the guideline.

• A study of the guideline development on the facilitation of clinical accompaniment should be undertaken.

• Further research on the military transition should be done.

7.5.2 RECOMMENDATIONS FOR PRACTICE

• Based on the scope of this research, the guideline was developed for use in the military setting only and not for the private or public sector. Recommendations made can be incorporated in the military health standard working procedures and be utilized by both the unit managers and nurse educators for the facilitation of transition period.

7.5.3 RECOMMENDATIONS FOR EDUCATION

• Education in nursing is the core of nursing practice. Different programmes in the nursing field could benefit from the use of guidelines e.g. guidelines on clinical accompaniment, guidelines on curriculum development, guidelines in assessment and moderation of exams, guidelines improving a system of continuous assessment etc.

• Nurse education has limited guidelines that have been developed, presented and implemented. Regular seminars, conferences and workshops should be held particularly to sensitize the education field in nursing with regard to the importance and use of best practice guidelines.

• It is suggested that every nurse educator be able to develop a guideline pertinent to his/her programme of speciality, that is based on the best available evidence.

• Student nurses should be motivated to search for and use practice guidelines available in their different programmes in order to get a clearer vision of what
each programme entails and what are the best practices that underpin each programme.

7.6 CONCLUSION

The transition from student to professional nurse can be stressful and the stress can be attributed to the need for support during and after qualification. More recently, Duchscher (2009:1104) suggested that newly qualified nurses experience ‘transition shock’, when they experience feelings of anxiety, insecurity, inadequacy and instability. Stress, anxiety and uncertainty may be attributed to not feeling prepared and lacking confidence (Doody, Tuohy and Deasy, 2012:684). New graduates are often unaware of the level of responsibility required of them as professional nurses and lack confidence in their ability to make clinical judgements. Graduates need time and experience to develop confidence, learn responsibility and think critically (Etheridge, 2007:24).

The lack of required standardized practice guidelines for transition in nursing has several implications, including high turnover rates among first-year nurses and problems with patient safety (Spector and Echternacht, 2011:19). The study findings revealed the absence of a best practice guideline in SAMHS for the transition of final year nursing students and the researcher succeeded in developing a best practice guideline which was not available in SAMHS at that stage and that will facilitate the transition of final year nursing students to professional nurses in SAMHS. The guideline is intended for use by the unit managers and nurse educators for the successful preparation of the final year nursing students and novice professional nurses to transition into the professional nurses’ role. Novice professional nurses highlighted how disillusioned and anxious they felt in their first months after completion. They experienced reality shock as they felt unprepared for the role of the professional nurse. A contribution to the nursing practice, research and education was achieved through this study.


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Edwards, D., Hawker, C., Rees, C., Bennett, P. 2009 The effectiveness of strategies and interventions that aim to assist the transition from student to newly qualified nurse. *The Wales Centre for Evidence Based Care*. Cardiff, Wales. 1-18.


Jesson, J., & Lacey, F. How to do (or not to do) a critical literature review. *Pharmacy Education.* 6(2): 139–148.


Resnik, D.B. 2013. What is Ethics in Research and Why is it Important? *National Institute of Environmental Health Sciences*.


SANC: See South African Nursing Council


South African nursing council .regulations relating to the approval of and the minimum requirements for the education and training of a learner leading to registration in the category auxiliary nurse. R169


World Health Organization


APPENDICES

Annexure A: Request to conduct research in 3 Military hospital

RESTRICTED

NURSING COLLEGE

3MH/R/84003086MC
SAMHS Nursing College
Private Bag X40003
Brandhof
9324

Col F J. Matthee
3 Military Hospital
Private Bag X 40003
Brandhof
9324

30 October 2013

REQUEST TO CONDUCT RESEARCH IN 3 MILITARY HOSPITAL: 84003086MC
MAJ E.M. CAKA

1. Approval is hereby requested to conduct research in 3 Military hospital for Doctoral thesis on the topic: A Best Practice Guideline facilitating the transition of final year nursing students to Professional nurses in SAMHS.

2. Data will be collected from unit managers and novice professional nurses.

3. I hope my request will be accepted.

(E.M. CAKA)
HOD SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Approved/ Not approved:

World-class Clinical Service

RESTRICTED
Annexure B: Request to conduct research in 1 Military hospital

NURSING COLLEGE
3MH/R/B4003086MC
SAMHS Nursing College
Private Bag X40003
Brandhof
9324
16 January 2014

Brig Gen N.P. Maphaha
1 Military Hospital
Pretoria
Thaba Tshwane
0143

REQUEST TO CONDUCT RESEARCH IN 1 MILITARY HOSPITAL: B4003086MC
MAJ E.M. Caka

1. Approval is hereby requested to conduct research in 1 Military hospital for Doctoral thesis on the topic: A Best Practice Guideline facilitating the transition of final year nursing students to professional nurses in SAMHS.

2. Data will be collected from nursing unit managers and novice professional nurses from the 23rd to 24th January 2014.

3. I hope my request will be accepted.

(Signature)
(E.M. Caka)
HOD SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Approved/Not approved:
Recommended.
The recommendation must go through the nursing to approve.

Interim Report for approval by: 17/01/14
Annexure C Request to conduct research in the nursing college

RESTRICTED

NURSING COLLEGE

Telephone: (051) 4021850
Facsimile: (051) 4021877
Enquiries: Maj E. M. Caka

SAMHS Nursing College
Private Bag X40003
Brandhof
5324

20 January 2014

Lt Col P.C. Letebele
SAMHS Nursing College
Private Bag X 1022
Thaba Tshwane
0143

REQUEST TO CONDUCT RESEARCH IN THE NURSING COLLEGE:
84003086MC MAJ E.M. CAKA

1. Approval is hereby requested to conduct research in Nursing College for a Doctoral thesis on the topic: A Best Practice Guideline facilitating the transition of final year nursing students to Professional nurses in SAMHS.

2. Data will be collected from final year nursing students and nurse educators.

3. I hope my request will be accepted.

(E.M. CAKA)
HOD SAMHS NURSING COLLEGE BLOEMFONTEIN: MAJ

Approved

As recommended by Dr. Intelligence
Studies must not interfere with the student program.

World-class Clinical Service

RESTRICTED
Annexure D: Request from NMMU to conduct research in the military hospitals

October 2013

• PO Box 77000 • Nelson Mandela Metropolitan University
• Port Elizabeth • 6031 • South Africa • www.nmmu.ac.za

Dear Sir/ Madam

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN MILITARY HOSPITALS

My name is Mrs E.M. Caka, and I am a Doctor of Philosophy student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. The research I wish to conduct for my Doctoral treatise is entitled: A Best Practice Guideline for the transition of final year nursing students in the SAMHS. The project is being conducted under the supervision of Professor M. Van Rooyen and Dr P. Jordan at the Department of Nursing Science at the NMMU.

I am hereby seeking your consent to do research in the following military hospitals: 1 Military hospital in Pretoria and 3 Military hospital in Bloemfontein, to provide participants for this project.

I have provided you with a copy of my treatise proposal which includes copies of the consent forms to be used in the research process, as well as a copy of the approval letter which I received from the NMMU Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Defence with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me:

Cell nr: 0748358813  Tel. nr: 051 422 5655
Fax nr: 051 4021877  Email: caka@polka.co.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Mrs E.M. Caka
Annexure E: Letter to the participants

INFORMATION TO THE PARTICIPANTS AND INFORMED CONSENT

I Maj E.M. Caka 84003086MC am doing a research study on the development of Best Practice Guidelines for the transition of final year students in the SA Military Health Service. I am registered as student with Nelson Mandela Metropolitan University as a PhD student.

I would like to invite you to participate in my research study. The participation is voluntary and you can withdraw at any stage of the study and will not be penalized.

There are no monetary benefits for the participants, but the guidelines developed will benefit the institution by rendering work ready novice professional nurses.

The study is completely risk free. Confidentiality of the information provided by the participants will be maintained, although complete anonymity cannot be guaranteed. No names will be used during the study. The study results will not be published without your consent.

Should you require more information feel free to contact me. My contact details are as follows:

Cell: 0846725858                   Fax: 051 4225655
Tel: 051 4021850                   e-mail: caka@polka.co.za

Thank you
Mrs E.M. Caka

INFORMED CONSENT

I hereby agree to participate voluntary in the research study: A Best Practice guideline for the successful transition of final year nursing students to professional nurses in SAHMS

Signed at _____________________ on this ---------- day -------------------------- 2013

Signature of participant  ---------------------------------------------
Annexure F: Military ethics approval

RESTRICTED

Tel: 012 314 0487
Facsimile: 012 314 0623
Enquiries: Prof / Lt Col

M.K. Baker

IMH/302/6
1 Military Hospital
Private Bag X1026
Thaba Tshwane
0143
2 February 2014

CLINICAL TRIAL APPROVAL: “A BEST PRACTICE GUIDELINE FACILITATING THE TRANSITION OF FINAL YEAR NURSING STUDENTS TO PROFESSIONAL NURSES IN THE SAMHS”

1. The 1 Military Hospital Research Ethics Committee (1MHREC), adhering to GCP/ICH and SA Clinical Trial guidelines, evaluated the above-mentioned protocol and additional documents.

2. The following members approved the study:
   a. Lt Col M.K. Baker: Neurologist, male, chairman 1 MHREC.
   b. Lt Col C.S.J. Duvenage: Specialist physician, female, member 1 MHREC.
   c. Lt Col D. Mahapa: Dermatologist, female, member 1 MHREC.
   d. Lt Col A.D. Moselane: Urologist, male, member 1 MHREC.
   e. Lt Col E.J. Venter: Periodontist, male, member 1 MHREC.
   f. Maj M.L. Kekana: Specialist physician, female, member 1 MHREC.
   g. DR T.J. Mare: Advocate, independent of the organization, male, member 1 MHREC.
   h. Mrs. C. Jackson: Layperson, independent of the organization, female, member 1 MHREC.

3. The following documents were evaluated:
   a. Study protocol
   b. Curriculum Vitae EM Caka
   c. Information to the participants

4. The recommendations are: The study was ethically approved on 28 February 2014. The principal investigator, EM Caka, will be supervised by Prof RM van Rooyene. Report backs are to be made to the 1MHREC six monthly, in the event of any serious adverse events and on completion or termination of the study. Should publications result from the study the relevant manuscripts will also need to be approved by Military Counter Intelligence.

5. The 1 MHREC wishes you success with the study.

(MK BAKER)
CHAIRMAN 1 MILITARY HOSPITAL RESEARCH ETHICS COMMITTEE:
LT COL / PROF

Health Warriors Serving The Brave
RESTRICTED

2000 UH 19 AUG 2005 REPLY DATED 03 MAR 2003
Annexure G: Defence Intelligence approval

Defence Intelligence
Department: Defence
REPUBLIC OF SOUTH AFRICA

Telephone: (012) 315-0545
Fax: (012) 326-3246
Enquiries: WO1 K.Skweyiya

SAHMS Nursing College
Satellite Camp Bloemfontein
P/Bag X 40003
Brandhof
9324

Attention: (Maj E.M. Caka)

DI/SDCI/R/2013/3/7
Defence Intelligence
Private Bag X367
Pretoria
0001
27 January 2014

AUTHORITY TO CONDUCT RESEARCH IN THE DEPARTMENT OF DEFENCE (DOD) IN FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN NURSING: MAJ E.M. CAKA

1. Your email 3MH/R/84003086MC received on the 22nd November 2013 has reference.

2. Maj E.M. Caka is hereby granted permission from a security perspective to conduct research in the DOD on the topic entitled “A Best Practice Guideline Facilitating the Transition of Final Year Students to Professional Nurses in the SA Military Health Services (SAHMS)” under the auspices of Nelson Mandela Metropolitan University as a prerequisite for the attainment of Doctorate as requested.

3. The final research product must be submitted to Defence Intelligence (DI) Sub-Division Counter Intelligence (SDCI) for scrutiny before it is released to any entity outside the DOD.

4. For your attention.

(S.S. MODISE)
ACTING CHIEF DIRECTOR COUNTER INTELLIGENCE: BRIG GEN KS/KS (Maj E.M. Caka)

Restricted
Copies to:
Supervisor: Prof RM van Rooyen
Co-supervisor/s: Dr PJ Jordan

Summerstrand South
Faculty of Health Sciences
Tel. +27 (0)41 5042121 Fax. +27 (0)41 5042654
Nouwaal.isaacs@nmmu.ac.za

Student number: 212456652
Contact person: Ms N Isaacs
28 November 2013
Mrs EM Caka
11 Riekool Street
Pelissier Street
Bloemfontein
9301

FINAL RESEARCH/PROJECT PROPOSAL
QUALIFICATION: PhD (NURSING)
TITLE: A BEST PRACTICE GUIDELINE FACILITATING THE TRANSITION OF FINAL YEAR STUDENTS TO PROFESSIONAL NURSES IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE

Please be advised that your final research project was approved by the Faculty Research, Technology and Innovation Committee, subject to the following amendments/recommendations being made to the satisfaction of your Promoters:

COMMENTS/RECOMMENDATIONS

1. Goals and objectives
   - Review the purpose, it should read “explore and describe the experiences of health practitioners regarding the role transition of final year nursing students…”
   - Point 5.3 Replace the word minimal with basic in the 5th sentence of point 5.3.
   - Add the setting on page 13.
2. Design/Method
   - Page 18
   - Delete the two sentences at the end of the contextual design.
3. Participants and sampling
   - Define novice professional nurse.
4. Data collection
   - Top of page 21 – first sentence at the top of page
   - Replace views and opinions with experiences.
   - Page 26
   - Correct the spelling of “sites” should be “sites”.
5. Budget
   - The budget was unrealistic.
6. Dissemination of results
   - Use of the phrase “hit the ground running” and on page 11 at the top of the page “hit the floor running”.
7. References (text)
   - Some dates of publications cited in text do not correspond with the dates in the reference list.
   - The use of et al was inconsistent at times.
Annexure I: Copy of AGREE11 instrument

COPY OF THE AGREE 11 INSTRUMENT

<table>
<thead>
<tr>
<th>SECTION A: SCOPE AND PURPOSE</th>
<th>Strongly agree(4)</th>
<th>Agree(3)</th>
<th>Disagree(2)</th>
<th>Strongly Disagree(1)</th>
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<tr>
<td>The overall objectives(s) of the guideline is (are) specifically described</td>
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<td>The review question(s) covered by the guideline is (are) specifically described</td>
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<td>The patients/participants to whom the guideline are meant to apply are specifically described</td>
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<tr>
<th>SECTION B: STAKEHOLDER INVOLVEMENT</th>
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<tr>
<td>The guideline development group includes individuals from all relevant professional groups</td>
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<tr>
<td>The patient’s/participants’ views and preferences have been sought</td>
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<td>The target users of the guideline are clearly defined</td>
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<td>The guideline has been piloted amongst target user</td>
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<th>SECTION C : RIGOUR OF DEVELOPMENT</th>
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<tr>
<td>Systematic methods were used to search for evidence</td>
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<td>The criteria selecting the evidence are clearly described</td>
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<tr>
<td>The methods used for formulating the recommendations are clearly described</td>
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</table>
The benefits, side effects and risks have been considered in formulating the recommendations.

There is an explicit link between the recommendations and the supporting evidence.

The guideline has been externally reviewed by experts prior to its publication.

A procedure for updating the guideline is provided.

**SECTION D: CLARITY AND PRESENTATION**

The recommendations are specific and unambiguous.

The different options for management of the condition are clearly presented.

The key recommendations are easily identifiable.

The guideline is supported with tools for application.

**SECTION E: APPLICATION**

The potential organizational barriers in applying the recommendations have been discussed.

The possible cost implications of applying the recommendations have been considered.

The guideline presents key review criteria for monitoring and/or audit purposes.

**SECTION F: EDITORIAL INDEPENDENCE**

The guideline is editorial independent from the funding body.

Conflicts of interest of guideline development members have been recorded.
Annexure J: List of acronyms

AGREEII- Appraisal of Guidelines for Research Evaluation II

BPG- Best Practice Guideline

CO- Candidate Officer

SAMHS- South African Military Health Services

DENOSA- South African Democratic Nurses Association

CINHAL- Cumulative Index to Nursing and Allied Health Literature

NICE- National Institute for Health and Clinical Excellence

IEEE- Institute of Electrical and Electronics Engineers

Pubmed- Public Medicine

SANC- South African Nursing Council-
ANNEXURE K: GUIDELINE

A best practice guideline facilitating the transition of final year nursing students to professional nurses in SAMHS

Scope and Purpose

The following section will embark on the discussion of the objective of the guideline, the integrative review question and the target population.

Objective:

The objective of this best practice guideline is to make suggestions for the smooth facilitation of the transition process from the student nurse to the professional nurses’ role in the South African Military Health Service (SAMHS).

Review Question

The research question together with the integrative review question were utilized to guide the study in order to obtain the best data and literature available on the transition of final year nursing students to professional nurses were stated as follows:

How prepared are the final year nursing students to take up the role of being professional nurses in the SAMHS and how can this process be facilitated?

What is the best available evidence that will guide the development of a best practice guideline for the transition of final year nursing students to professional nurses in SAMHS?

Target Population:

The guideline is intended for use by unit managers and nurse educators in order to facilitate the transition of final year nursing students and to better prepare the novice professional nurses to take up the role of being professional nurses in the SAMHS.
Stakeholder involvement:

The guideline was not developed by a guideline development group as is the norm for guidelines. The researcher identified the gaps indicative of the inadequate preparation of the final year nursing students and, together with two well experienced supervisors, developed the guideline. The gaps included poor delegation and supervision of subordinates by the novice professional nurses, poor decision making on behalf of the patients, inadequate psychomotor skills, where it becomes a challenge for a novice professional nurse to insert an intravenous infusion without supervision and conducting of doctors’ rounds, amongst others. These gaps signified the need to effect a successful transition of final year nursing students to professional nurses by developing a best practice guideline that will facilitate the transition period. The guideline was not piloted amongst users as the researcher needed a true reflection and honest opinions about the guideline from the onset. The expert panel of reviewers was consulted to review the guideline as to whether it meets the standard appropriate for use in the organisation. The initial or primary expert panel of reviewers consisted of six members and a further three members were sought to reach consensus on the guideline after the review by the initial panel. Three members were from different universities and experienced in the review of guidelines, one member was from the SAMHS nursing college and is responsible for quality assurance of the nursing college. Two members were from the clinical area in SAMHS, where one member is head of the hospital and has a greater responsibility to ensure a successful transition of final year nursing students, and one in the nursing directorate. Two members from the public academic section hold a PhD degree in Nursing, and one member a Master’s degree, a member from SAHMS nursing college holds a Master’s degree, one member from the SAMHS clinical area holds a BA Nursing Education and Administration and one member from the SAMHS nursing directorate has a Master of Business Administration. Each member of the panel had a view and suggestions towards the improvement of the guideline.

The views of the students, unit managers, novice professional nurses and nurse educators were also all taken into account during the development of this guideline. The in-depth face to face interviews with the unit managers and nurse educators, and the focus group discussions with final year nursing students and novice
professional nurses afforded the researcher with rich data together with the amalgamated data from phases 1 and 2 and the data from the appraised guidelines contributed to the suggestions for the guideline. The comments and suggestions from all members of the expert panel shaped some views of the guideline.

**Rigour of development:**

A best practice guideline was developed and supported by the data obtained from phases 1 and 2, the integrative literature review and the adjustments made from the inputs of the panel of expert reviewers. The search for this topic included nursing and medical references and health related fields. The literature was searched exhaustively and the search process included articles found in databases, grey literature, for instance unpublished theses and dissertations responding to the transition of student nurses to professional nurses. Search engines were used to thoroughly search for clinical guidelines. Annexure O provides a table detailing search engines, key words used and types of literature searched.

A combination of key words; “transition”, “best practice guideline”, “student nurses”, “factors influencing transition”, “professional nurses” and “healthcare” were used to enhance the search in all the data bases. All words were searched under full title and with full PDF. The abstracts were also read to get a view of the topic under discussion before reading the whole literature.

The above strategy ensured that a comprehensive search was conducted and a full text provided a more elaborate comprehension of the topic under discussion. A total of twenty four (24) guidelines on transition were retrieved. After the appraisal, seven (7) guidelines were included for data extraction and synthesis in the integrative review. Nine (9) guidelines were excluded from the analysis as they were either not very relevant to the topic or not meeting the criteria for evaluation while eight (8) guidelines were not considered for inclusion at all. An independent appraiser was used to appraise the guidelines and a consensus meeting achieved agreement between the researcher and the independent appraiser. Analysis and extraction of data was done from the selected guidelines. Thereafter the themes were formulated from the triangulation of data from phases 1 and 2 and from the data extracted and synthesized from the appraised guidelines.
A draft guideline was then formulated under the guidance of experienced supervisors and submitted to the expert panel of reviewers for their comments and/or suggestions where, after effecting the changes, a final guideline was developed. The guideline will be of value to the institution as the final year nursing students will be effectively prepared by the nurse educators and unit managers to be able to transition successfully to the role of being professional nurses. Novice professional nurses will receive adequate preparation on commencement of employment to take up the role of being professional nurses. The guideline will not be allocated a review date due to the academic nature of this study. A post–doctoral study will have to be undertaken for the guideline implementation which will then include the review date for the guideline.

**Clarity and presentation of recommendations:**

The suggestions based on the evidence from guidelines found and appraised, the inputs of the panel of reviewers and data from phases 1 and 2 are presented in this section. The four themes that formed the core of the suggestions for the guideline will be presented. The language used for this study is English due to the overall familiarity of the researcher and the readers.

**Support to prepare final year nursing students to take up the role of being professional nurses**

The concept "support" means to give strength to or encourage or to help (Wehmeier, 2005:1486). Student nurses and novice professional nurses need support and encouragement to be able to function competently and efficiently in their new roles as professional nurses. The following suggestions were derived from the Level 1 evidence synthesised and the data collected from the different groups of participants. In order to achieve the support for final year nursing students and novice professional nurses it is suggested that the unit managers should:

- Have an effective orientation and induction programme in their various units that will clearly guide both the students and the novice professional nurses on the tasks and responsibilities to be undertaken in the unit (Klomp, 2009:3)
• Ensure that the peer support groups are available to give the novice professional nurses the opportunity to obtain support from their peer mates (AONE, 2010:2)

• Ensure that the peer forums are viable and effectively utilised, so as to serve as the platform where students and novice professionals can be able to voice their concerns without intimidation (Participants)

• Give feedback on a regular basis on the progress of students and novice professional nurses, as this will show that their efforts to learn are recognized (Klomp, 2009:5)

The nurse educators on the other hand, to achieve the support for the final year nursing students, are advised to:

• Pay regular visitations in the form of clinical accompaniment to the students when allocated in the clinical area in order to support their learning (Medical Radiation Technologists, 2013:4)

• Ensure that students have student forums where their challenges are voiced or communicated (Participants).

• Ensure clear objectives when students are allocated in the wards, in that way it will be clear as to what the expectations are for them (Participants).

The need for socialization and belonging to enhance transition of final year nursing students

Professional socialisation can have a positive impact on the learner by developing their personality into that of the profession and fostering the caring role of nursing as a profession (Mackintosh, 2006:953). Caka (2010:44) discovered the impact of socialisation in nurse training as boosting confidence and enhancing a feeling of belonging in the profession, which could further advance the retention in the profession. For transitions to be effective and successful students should have a feeling of belonging to the group and be part of the team.

Suggestions made on the issue of belonging derived from the Level 1 appraised guidelines, the data collected from the participants and the suggestions raised by the
expert panel of reviewers were formulated as listed below. The unit managers are advised to:

- Include the novice professional nurses in their team building sessions that will foster the feeling of belonging (Participants).
- Allocate a mentor for each student and novice professional nurse in the unit in order to socialise them in the routine of the department at a manageable pace (Klomp, 2009:4).
- Be observant to notice the signs of alienation from students and newly qualified professional nurses and to refer them to the relevant services if the need arises e.g. psychological or social services (Klomp, 2009:7).

The nurse educators are advised to:

- Establish a peer mentoring system for students allocated in different departments in order to socialise the new students in the units (Klomp, 2009:4)
- Plan and implement clinical accompaniment to boost the morale of the students and a sense of belonging (Medical Radiation Technologists, 2013:4).

**Positive clinical learning environment to enhance the skills and competence of novice professional nurses**

Literature demonstrated that healthy work environments were associated with less reality shock for novice professional nurses in the clinical area (Kramer, Brewer and Maguire, 2013:250).

The following suggestions were made to address the issue of creating a positive clinical environment following the suggestions based on the Level 1 best practice guidelines that were evaluated, suggestions from the expert panel of reviewers and the data collected from the participants. It is suggested for the unit managers to:

- Be approachable and open, in that way a non-threatening atmosphere will prevail so that students and novice professional nurses are able to learn in a more relaxed atmosphere to enhance their clinical skills (Rush, 2013:23)
- Advocate for the novice professional nurses to be provided with civilian uniforms after qualification until they have completed the necessary military
courses for their promotion in the ranks. This will give them assertiveness and a sense of authority which will develop their leadership skills and role competence (Participants)

- Establish open communication channels by having regular departmental meetings where students and novice professional nurses are able to communicate openly without fear (Hayes, 2014:9).
- Evaluate the novice professional nurses’ clinical skills and performance on a regular basis and report to the management any prospects of the novice professional nurse being promoted to higher positions (Nurses Association of New Brunswick 2012:7).
- Have regular in-service trainings for students and novice professional nurses to learn in the clinical learning area and to continuously improve their competence and clinical skills (Medical radiation technologist 2013:4).

The suggestions for the nurse educators are to:

- Advocate for a clinical department in the hospitals that will liaise with the nursing college and will in turn foster continuity of learning for the students to improve their clinical skills (Participants).
- Plan the allocation programme in such a way that unit rotations are done every six weeks instead of four weeks as this will afford the students the ability to settle in and learn more in the unit, before being allocated or moved to a new department. The lengthy stay in the unit will boost their competence in that field (Healy 2012:35).

**Recommendations to address organisational factors that impact negatively on transition**

Statistics from the South African Nursing Council show a 42% decline in the nurses who completed their training from 1996-2005. According to statistics in SAMHS for the period June 2010 to March 2012, the turnover of qualified nurses was 30%, where 25% of these have been lost to other organisations; the remaining 5% was divided between retirement and resignation out of the profession. Issues were raised by the participants during data collection that were more organisational and that impacted negatively on the transition of final year nursing students to
professional nurses. One of those issues was shortage of staff. The shortage of staff both from the hospital and the nursing college in SAHMS is a reason for concern as it affects the time that should be spent with students in the clinical area and the mentoring of novice professional nurses. The negative attitudes of the nursing personnel also did not ease the transition period as the students depend on the nursing personnel to assist with the mastering of the clinical skills. A more open and accommodative approach on the part of the ward personnel could actually be of value to the students and novice professional nurses. The issue of transitioning from a student nurse to a professional nurse but not transitioning from a Candidate Officer to an Officer proved to cause frustrations for the novice professional nurses as this is an indication that they still cannot give orders militarily. They need both transitions to be effected simultaneously.

The following suggestions were made based on the organisational factors affecting the transition negatively. The suggestions stemmed from the appraised guidelines, and the data triangulated from phase 1 and 2. It is suggested that the unit managers should:

- Advice the management on the utilization of agency nurses to curb the shortage so that the permanent staff can be able to give attention to the learning needs of the students and novice professional nurses as this could improve retention rates (Participants).
- Create personnel and development training programmes that will enhance retention and promote transition (Healy 2012:33)
- Give report on their monthly meetings to the management with regard to the need for novice professional nurses to attend the military courses promptly in order to allow them complete authority over their subordinates (Participants)
- Ensure that the attitudes of staff members are positive towards the nursing students and novice professional nurses by highlighting their present and future contribution to the organization (Participants)
The nurse educators on the other hand should:

- Facilitate regular meetings between the academic and the practice settings to ensure that a dialogue continuously exists to address preparation issues for transition of final year nursing students to professional nurses (AONE, 2010:3).

**Summary of Suggestions for the guideline**

The suggestions specified for the guideline can be used to guide the unit managers as well as the nurse educators to enhance a smooth facilitation of the transition of final year nursing students and novice professional nurses to the role of the professional nurse. The successful transition could be achieved by supporting the final year nursing students and novice professional nurses for the role and to ease the transition period through socialisation and giving them a sense of belonging, providing a positive clinical learning environment for them to grow professionally and to mature and lastly to advocate for them in correcting the organisational issues that impede successful transition.

**Conclusion**

There is a great scarcity in the guidelines that have been developed addressing the transition of final year nursing students to professional nurses. Most of the issues affecting the transition of final year nursing students to professional nurses have been addressed in programmes but not particularly guidelines. The SAMHS has absolutely no guidelines whatsoever addressing the transition of student nurses. The literature searched and used for the development of this guideline however played a pivotal role. The participants’ views gave a good contribution to the development of this guideline. The guideline was however not piloted amongst the target users, the final year nursing students, novice professional nurses, unit managers and nurse educators, as this was not part of the scope of this study. No mentions of the risks pertaining to the study were made as the risks were not anticipated. A further research could be undertaken to enhance the implementation of this guideline in clinical practice.
Annexure L: Characteristics of guidelines included

CHARACTERISTICS OF INCLUDED STUDIES FOR REVIEW ON THE TRANSITION OF FINAL YEAR NURSING STUDENTS TO PROFESSIONAL NURSES

<table>
<thead>
<tr>
<th>Number</th>
<th>Reference</th>
<th>Reason for inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Canadian Association of Medical Radiation Technologies. 2013. Effective preceptorship: A guide to best practice. 1-16</td>
<td>Relevant to the study</td>
</tr>
<tr>
<td>2</td>
<td>Hayes, PD.2014.Transition to Employment and Professional Practice Guidelines: Evidence-Based. 1-20</td>
<td>Relevant to the study</td>
</tr>
<tr>
<td>3</td>
<td>Healy, M and Howe,V Early. 2012. Study of Early Graduate Nursing and Midwifery Programs. Department of Health Nursing and Midwifery Policy. 1-117</td>
<td>Relevant to the study</td>
</tr>
<tr>
<td>4</td>
<td>Klomp,C 2009. Early Graduate nurse Program Guidelines .Nurse Policy, Workforce, Leadership and Development.</td>
<td>Relevant to the study</td>
</tr>
<tr>
<td>5</td>
<td>Nurses Association of New Brunswick. 2012. Practice Guideline: Graduate Nurse Scope of Practice.1-10</td>
<td>Addressing the review and research questions</td>
</tr>
<tr>
<td>7</td>
<td>AONE. Guiding principles for the newly licensed nurses’ transition into practice. 2010 American Organization of Nurse Executives. 1-3</td>
<td>Addresses the review question</td>
</tr>
<tr>
<td>Number</td>
<td>AUTHOR &amp; YEAR OF PUBLICATION</td>
<td>REASON FOR EXCLUSION</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>RCSA.2013. Best Practice Guidelines and Recommendations: Transition of Workers..Code for Professional Conduct. 1-5</td>
<td>Not addressing the topic</td>
</tr>
<tr>
<td>3</td>
<td>Tasmania. 2011..Transition to Practice for Nurses and Midwives Department of Health and Human Services, Chief Nurse and Allied Health</td>
<td>Not meeting the score requirements under AGREEII</td>
</tr>
<tr>
<td>4</td>
<td>Khoury, G, Vakili, S. 2013. Facilitating a Smooth Transition from New Graduate to Professional Nurse Utilizing an Evidence-Based Evaluation Tool University of San Francisco</td>
<td>Not meeting the requirements for a guideline under AGREEII</td>
</tr>
<tr>
<td>6</td>
<td>Weaver, SJ, Rosen, MA, Salas, E, Baim, KD, King, HB. 2010. Integrating the Science of Team Training: Guidelines for Continuing Education</td>
<td>Not addressing transition of nursing students</td>
</tr>
<tr>
<td>7</td>
<td>2014. Care Transitions: Best Practices and Evidence-based Programs Centre for Healthcare Research and Transformation</td>
<td>Not addressing transition of nursing students</td>
</tr>
<tr>
<td>8</td>
<td>Fitzgerald, C, Kantrowitz-Gordon, I, Katz, J, Hirsch, A. Advanced Practice Nursing Education: Challenges and Strategies</td>
<td>Not meeting the score requirements under AGREEII</td>
</tr>
<tr>
<td>9</td>
<td>Spector, N. 2013. . A Regulatory model for Transitioning Newly Licensed Nurses to Practice</td>
<td>Not meeting the score requirements under AGREEII</td>
</tr>
</tbody>
</table>
Annexure N: Request for permission as independent reviewers

1/10/2014

RE: REQUEST FOR PERMISSION AS INDEPENDENT REVIEWERS FOR A BEST PRACTICE GUIDELINE

My name is Mrs E.M. Caka, and I am a PhD student at the Nelson Mandela Metropolitan University (NMMU) in Port Elizabeth. The research I wish to conduct for my PhD treatise is entitled: A best practice guideline facilitating the transition of final year nursing students to professional nurses in SAMHS. The project is being conducted under the supervision of Professor Dalena van Rooyen at the Department of Nursing Science at the NMMU.

I am hereby seeking your consent to evaluate and rate my guideline to ensure trustworthiness in the utilization of this guideline in the military hospitals.

I have provided you with a copy of my draft guideline and the AGREE11 instrument which you will use for the evaluation of the guideline.

Upon completion of the study, I undertake to provide the Department of Defence with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me:

Cell nr: 0748358813  Tel. nr: 051 4022470
Fax nr: 051 4022471  Email: caka@polka.co.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Mrs E.M. Caka
Annexure O: Table for searched databases for best practice guidelines

TABLE FOR SEARCHED DATABASES FOR BEST PRACTICE/CLINICAL GUIDELINES

<table>
<thead>
<tr>
<th>Data Base</th>
<th>Search Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scottish Intercollegiate Guidelines Network (SIGN)</td>
<td>Clinical practice guidelines and transition and nursing students and healthcare</td>
</tr>
<tr>
<td>National Institute for Health and Clinical Excellence</td>
<td>Clinical practice guidelines and transition and nursing students and healthcare</td>
</tr>
<tr>
<td>(Appraisal Research and Evaluation) Collaboration</td>
<td>Critical Appraisal tool for Guidelines- AGREEII tool</td>
</tr>
<tr>
<td>Denosa</td>
<td>Clinical practice guidelines* transition and nursing students and healthcare</td>
</tr>
<tr>
<td>Royal College of Nurse</td>
<td>• Clinical practice guidelines* transition and nursing students and healthcare</td>
</tr>
<tr>
<td>US National Guideline Clearinghouse</td>
<td>• Clinical practice guidelines* transition and nursing students and healthcare</td>
</tr>
<tr>
<td>Registered Nurses of Ontario (Rnao)</td>
<td>• Clinical practice guidelines* transition and nursing students and healthcare</td>
</tr>
<tr>
<td>Medical guideline</td>
<td>• Clinical practice guidelines* transition and nursing students and healthcare</td>
</tr>
</tbody>
</table>
# Annexure P: Guidelines not considered for inclusion

## GUIDELINES NOT CONSIDERED FOR INCLUSION

<table>
<thead>
<tr>
<th>Number</th>
<th>Reference</th>
<th>Reason for non-consideration</th>
</tr>
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<tbody>
<tr>
<td>7.</td>
<td>Clare, J, van Loon, A and Flienders University.</td>
<td>Outdated</td>
</tr>
<tr>
<td>2003. Best Practice Principles for The Transition from Student to Registered Nurse. Collegian. 10(4);25-31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
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</tr>
</tbody>
</table>
Appendix Q: letter of language editor

24 Justin Road
Broadwood
Port Elizabeth 6070

TO WHOM IT MAY CONCERN

I, Aileen Gail Klopper, declare that I have assessed and edited the treatise of E M CKA entitled:

BEST PRACTICE GUIDELINE FOR THE TRANSITION OF FINAL YEAR NURSING STUDENTS TO PROFESSIONAL NURSES IN THE SOUTH AFRICAN MILITARY HEALTH SERVICE

Submitted in fulfilment of the requirements for the degree of DOCTOR OF PHILOSOPHY IN NURSING in the FACULTY OF HEALTH SCIENCES

Any queries related to the editing of this treatise can be directed to me at 074 3209463.

Signed at Port Elizabeth on 30 January 2015.

Ms AG Klopper (MA HWM)
ANNEXURE R

Extracts from data collection

Students (Focus Group 2)

Researcher: How prepared do you think you are to take up the role of being professional nurses?

P 1 Honestly we are not prepared and the other thing that contributes is the attitude of professional nurses. Just think when you are doing 2\textsuperscript{nd} year and you ask me something or there’s a procedure going on in the ward I have not been exposed to that particular thing it is for sister for now to show me this is how it’s done but for someone to be saying now go and fetch sterile water and I ask what is sterile water and someone says ahh you guys you just useless. So now students tend to they tend to stand back because they are afraid of being called useless and stupid you understand. Yes that’s the other thing.

P8 I’ve had that bad experience and I never ever wanna work there that was in theatre and I felt so useless, indeed you feel useless, you understand. If somebody is asking you please pass me a pair of gloves and somebody says those ones are stupid and useless they don’t even know what a pair of gloves is, you know even a first year student understands, that really

P3 and also incidents in 1 military hospital in where these procedures at fourth stage and at the end of the fourth stage you must catch 15 babies so for me to wear the green bar for next year I must know how to catch a baby and now the following happened in ward 3 I was ready to catch a baby I was scrubbed and everything when the head came the sister pushed me away she came to catch the baby, she tells me get the register I will sign for you. With all due respect I did not deliver that baby. What about when a scenario comes and the sister is not next to me and maybe does something wrong cause I was pushed away when the baby was delivered.

P4 And to add on what she is saying, eh, and in 1 mil cases like that they do happen like when I started with 3\textsuperscript{rd} year, you cannot expect us like we are ninety or eighty something we are doing induction in the same ward and is congested, expect me to know where is what and there was a delivery and they say go and fetch what what, I
know what is ringers lactate but I don’t know where it’s ringers lactate because that ward is not like the other wards. So when we are going out and then we come the mother that was delivering that child was sitting there and then the captain that was in that ward at that time she said, listen you are not midwives you can’t come and mess with that baby and then we have been progressing this lady and then we are waiting for the delivery and then she says that and then that woman looked at us like, wow, what you are doing all this time was wrong

Researcher: What measures can be taken to prepare you to take up the role of the professional nurse efficiently after qualifying?

P7 There is one big thing that should be done in 1 mil I don’t know with other hospitals anger management , they have to do that there is a big problem that in fact to students whereby students will leave the wards without knowing anything, I would say I had an advantage of knowing a lot of things because I’ve been working for a long time . I had that exposure as an enrolled nurse and I had people who wanted me to do those things and they correct me and they supervise me. That is why I’m saying I’m confident that I can run the ward. There are certain wards that I cannot run, but the general wards yes I can, but most of the females especially who are in 1 mil in the management area, be it the unit or in the area, they have to be dealt with in another way, anger management, they are full of anger I don’t know what is it but there is something that they don’t get they are not satisfied with something and unfortunately we become the victims .

P3 I think even now when we go there, as comserves, we won’t learn we will only start feeling competent when you are allocated to a ward where you can go and settle and that people take you as one of their own and then you can start being on your feet. Maybe like in the orthopaedic ward you will become the orthopedic sister because, you know I’m working there. I’m 16 years in the defence force and I’ve worked in 1 mil since then and that’s also things that I’ve picked up, like I said here a student is a student they want to push you around until you get your feet

P6 I think one of the other issue is that the professional nurses they are the ones who are supposed to teach us because we are going to be future RNs, so if an RN is going to say I’m not here to teach students and then at the end of the day, the very
same person is saying I don’t know in the future when I’m on pension and then I come here whereas you guys don’t know anything. I ones asked the other one if you say we don’t know anything isn’t it your responsibility to teach me so that I can nurse you, so if they are not willing to teach us, who is going to teach us, because obviously we won’t be nurses who are competent if someone is not going to teach you.

What inputs can you give with regard to your need for preparation for the role of a professional nurse?

P5 I think in-service training is very important when we go out like Jubilee, I’ve been exposed to Jubilee psych ward when you are every morning there’s someone who is giving a lecture on the conditions that they having in the ward and when you come tomorrow you are the one the next day is another one we don’t get it in 1 mil.

P2 The other thing is, the placement is short. Sometimes you go for Midwifery in March, then you only go again in August and you feel, what did I do? If they can at least increase the placement period, you will learn something and you will know what to do, that’s just to chop and change.

And like is pointless if we can be there for long and we still don’t know anything. You find that the class block is rushed, then on Thursday night we just coming to pass that test on Friday so that you qualify for exam. But then when we get to the practical, there’s this much that we know, cause we were rushing through class.

P10 The other thing Major I don’t know if it will possible but you I do feel that in 1 military hospital maybe they need some young blood people who have just qualified, 30 year old and 40 year olds to be matrons maybe they will bring change, cause now in 1 military hospital I feel like they only want students when they need students to work you know. They don’t take students as if they really are students, I mean we do not know, we must learn from them, so I think there’s a need for young blood.

P1 You find that that very same matron that is giving you grief, she is giving you grief and she can’t teach you because she doesn’t know herself, she practiced nursing maybe 30 years ago. The protocols have changed, everything is different but the very same person is wanting to charge you for not doing something.
P9 Giving another example we had a strike at eh the nurses strike, that is the South African nurses not the military ones the civilian ones we were taken out to work there when we were working there all the students we allocated to the wards and I’ve seen I’m talking about people that I’ve worked with, I’ve seen Colonels and Majors, you name them mopping the floors, they didn’t want to do the nursing duties and they are matrons in 1 mil, but now because there’s money that is going to be paid for that operation they were there to come and mop the floors, they were not there to nurse the patients. Bed side nursing was never there. I was allocated in post labour ward where there were transfusions, and by then according to the book I needed somebody to supervise me. Registered nurses, qualified registered nurses were saying I’m not going to do it, after the transfusion we removed the container which was empty we have to run the normal saline and that registered nurse said no have to put another one on top of the other one and beside that there is a drug that is given to the patient before you can administer another blood, when I tell her about that she said no, no, no we are not going to put it call a doctor to come and prescribe and it is not a policy it is a protocol that is made, that if a patient is on blood you give breaks, you flush you give another one but it was not done like that and it were people that were saying we are working for the country. At the end of the day if I follow what they did I would have killed the patient. The patient had to get three units so if I put them in succession what will happen to the patient.

**Focus group 1 (Bridging Course Students, Bloemfontein Nursing College)**

Researcher: How well prepared do you think you are to take up the role of being professional nurses?

P3 I will say eh, due to the experience I had the privilege of ordering drugs, and I also worked in high care, when I see what I have done what they have done I think I am prepared but that is practical, practical I am prepared theoretical I have a lot to learn, because I nurse a patient I know what I must do but it is a little bit difficult on writing it down what I have done. So I think my theory I still have to work on it theory wise I am not ready.

P1 Yah is like she said, practica we and also with the long time we wanted to do the course because every year we prepare ourselves and the feedback is negative. You
are so ready and then you get declined and then you think it is not gonna happen you call off now because nothing is coming to you. Practicals as she said yes theory it was a shock to us, it was like cold water on to us so we had to learn to compare practica and theory so that they can work together

P4 As we have staff nurses for a long time, and we have been working with the professional nurses, seen what the patient needs and we don’t’ have the limit only this thing that we have to watch the scope of practice there are things that you can’t do because of your scope of practice . I think now on this opportunity that we have been given to become registered nurses it is our chance to work with patients eh without limitation and then eh as we have been nurses for a long time we are we , it is our duty to help the patients that is the work that we know and I think we are going to be competent professional nurses . Now as we students we are learning everything and understand everything how to and then when to do it with the patient. So I am prepared.

P2 No anyway I’m prepared to be a registered nurse since where I was coming from I was given an opportunity to run the ward alone to be responsible, to give orders to my subordinates and they listen to me and then I think I am prepared because where I am coming from they give me a lot of things then since coming here I also experienced a lot of things in the ward whereby they give me the opportunity also to start counting the drugs, giving out the drugs so that’s where I am learning to be responsible.

P3 The experience plays an important role in preparing us to be professional nurses, like I also had a lot of experience like she said, running the department doing the off duties, the ordering a lot of experience and a lot of opportunities we were given as well. The matron will come and say you are the senior in the department your sister is on leave you must take over, then you take over. The only opportunity was not like in the sense of giving the drug key, but you work, the drugs will be taken out and given to the patient that you done but what they done is that they put a lot of responsibility I am talking about myself my experience that you are taking out for your patient to give care so that experience makes me clinically ready for patient care and to be a sister in the department.
Researcher: What measures can be taken to prepare you to take up the role of the professional nurse efficiently after qualifying?

P4 I think now that we have been at school I think this time is the time whereby we know exactly what we are supposed to do because by the time we were still staff nurses we were just using experience as to how things are done, but now if you are going to learn from the book and things from the tutors and I think we will do the right thing as is supposed to be the way the registered nurse is supposed to do things

P3 Actually it makes more sense as to why we are doing things because you got klappe by the eyes this is how it is supposed to be done at the end of the day you do not realize why you are doing it but you know you must do it so now actually the book is nice it informs you why you done it. The practica and the theory is now making sense why I am doing the blood pressure why I am doing this and this it gives you oh, that is why it broadens your patient view it makes it much better.

P1 This morning I realized I was in a situation where I was delivering babies, without anyone to help, I was the only one I was saying oh the baby is going to school this year but now I mean in the ward, maternity ward and the sister is guiding us, she is delivering the babies is like now for me now it’s making sense now. I was just doing it because there was no one else I have done it because that’s what I have observed and I think this was the right way of doing it but now it makes more sense. Now she is telling me you do it because this and this is the reason and eh, there is a right way to do it and not that, at the moment I was just doing it I must help and I think that’s how you do it, but I didn’t have the experience that time and did enjoy it very much this morning.

P2 When it comes to the checking of drugs and the administering of drugs for me it went well with the captain this morning because now I am able to take out the drugs for the patients. She showed me a lot and I was working in the psych side she taught me that I must also communicate with the patient and check the force number because they used to change their names, so I think now I am in the right track.

P1 The previous experience help a lot
P3 I was given an opportunity a couple of times to draw off-duties for our department then we had to do the balancing and everything, so in that sense I was fine, ordering of drugs, ward stock even your quotations to get your quotations for your stocking equipment that I done it before, so I am comfortable because I have done it for a very long time so in that way I am comfortable with it. Even writing a letter that the patient was here for this and this and that, giving him a letter for his unit, receiving patients with DD63s I am well prepared for those situations calling the doctor, telling him about the emergency situations, telephonic prescriptions yes,

Researcher: What inputs can you give with regard to your need for preparation for the role of a professional nurse?

P1 Things like doctors’ rounds, because we were doing it since we qualified as staff nurses

P4 Yah I think with us with the experience that we have for administration is just to verify what we have been taught and see if it’s the right thing or the wrong thing and where we were saying some things were wrong now we can know that was not supposed to be done like that it was supposed to be done like this, so I think with experience that we have most of the things are not new to us and then we are not like someone who is from school whereby everything is going to be learnt by seeing it now. With us I think we just have to learn theoretically then practically we are not going to struggle that much so

P3 I think the only difference is that, every department has their own way of doing things that is for us now to learn their way now of how they are doing it until you go to your own department where you are working. So that is the only difference that is gonna happen

P2 During the rounds the doctor can give you the chance to ask questions or ask you what is this and this and you stand up and you are answering all this students and if you wrong they will help you with the right answers

P3 What I don’t like about this place is when you challenge the doctor about something, they become very negative, they just wanna cut you off, some of them will give you information asking you how much do you know this. I was telling them
about this wound dressing that I doing and it was like why do you want to know better that me, then I said you know, let me zip it otherwise, It me just listen to you.

**Novice professional nurses (Focus group 2)**

How did you experience your transition from being a student nurse into a professional nurse?

P4 Uhm, I'll say it was fine, it was ok, cause at the college we were given opportunity in our third year for us, to try and do some of the things that, eh professional nurses do, the responsibilities, we got the responsibilities, but coming from 1 Mil to here, after our com-serve we were told that we will be used as ENs, for us that was a set back, because at 1 Mil we were used as professional nurses, cause you know when you do com-serve you have to work under R/N but to actually say no you will be used as EN.

P1 There were people that really threatened me that I felt threatened about that in the ward I can't delegate because at the end of the they will tell me whatever that they are telling me. And the other thing is most of the departments where I’ve worked in, everybody is working. I was not sure actually of what I was doing. I was not that prepared for the role at least not 100%.

P3 I cannot delegate this person cause she is older than me, ja the age wise also. So now even drawing the line between this people it takes times to get to that one believe you me. I ended up doing everything in the ward like as R/N and E/N because like I was scared to delegate someone.

P4 With the transition, for me it was not that difficult cause, we were prepared from third year already, they treated us as in charge, they gave us the keys already and then the sisters will just supervise us and we gave medication things like that, so the transition was not that bad. But when I came to 3 Mil, was totally different, they treated us like ENs, for one year then after one year, they expected us to be sisters again just like that, that made it difficult.

P2 The college is preparing you for the role theoretically, but the clinical side is the one that is lagging.
When we came here we expected to be alone, cause they left us alone and stuff like that, even in 1 Mil they left us alone with 20 patients but when we came here they didn’t leave us alone for a whole one year. And then after one year, they started leaving us alone now, so we had to learn the hard way.

Researcher: How prepared were you when you took up the role of being professional nurses?

P3 To take the role of the sister, I won’t say we were not prepared I won’t say we were fully prepared, I won’t say that, but we, you learn, the four years that you spend in hospital, you learn, a lot of things even though you are not responsible for doing them, but it’s just that our hospitals are, there’s not a lot of exposure to a lot of things, so you come here and you’re expected to know some of the things. Like when doing you com-service, you work, we working as ENs, and then the following day you qualify, them they expect you to now be a professional nurse, you must know everything, you understand. Say like now you’re working in casualty department, and the whole year you’re not allowed to work as an R/N and then the following day they leave you alone. That whole year, there’s something that you’ve never experienced in your profession and you are expected to know how to manage it, so that was………..

P1 I think practically, the military hospitals, they just don’t prepare us, because the practical things that you see hare are just minor things. Once in a while something major will come and you don’t know how to manage it cause you just, you read about it, but you just don’t know how to handle it, you’ve never seen it, now you have to now think, remember what the book say, and the nook and the practical thing are too different, for that was the problem with us.

P5 We didn’t get enough exposure, like with Midwifery, we were at least allowed to work in public hospitals, s we were exposed to a lot of things, but now you come here to trauma, here it’s a clinic, it’s literally a clinic. There’s no challenge whatsoever to learn and be ready and actually be. If you get practical exposure cause, in the military setting we don’t get enough, there’s not enough cases here, for us to be actually ready. Our, my colleague who qualified the same as me whose working in the public setting or private setting, have
much more experience than me, because they are exposed, you know with nursing, the more practice, the better you become. So, with us, that’s out disadvantage, and then you get this public hospital, to face those thing that you’ve never seen and you’ve never managed.

P6 I remember during my com-serve I was sent to Virginia hospital, it was only me, and this other captain and it was only the two of us who were nurses. She has never worked I a maternity ward, lucky enough I had just finished and I was, a little bit exposed, so you see, it was the captain here and me the com-serve we were left there only the two of us nurses, to manage the hospital with no nurses of the surrounding place and we had to be at our ends wits, lucky enough we didn’t have any mortalities, we were thrown in the deep end, although we don’t get expose to this things.

Researcher: How has the transition period affected your performance as a novice professional nurse?

P3 Eh, ah, they expected us to do most of the EN things, and function under supervision yet they gave us the drug keys, we must give out drugs, must still do. We didn’t really know what is our function or care function, and when we sign our duties, those things we sign duty sheets, it’s like we must do vital signs do total care of the patient and things, and then a month after you sign a different duty sheet after I finish com-serve, the I am responsible for the allocation and for the supervision and stuff like that, which didn’t make sense to us, cause, already we were prepared for those things and then they took us back to our second year. I felt like I was treated like a second year when I came here. It was difficult, like, it’s nursing you have to get together it’s a calling. The performance definitely dropped, cause of, from third year you are prepared to be a manager

P1 While my colleagues were busy progressing in 1 Mil they were left alone to do basics in the ward, stuff like that during the com-serve year, here it’s different.

P7 The thing is when we come here we work like E/Ns so it sort of delays the transition period, you fall behind but you must also be hands on if you have the learn
P2 Ah, it has a lot, like now you see, I am still a CO. 8 years I am still a CO, like now when ah, the bridging course started, we have Warrant officers and we have staff sergeants, those people are higher rank, professionally, I am higher than them but now if you have to delegate somebody and is a staff sergeant, I once had this one experience, just now a few months ago, and this person literally refused, he refused, you understand and I can't say anything, military wise, even if we have to go to military court, he’s going to win the case, he is a staff sergeant, I am just a CO.

P1 Professionally yes, we, we, get a chance to be given the opportunity but, you understand that, at the end of the day, it doesn’t really help us, ja we are, we, get frustrated. But agoi, and at least we get to be, we are given those opportunities, we just have to used them, I mean I can make decision, when I am running shift, I can manage a department alone.

P4 The other problem that we encounter is that when it comes to patients since well, since you qualify and at first you are having this lower rank, so the patients some patients they underestimate according to the ranks. If you come in and they are calling for assistance and you come in they will just look at you at the shoulders and say CO, no, no, no I want the sister here who are you and you tell them I’m the sister here no I want the Captain. Then you find it offending or something but somewhere down the line you start to accept that ok this is normal, normal behavior from other people they behave this way. The other thing I used to do is stay calm and tell them ok I am the sister here yes, and what the other sister can come and do to you I can, I will never come and waste your time I could have assisted you immediately.

Researcher: What measures can be put in place to ease the transition?

P3 They must give us more responsibility and expose us more to the ward. They must leave us to run the ward and we can only go and ask if something is too difficult for us in that way we will be independent and competent, but if they don’t allow us then we will forever fall back.

Researcher: How do you think a best practice guideline can assist in facilitating the transition?
P1 You know Major I think if we had clear guidelines on what to do and to expect when we start in the wards as professional nurses, it would make things very easy.

P6 Yah it’s true what she is saying It’s difficult just to come in and you don’t even know what you are doing. We need something to guide us, maybe a document to tell us what is what.

It could really be easy for us if we come and we find some sort of direction you know, something that’s guiding us, rules like you know maybe a tool or something.

P2 Sometimes you want to work independently but now you have someone in-charge then it’s like you are I can say not a responsible person. As early as possible they must give us the opportunity to run the wards as early as comm.-serve they must sommer start there not to say they must wait until you are newly fully qualified professional nurse you see they must start as early as possible, cause they are having this thing that the comm.-serve must not work alone.

Researcher: What are the lessons learnt from your transition experience? That I’ve learnt? Do everything yourself and where you can’t, ask for help.

P4 You see, there’s a difference between males and females. Males are dodgiest as a student t you tend to do what the students are doing. I didn’t see anything wrong that I was doing I was hands on where I didn’t know I was asking especially when we got to 3Mil. You see we were never left alone to run the departments when we came here from comm.-serve we were working with big people all the time.

P2 You see it would happen easy if we were prepared at an early stage, like 3rd year we are already prepared though sometimes as a student you are having another mentality that I am not a working force and also you don’t want to expose yourself also.

P5 For the next com serves that are coming in January they must not treat them, they must sign, they must treat them like professional nurses, and also be eh, they can be under supervision for three months at leas and then after that they can be left alone with the ward and things like that.
And if they should be with the and when they are under supervision they must be at
least be two ENs that one and the sister who is going to overlook the com serve, give more responsibility to the com serve.

P3 If can be more ideal if it's a com serve with a bridging course student and a sister cause now the bridging cause students currently they are functioning as ENs when they are also supposed to be functioning as professional nurses, like in the morning the bridging course must take over, allocate all of us, to get the feeling how is it to be a sister, allocate us, take, check us and allocate us for tea, first be the in-charge try to do off-duties already, for when next year they are expected of doing it already they know what is happening.

But now they are doing vital signs, dressing the wounds.

**Lecturer 1**

Researcher: How prepared do you think the final year nursing students are to take up the role of being professional nurses?

Theoretically yes, I think they might be prepared but practically I don't think they are, and remember nursing is practical not theory, so if they are not practically prepared it means they are not prepared period.

Q- What makes you think that they are not clinically prepared?

Yoh, let me say the issue of exposure in the form of learning opportunities. Learning opportunities have been a very serious problem until I think last year, cause our students were allocated to 1ml hospital and Far East and eh, just few hospital or areas, clinics and we never had agreements with areas like Kalafong and Jubilee, which we got you know we have just been accredited last year and we started late. I think the fourth years did not benefit actually that much, the group that is going to benefit more is from first years and second years and the rest will only benefit because now we are using Jubilee hospital for midwifery and Psych we are also using Kalafong for GNS and what I think a bit of psych.

I think currently what is happening is that there is more emphasis on psych and midwifery in 3\textsuperscript{rd} year and 4\textsuperscript{th} year. Ok there is still a bit of general nursing science that they do that is still being given. With 3\textsuperscript{rd} year they do although I don't know the
number of hours currently but they still do GNS. They can still make sure that they integrate management among those specialty areas. They mustn’t encourage students just to concentrate on that particular subject that is how I feel. As a lecturer you advice that this month you are doing community, this month you are doing psych, but you must take you GNS books with you to the clinical area, that is integration, so that when you get an opportunity like if you see that this is more of GNS then you can use that, don’t say nna I am just here for community, because I think this thing of separating you won’t realize that the principles are interrelating.

What strategies can we use to better prepare them?

Yah, you know this one is a little bit tricky, because currently I would say that eh, the strategies are in place, they are but is seems like they are not working, because if they were really working our product would not be the product that we are seeing at the moment, but eeh, one thing for sure what I have realized is, we are still lacking staff for accompaniment, because you know most of the people tend to learn better if you know learning by example. Creating mentoring is one of those better ways of building a person to be skillful and you know to be prepared in all the areas, but half the time you find that a lecturer is supposed to be here, prepare for block and is expected that the following month she is supposed to follow up the students, whereas obviously you will find out that even the first years are still around and it’s not easy. The lecturer is still finalizing, doing whatever, tests marks at the same time maybe try to look into the issues of assignments and whatever.

Researcher: How do you think a guideline can assist with this process?

Yah, like you talked about the development of best practice guidelines, I think if the college can have that for the hospitals during the last year of placement of the students it will actually also guide them on what to do and what to prepare for them. That will actually help a lot. I think they will see that the college is doing something to meet them half way. I am happy that they will come from us, I mean the guidelines, from the college to see that we are prepared to take a stand. Like I said mentoring can actually be part of the guidelines that is something they can do on that other side once the students are already in fourth year.

Researcher: What skills and competencies can be enhanced in their preparation?
Communication skills, decision making skills those can be emphasized, apart from the mere practical basic care nursing skills, that should also be included, especially now that if we say we cannot allocate this person who say according to the nursing council this person is competent is registered but still we cannot allocate or use this person as a registered nurse. We need to develop a lot of general nursing skills above the rest. I am not actually excluding the specialty areas but you know if you have the basic principles of patient care then you are able to apply the other skills in other areas. So communication skills, practical skills referring to basic care nursing skills like admission, bath those are the basic skills, yah, history taking from there we can support the managerial skills, decision making, complete management and all those things.

Researcher: How well prepared do you think the newly qualified professional nurses are?

No they are not prepared I don’t even think they are ready umh, they are still struggling in some things, and I sense eh they have a sense of fear, they are not confident if you are not confident you are scared to come out and stand, you cannot even see that you know where are they short until you actually talk to them or do a round with them it’s then that you will find exactly where is it that they lack.

What role can you as a manager play to facilitate a successful transition period?

I think having someone along-side just to make sure that whatever confidence they have to build up and to encourage them to make mistakes and like whenever you are with them to do whatever they think is right to correct if it’s wrong immediately if it’s good applaud and move forward and I think if you see them good in people and praise the good it encourages them to come out and they gain the confidence and they get more involved. The other is that we need like you said you are going to develop the guideline that is actually what we need to ease the transition. Some, some document that can lead us as to how we receive them and how we actually prepare for them before they complete you see. I think the college must give us some guidelines I am actually happy that this will happen, it will really assist us. Something that is working for everybody.
What skills and competencies are you expecting from a novice professional nurse?

Uhm, number one I think they should be able to understand their role as professional nurses at that level what their role is. And number two they lack some of the admin aspects in their practice yes the other things we go along I think to understand the role and exercise it.

We are trying to assist them in achieving the admin role and if I may go back a little bit, I normally take my time and teach the students if they come through I normally take time and sit with them. So I think if we try and because I wished that wherever they are rotated in the hospital someone gets time to teach them something. Just to reinforce what they have learnt and to try and get them more involved cause they come in the ward, they do routine and then they sit in the tea room and then you go to them and you say but you are here to learn and until you understand this diagnosis and what it means to you as a nurse, it won’t just be a diagnosis but it needs you as a nurse to contribute, until you understand what is expected of you of this diagnosis of this patient you will just get bored and sit here and drink tea the whole day. We try and involve them, we draw an in-service training programme and say you will present this topic to everyone today and then we listen to you we correct you we ask you questions we add where we see you are lacking and I think if we try and do that as the hospital we can pick them up and get them ready at the end of their four years.

How can a guideline assist you as a manager to ease the transition?

I truly think guidelines can assist us in knowing exactly what to do and where and when to start with the preparation. Sometimes we think we know, i mean i think we know, but as to how the college want them prepared that is not clearly communicated. Eh, the guidelines are really a good idea, anything that will help.