WILL SOMEONE WALK WITH ME?

A case study exploration of Graduate Nurses’ perceptions of the preceptored experience

Cheryl Atherfold

A thesis presented in partial fulfillment of the requirements for the degree of Master of Health Science in Nursing at Unitec Auckland

2008
Abstract

The transition from student to registered nurse is a challenging and often stressful time in a nurse’s career. “Will someone walk with me?” is a case study research project that explores the graduate nurses’ perceptions of preceptorship as a strategy to support this transition at Lakes District Health Board (DHB). As a provider of graduate nurse programmes since 1995, Lakes DHB has provided preceptorship for the nurse in the initial period of clinical practice. Annual evaluation by questionnaire identified that this has been applied in a range of ways in different clinical settings with varying degrees of effectiveness.

Further inquiry into graduate nurses’ perceptions of the preceptored experience during the first twelve weeks of practice within Lakes DHB forms the basis of this research project. The intention is to utilise this insight to further inform the development of preceptor education programmes and application of the preceptor role in the practice setting. Using the case study research method, data has been collected from fourteen participants using semi-structured interviews, focus groups and secondary data from the previous year’s questionnaire undertaken by preceptors and graduate nurses.

Thematic analysis of the data has resulted in two categories, each with three associated themes. The first category relates to functional factors in the way the preceptorship role is applied. This explores the role of the Clinical Nurse Educator (CNE), organisation within the unit and the teaching of clinical skills. The second category relates to psychosocial considerations and includes the graduates sense of being scared and advocacy of the preceptor, socialization and team support, and the preceptor’s own experience as a registered nurse.

Recommendations from the research include the allocation of a dedicated preceptor selected with consideration for relational ability; complementary rostering and workload allocation to ensure that the preceptor and graduate nurse work together; early notification when preceptor arrangements break down; implementation of a clinical coaching plan; and strengthening the CNE’s role as a leader facilitating and supporting
preceptorship in the units. Opportunities for further research that arise from the study include the perceptions of the preceptors and the nursing leadership in clinical areas.

Structuring the application of preceptorship, to ensure that all of these aspects are woven throughout the graduate nurse’s transition results in Korowai Aroha, a cloak of covering for a supported transition that facilitates the development of practice.
The journey of this thesis could not have been made without those who have walked with me.

My sincere thanks to the graduate nurses of the 2007 Lakes DHB Nursing Entry to Practice Programme. Your willingness to participate and ‘give voice’ to your experiences has provided the fibre of this study. Your contribution has meaning both now and in the future, as it shapes the way preceptorship is applied and continues to develop. Thank you also to those nurses who walked with and preceptored the graduate nurses supporting their transition to the registered nurse role.

Ma nga reo o te manu hei tangi
Ma nga reo o te Tangata hei koreorero
(Personal Communication, Gypsy Roberts, Te Arawa, 22/04/08)

I would like to thank Sue Gasquoine and Jill Yielde r, my supervisors at Unitec for their guidance, direction, and encouragement; you have each given of your own strengths in aiding the development of my work. I have especially appreciated your support during the times when unanticipated setbacks have occurred.

Lynn McLachlan, thank you for mentoring me through this journey and demonstrating the caring aspects of nursing whilst challenging my own learning to consider discoveries outside of my usual comfort zone.

Gary Lees, Director of Nursing and Midwifery at Lakes DHB, thank you for supporting the study, providing access for data collection, and for guidance and support as I processed some of the complex aspects of the data throughout.

Cathy Cooney, CEO, Lakes DHB, thank you for sharing the history of graduate nurse programmes at Lakes DHB, and for your ongoing interest and support.

Ngaroma Grant and Gypsy Roberts, Te Whakaruruhau, thank you for listening and guiding as I developed the way to incorporate the characteristics of Lakes DHB NETP programme and how they link to preceptorship needs.
My colleagues in the Clinical Nurse Educator group, the Department of Nursing and Midwifery, Clinical Teams and Whanau nurses. You have participated in many aspects of the work of this study, contributing to the growth of graduates, preceptors and myself.

Jo Scott, thank you for your amazing technical and administrative support, and also your encouragement and advice.

The Unitec Distance Library Team, Sean Petrie and Jeanne Reihana, and the Lakes DHB Clinical Library Staff, Janet Arnet and Patricia Sheehan. Thankyou so much for supporting the search for credible information to support this study.

Those who travel in ‘the car’ with me between Rotorua and Taupo hospitals each day, your collective wisdom and unique humour has been invaluable.

Whanau; My husband Simon and our daughter Brooke, my parents, my sister Lynda, extended family and friends who have supported with encouragement and in many practical ways. Thank you for believing in me.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract:</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements:</td>
<td>iv</td>
</tr>
<tr>
<td>Table of Contents:</td>
<td>vi</td>
</tr>
<tr>
<td>Table One: Definitions of Beginning Practitioner and Competent Nurse</td>
<td>7</td>
</tr>
<tr>
<td>Figure One: Lakes District Health Board Nursing Entry to Practice Programme Learning Framework</td>
<td>8</td>
</tr>
<tr>
<td>Figure Two: Lakes District Health Board Cultural Competency Framework</td>
<td>10</td>
</tr>
<tr>
<td>Figure Three: Artwork from group evaluation of 2007 NETP Programme</td>
<td>65</td>
</tr>
<tr>
<td>CHAPTER ONE: INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>The journey begins</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td></td>
</tr>
<tr>
<td>CHAPTER TWO: CONNECTING WITH THE CASE</td>
<td>5</td>
</tr>
<tr>
<td>Preceptorship within Lakes DHB Nursing Entry to Practice Programme</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td></td>
</tr>
<tr>
<td>CHAPTER THREE: LITERATURE REVIEW</td>
<td>13</td>
</tr>
<tr>
<td>Retention</td>
<td></td>
</tr>
<tr>
<td>Experiences of graduates</td>
<td></td>
</tr>
<tr>
<td>Organisation and application of the preceptor role</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td></td>
</tr>
<tr>
<td>CHAPTER FOUR: RESEARCH PROCEDURES</td>
<td>25</td>
</tr>
<tr>
<td>Research method</td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td></td>
</tr>
<tr>
<td>Data analysis</td>
<td></td>
</tr>
<tr>
<td>Ethical considerations</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td></td>
</tr>
<tr>
<td>CHAPTER FIVE:</td>
<td>PRESENTATION OF THE DATA AND DISCUSSION</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Category 1: Functional Factors</td>
<td></td>
</tr>
<tr>
<td>Category 2: Psychosocial Factors</td>
<td></td>
</tr>
<tr>
<td>Linking the categories together</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER SIX:</th>
<th>KOROWAI AROHA: RECOMMENDATIONS AND CONCLUSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threads of Change: Implications for practice</td>
<td></td>
</tr>
<tr>
<td>Recommendations</td>
<td></td>
</tr>
<tr>
<td>Strengths and limitations of the study</td>
<td></td>
</tr>
<tr>
<td>Further research</td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td></td>
</tr>
</tbody>
</table>

| BIBLIOGRAPHY: | 79 |
| GLOSSARY: | 92 |

<table>
<thead>
<tr>
<th>APPENDICES:</th>
<th>APPENDIX ONE: Ethical Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unitec Research and Ethics Approval</td>
<td></td>
</tr>
<tr>
<td>Lakes DHB Research and Ethics Approval</td>
<td></td>
</tr>
<tr>
<td>Director of Nursing &amp; Midwifery Support</td>
<td></td>
</tr>
<tr>
<td>Te Whakaruruau Support</td>
<td></td>
</tr>
<tr>
<td>Information Sheet</td>
<td></td>
</tr>
<tr>
<td>Consent Form</td>
<td></td>
</tr>
</tbody>
</table>

| APPENDIX TWO: Questions for Focus Groups and Interviews |
| APPENDIX THREE: Preceptor Policy and New Graduate Policy |
| APPENDIX FOUR: Summary of Preceptor/Preceptee Evaluation Questionnaire |

| | |
| | |
INTRODUCTION: The journey begins

Qualifying and becoming a registered nurse is one of the most significant transitions in a nurse’s career. It is complex and challenging, carrying with it a sense of achievement and celebration along with the often overwhelming sense of responsibility and concern about how to meet all that is now required. The nursing profession has implemented the preceptor role to walk alongside graduate nurses to facilitate this transition in a supportive way.

As the coordinator of the Nursing Entry to Practice (NETP) Programme at Lakes District Health Board (DHB), I became aware of variations in the way that preceptorship was applied in the graduate nurse transition to the registered nurse role in different clinical settings. Lakes DHB has been providing a programme to support nurses making this transition since 1995 and preceptorship of the nurse in the initial period of clinical practice has been and still is a significant part of this. Drawing on the literature, preceptorship is portrayed as a complex concept and may be defined as a developmental process where, in an atmosphere of trust, experienced colleagues can draw on their own experience to guide and educate as clinical facilitators, bringing support, socialisation and role modeling to the student to registered nurse transition (Bond & Holland, 1999; Morton-
Cooper & Palmer, 1993; Armitage & Burnard, 1991; Beckett & Wall, 1985). Titchen’s (2003), notion of a critical companion further informs these views of preceptorship as:

a holistic, person centred, helping relationship in a health care context, in which an experienced facilitator accompanies a co-learner on an experiential learning journey (p.33).

These collective attributes and expectations form the basis of preceptorship at Lakes DHB. For the purpose of this research project, a graduate nurse is defined as one who has completed a Bachelor of Nursing degree and achieved registration as a nurse within the last four months and is beginning the journey into practice (Nursing Council of New Zealand, 2005a). They endeavour to apply what they have learned in the undergraduate programme as they develop understanding of the context and reality of practice (Benner, 1984). The impression I had about the variety of ways preceptorship was applied was further confirmed by annual evaluation using questionnaire and anecdotal feedback from graduates and preceptors.

‘Will someone walk with me?’ is a research project that aims to address this variance by gaining a deeper view of the graduate nurses’ perceptions of the preceptor experience during the first 12 weeks of practice. The intention is to utilise this insight to further inform the development of preceptor education programmes and the application of the preceptor role for graduate nurses participating in the NETP Programme. As the purpose of the project is focused on Lakes DHB, the Case Study research method is used. This examination of the preceptored experience of the graduate nurse utilises data from interviews and focus groups to explore what happens and how changes can be made to better facilitate the transition from student to registered nurse. Secondary data from the 2006 preceptor / graduate nurse evaluation questionnaire will also be referred to.

A critical review of literature relating to preceptors and graduate nurses affirms that preceptorship has a positive impact on the transition from student to registered nurse. For the experience to be effective a structured approach to how preceptorship works is required. This includes rostering, teaching of clinical skills, reflection and problemisation. Where this occurs practice confidence, job satisfaction and retention are greater. The
limited volume of literature specifically regarding the graduate nurses’ experience indicates a gap, thus supporting the research question developed for this project:

“How has the preceptor supported the transition of the graduate nurse to the registered nurse role?”

The project is limited to the perceptions of graduate nurses within the hospital setting where the NETP Programme requirements apply. Perceptions of other stakeholders within the graduate nurses’ transition have not been explored with the exception of the inclusion of the secondary data from the preceptor evaluation questionnaire.

Chapter One introduces the journey of this research project which began with the assumption that we expect the preceptor to be the nurse who will walk with the graduate nurse. There was also the realisation that variations in the way that preceptorship was delivered impacted on the quality of the transition to the registered nurse role. The roles of the preceptor and the graduate nurse are defined and the question of how preceptorship supports the transition at Lakes DHB is asked. Chapter Two introduces the Lakes DHB NETP Programme as the case explored in this research project. The background and context of the NETP Programme preceptorship requirements at Lakes DHB are profiled. Chapter Three explores literature relating to preceptorship and graduate nurses including information about programmes that include preceptorship as part of the transition. Chapter Four outlines the research design, case study methodology and the research processes profiling the data collection, participants, data analysis and ethics procedures. Chapter Five presents findings in two categories each of which has three themes. The first, is regarding functional factors and the three themes discussed in this category are: the Clinical Nurse Educator (CNE) role; organisation within the unit; and the teaching of clinical skills. The second category consists of psychosocial considerations and discussed is: the sense of being scared and the preceptors’ advocacy; socialisation and team support; and the preceptors own experience as a registered nurse. Links are made between the categories and artwork articulating the graduates’ perceptions at the programme evaluation is included. Chapter Six incorporates implications for practice, recommendations, strengths and limitations of the project, opportunities for future work, and draws conclusions.
SUMMARY
The preceptor role is expected to provide the answer to the question asked in the title of this research project 'Will someone walk with me?'. It is a core component of the NETP Programme at Lakes DHB (2006c) which aims to support the transition of graduate nurses to the registered nurse role. There is variance in the way that the role is applied in practice. The case study research method will be used to explore this in detail. Data collection has included focus groups and individual interview with reference to secondary data in the form of an evaluation questionnaire. Insights gained from thematic analysis of the graduate nurse perceptions will be used to inform the future development and application of the role. Implications for practice will be identified and recommendations regarding this made. Conclusions will draw together the findings to effect changes that ensure that graduate nurses will have effective preceptorship during their transition to practice.

The Lakes DHB NETP Programme will be introduced in the next chapter.
CHAPTER TWO:

Connecting with Lakes District Health Board Nursing Entry to Practice Programme

This section addresses the background to the NETP Programme and associated preceptor requirements at Lakes DHB, as detailed introduction of the case to be explored forms part of the credibility and subsequent trustworthiness of the case study research method (Creswell, 2007; Yin, 1994). By understanding the philosophy and practice context of the NETP Programme, the expectations of preceptorship during transition to the registered nurse role can be explored. Lakes DHB, began delivering graduate nurse programmes in 1995 with the intention of supporting this transition. 1996 saw the commencement of formalised preparation of preceptors in the form of the preceptor course delivered by Waiairiki Institute of Technology based on the needs identified in practice (C. Cooney, 4 June, 2008. Personal Communication). Annual evaluation since commencement has seen these initial programmes evolve in response to the changing needs in practice. The intention of the current NETP Programme at Lakes DHB is to provide a supportive learning environment for this transition based on the specific clinical needs of the population of the Lakes District, across the care continuum, by facilitating practice development.
The Lakes DHB region covers a large geographical area from Maketu to Tongariro, the boundaries of which correspond with the boundaries of the Te Arawa canoe (Lakes DHB, 2004a). The descendants of the Te Arawa canoe landed at Maketu on the east coast of the North Island of New Zealand and over time spread inland to Mount Tongariro which stands in the centre of the North Island. The descendants of the people of that canoe form two main iwi known as Te Arawa and Ngati Tuwharetoa. The area includes two major urban areas, Rotorua and Taupo, with a hospital located in each. A number of smaller towns and settlements spread across large rural and farming areas. The population of the district is approximately 100,000 people. The proportion of Maori is higher than the national average of Maori (approximately 35% compared with the national average of 15%) who experience poorer health outcomes than Maori nationally (Lakes DHB; 2004a). Lakes DHB Clinical Needs Assessment (2004a) identifies higher than national averages of diabetes, cardiac disease and respiratory disease.

The NETP Programme has been designed to reflect the needs identified in the Lakes DHB Clinical Needs Assessment (2004a), and care delivery requirements based on the Health and Disability Sector Standards (Ministry of Health, 2001), across the care continuum. The content and sequencing of education in the NETP Programme is informed by these factors and aims to: “facilitate a supportive learning environment to effectively transition from student practitioner to competent registered nurse; and build on undergraduate education and experience using practical skills and critical thinking which are grounded in practice development reality” (Lakes DHB, 2006c, p.6). Graduate nurses are employed on the programme for twelve months in one or two clinical placements within Lakes DHB. They are employed 0.8 FTE with an extra 16 study days distributed over the 12 month period that reflect development of practice. Twelve of these days have a clinical focus; the remainder focus on organisational, cultural and health and safety processes.

During 2006 the NETP Programme was reviewed and modified to align with the standards developed by the Ministry of Health (MOH) (2005), and the Nursing Council of New Zealand (NCNZ) (2005a). The Lakes DHB NETP Programme (Lakes DHB, 2006c) is accredited by the Nursing Council of New Zealand and to successfully complete the programme participants are required to submit a portfolio of evidence that demonstrates the transition from beginning practitioner to practice at the Competent Level as defined
by the Northern Region Professional Development and Recognition Programme (PDRP), (2004) (Table One). This reflects the development of nurses based on the novice to expert skill acquisition model described by Benner (1984). The PDRP is also accredited by the NCNZ and as such meets competency requirements for the practice of registered nurses (NCNZ, 2005b).

### Table One: Definitions of practice

<table>
<thead>
<tr>
<th>Beginning Practitioner</th>
<th>Competent RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide nursing care for patient using skills gained from an undergraduate programme</td>
<td>1. Demonstrate competence in clinical skills, managing routine care and beginning to recognise recurring themes relevant to the area of practice</td>
</tr>
<tr>
<td>2. Develop relationships with patients to implement the Treaty of Waitangi (TOW) and ensure cultural safety in the practice setting</td>
<td>2. Develop partnerships with patients that implement the TOW and ensure cultural safety in the practice setting</td>
</tr>
<tr>
<td>3. Require a high level of guidance and coaching</td>
<td>3. Seek guidance and support as required when providing care for clients with more complex needs</td>
</tr>
<tr>
<td>4. Consolidate knowledge and skills</td>
<td>4. Respond appropriately in emergency situations</td>
</tr>
<tr>
<td>5. Apply theory to practice</td>
<td>5. Demonstrate sound technical ability in relevant technical skills</td>
</tr>
<tr>
<td>6. Aware of emergency procedures</td>
<td>6. Develop time management skills and prioritises work appropriately</td>
</tr>
<tr>
<td></td>
<td>7. Proactive in seeking professional development opportunities for themselves and others</td>
</tr>
</tbody>
</table>

Northern Region PDRP, 2004.

The intention is that the preceptor works with the graduate nurse to achieve this competent level of practice which demonstrates these practice attributes based on the programmes Learning Framework (Figure One). The framework is strongly influenced by the Lakes DHB Nursing and Midwifery Strategic Plan (2006b), the National NETP Standards which incorporate the NCNZ competencies for the registered nurse (NCNZ, 2005a), the results of the staff survey carried out by Best Practice Australia in 2004 and 2006, and Lakes DHB Maori Health Strategy (2005a). The intention is for the programme to facilitate both the technical and emancipatory development of a person centred practitioner based on the assumption that the preceptor is the critical relationship for doing so.
Facilitation of the person centered practitioner
Technical & Emancipatory Development of the New Graduate

Cultural Competency Framework

Theory
- Critical Social Science – (Mezirow)
- Humanism – (Rogers)

Practical Facilitation strategies
- Clinical Supervision
- Experiential Learning
- Critical Reflection

The Strategies/tools
- Action Learning Sets – Reflection-on-action
- Critical Companionship – (Titchen, 2003)

Preceptorship
- Critical companionship
  (Titchen, 2003)

The Relationship Domain
- Mutuality
- Reciprocity
- Particularity
- Graceful Care

Cultural Practice Development

Rational-intuitive Domain
- Intentionality
- Saliency
- Temporality

Facilitation Domain
- Consciousness Raising
- Problematisation
- Self Reflection
- Critique

Competent registered nurse delivering patient centered care

Figure One: Learning Framework

Conceptual Development of Person-Centered framework for New Graduate Entry to Practice Programme
Clinical Nurse Educator Group and Graduate Nurse Co-ordinator, Lakes DHB, 2006

Lakes DHB Nursing & Midwifery Strategy
NETP Nursing Entry to Practice Program
Magnet Best Practice Australia Survey
Lakes DHB Maori Health Strategy

Conceptual Development of Person-Centered framework for New Graduate Entry to Practice Programme
Clinical Nurse Educator Group and Graduate Nurse Co-ordinator, Lakes DHB, 2006
The unique demographics within the region have led to the development and implementation of a Cultural Competency Framework (Figure Two), which links all aspects of practice to the patient. It features staged development of knowledge, skills, experience, behaviour and attitude using a bi-cultural approach rather than generalised cultural safety or cultural awareness.

The three levels of the framework align with competent, proficient and expert levels of practice as defined by the Northern Regions PDRP (2004) and Benners’ (1984) novice to expert transitions within nursing. The competent level acknowledges and refers to using correct information in clinical practice with the patient, whanau, colleagues and organisations. Guidance is sought from Maori support teams and the nurse is proactive in seeking development opportunities to become equipped to protect and facilitate patient and whanau participation in care building partnerships to achieve desired health outcomes. The proficient level implements these as for the competent level in the nurse’s own practice, while engaging in more complex partnerships and influencing the way that others in the health team can also achieve this. The expert level demonstrates continual and consistent implementation of these and initiates changes in the practice setting that incorporate these characteristics at every level (Lakes DHB Te Whakaruruhau, 2005).

The Cultural Competency Framework is not separate from other practice development but is interwoven into all aspects of the programme and Learning Framework (Figure One) with the main objective being to build capacity and competency that impacts patient outcome positively for the 50% of hospital patients who are Maori (Lakes DHB, 2005a). This cultural practice development is supported by the preceptor and incorporated into the preceptor development days at Lakes DHB.
Within the Lakes DHB nursing leadership structure, CNEs work in all areas where graduate nurses are placed and facilitate the allocation of preceptors in consultation with the Clinical Nurse Manager (CNM) for the area. Orientation programmes and the setting of objectives for each nurse are facilitated by the CNE based on the NETP Learning Framework in Figure One (Lakes DHB, 2006c).

Clinical placements during 2007, the year the data for this project was collected, included the surgical unit, medical unit, rehabilitation unit, children’s unit, orthopaedic unit and the inpatient unit at Taupo hospital which is a mixed surgical and medical ward. Up to six weeks shared clinical load forms the basis of the preceptor relationship. This can be allocated as four weeks for the first placement and two weeks in the second placement or another related clinical area if the nurses have only one clinical placement.
During this period of time it is intended that the graduate nurse is supernumery for at least three weeks and that they are rostered on the same duties as the preceptor for the entire period.

Lakes DHB has a preceptor policy (Lakes DHB, 2006e) and a graduate nurse policy (Lakes DHB, 2005b). Both of these documents clearly describe the expectations of such a relationship. However, the variety of ways they are applied include allocation of a different nurse as preceptor for each day a graduate nurse works in the initial weeks of practice; allocation of a lead preceptor who works the majority of shifts with the graduate nurse and a second preceptor who covers the lead preceptor’s days off for sickness, study days and other leave; or allocation of a single preceptor who works the same shifts with the new graduate for a designated period of time. Factors affecting the form and function of the preceptor role in practice include the workload allocation and the fact that as experienced nurses on the team, the preceptors are often allocated complex patients. While this provides learning opportunities for the graduate nurse, the overall workload for the preceptor is not reduced to reflect the time required for preceptor functions.

In depth exploration of the graduate nurses’ perceptions of this experience is necessary to inform a strategy for change, hence the development of this research project.

SUMMARY

The Lakes DHB NETP Programme is based on the priorities for clinical needs of the population within the district. Lakes DHB covers a large geographical area with both urban and rural populations. The two main urban areas align with the settlement of the iwi of the area these being Te Arawa and Ngati Tuwharetoa. Each of these urban areas has a hospital, Rotorua as the main base hospital and Taupo as a satellite. Both hospitals have graduate nurses. Maori are represented at higher than the national average within the demographics of Lakes DHB and also reflect poorer health outcomes than Maori nationally (Lakes DHB, 2005a). As this is a clinical priority a Cultural Competency Framework (Figure two) has been developed to be woven into the NETP Learning Framework (Figure One) to ensure that graduate nurses build capacity and competence as they work with the 50% of hospital patients who are Maori. The NETP Learning Framework focuses on developing a person centered practitioner at the
competent level, as defined by the Northern Regions PDRP. A preceptor is the nurse identified to walk this journey with the graduate nurse.

Historically, preceptorship is organised in different ways in each clinical area and preceptors are experienced nurses who often undertake other responsibilities alongside the role of preceptoring a graduate nurse. This results in varied experiences and outcomes for the transition of the graduate nurses.

Literature relating to how preceptorship is applied is reviewed in the following chapter.
CHAPTER THREE:

LITERATURE REVIEW

What is already known from the experience of others?

The purpose of this review is to critique literature that is relevant to the topic of preceptoring graduate nurses. Within the Lakes DHB NETP Programme (2006c), the preceptor holds a critical function in facilitating transition from the student to registered nurse role. Exploration of the literature has enabled me to gain insight into the experiences of others implementing transition programmes internationally and to consider the impact different experiences have had within nursing.

The search on the terms preceptor and graduate nurses was carried out in relation to nursing and nursing education. As preceptorship has been implemented in nursing since the mid 1970’s (Bain, 1996) national and international literature in English from the last ten years was examined including scholarly articles, and research with the aim of examining current views and experiences. Reports and editorials are referred to only to give insight into some of the discussion occurring within nursing regarding the topic. Significant earlier literature that relates to development of the preceptor role in nursing has also been considered.
Within the literature resulting from the search, there was a paucity of formal research regarding the graduate nurses’ experience of preceptorship in the student to registered nurse transition, resulting in a review limited to articles describing programmes and experiences that included only a relatively small portion of research based findings. From the literature reviewed three main themes emerged. These being: retention; graduate nurse experiences; and organisation and application of the preceptor role. Overall, the graduate feedback indicated that the support they received was helpful in the transition phase from student to registered nurse. However, further evaluation from these articles has enabled me to collate more specific information about the factors influencing the preceptorship experiences of graduates.

**RETENTION**

The impact of effective preceptorship on retention appears strong. Nursing shortages relate to turnover and retention and a positive transition experience has been recognised as a key factor in addressing these issues for graduate nurses (Orsini, 2005). In preceptoring the graduate nurse, issues such as socialisation, role modeling, critical thinking, skill building and the giving and receiving of feedback can be addressed (New Zealand Nurse Educator Roundtable Preceptor Subgroup, 2005) and the ‘notion of growing our own’ (Bradley, 2001) provides an opportunity to facilitate development and practice in a context that reflects the unique needs of our communities.

In an attempt to address turnover, Orsini (2005) explored the impact that a nurse transition programme made in the orthopaedic setting. Orsini’s study reflects comments from earlier literature identifying that of 5000 new graduates in California each year 80 – 90% of them will leave their first job within the first year of practice (Bradley, 2001). Although Bradley’s opinion was expressed in an editorial, its aim and associated value was in stimulating discussion and challenging the nursing profession regarding the ethics of responsible employers making an investment in education and support. A later study based in Denver identifies that graduate turnover ranges from 55 -61% in the first year (Casey, Fink, Krugman & Propst, 2004), both of these figures present significant concern for nursing workforce planning.
Orsini’s (2005) response to this challenge was to ensure that new graduates had a dedicated preceptor who was able to role model, advocate, teach and support them. Preceptor selection was made according to set criteria of practice attributes. This descriptive study focused on adult learner concepts with a structured week by week schedule of objectives and activities for 12 weeks. The initial group consisted of only three nurses and at one year the retention rate was 100% with all three remaining on staff at that time with a reduction in the overall turnover rate from 22.6% to 7.7% (actual numbers not noted). It is inferred that the positive outcomes with small numbers (three) in the first year were reproduced in the next year. Associated gains reported included reduced medical errors, and long term savings in terms of turnover. Increased job satisfaction was experienced by the new graduates and preceptors which were attributed to the teaching and learning environment. Literature and findings were linked in a descriptive way but some of the outcomes around job satisfaction appeared to be assumed from other data and were not actually noted. The feedback of the nurses was not included in the report and the lack of detail regarding the measurement of the gains other than retention makes them an assumption rather than an accurate conclusion. The relevance of this article which had small numbers is that it is based on a similar allocation of graduate nurses to those in a clinical area (unit) at Lakes DHB. Therefore ways that preceptorship has been applied may have similar benefits if reproduced locally.

Gurney (2002), also explored the notion of ‘growing our own’ in the emergency department in a 240 bed hospital in America. This cost effective initiative was in response to recruitment issues linked to the nursing shortage. Preceptors received training about the competency based concept of learning and critical thinking. Class sizes of new graduates were from one to five nurses. A key outcome in the feedback was the development of mutual collegial respect between the graduate nurse and preceptor. This links to the definition of Morton-Cooper and Palmer (2000) that valued trust as part of the relationship and the value of an effective relationship as components of facilitating adult learning within practice. The programme included a didactic study day each week over 16 weeks with a related clinical component and evaluation comprised of the authors’ impressions about the process. It identified that up to four new graduates on the programme in the unit at a time was effective in terms of ensuring a smooth and supportive transition to the department. As with Orsini’s (2005) study graduate nurse
feedback was not included in the evaluation and small number participating relates to the ratio of graduate nurses to more experienced nurses within a clinical area.

A structured and supportive approach to the first year of practice including preceptorship is supported by the work of Owens, Turjanica, Scanion, Sandhusen, Williamson, Herbert and Facteau (2001) that highlighted a positive impact on retention. They identify similar issues as Orsini (2005) and extended their programmes to a full year based on the notion that it takes approximately a year to master a job (Chang & Daly, 2001; Treadwell, 1996). The classic work of Benner (1994) based on the Dreyfus skill acquisition model supports this initial transition of novice to advanced beginner or competent level taking a similar period of time as does the Casey et al. (2004), study of 270 graduate nurse’s transition, which also identifies 12 months as appropriate. Retention continues to be a consistent theme, as it links to practice reality and the theory practice gap as a main concern of new graduate nurses. Owens et al’s. (2001) initiative of a structured first year of practice programme was evaluated in a variety of ways including cognitive tests, skill demonstration, role play, case study analysis, speaker evaluation, behavioral performance and qualitative feedback regarding what caused stress and anxiety. These aspects were not reported on in any depth as the main focus of the results was the positive impact on retention.

The above literature reinforces that a positive experience at the time of new graduate transition improves retention. An effective relationship with a dedicated preceptor equipped for teaching and learning in the allocated clinical area is a key component of this improvement. The organisational focus of much of the literature explored is a limitation and the next theme explores aspects that balance this with graduate experiences.

EXPERIENCES OF GRADUATES

Much of the literature critiqued is based on the perception of nursing leaders and lacks actual feedback and impressions from the graduates themselves. The view of graduate nurses and preceptors is key to the enhancement of educational activities. However, there appears to be lack of quality literature considering both aspects. An exception is the compiled data of Roche, Lamoourex and Teeha, (2004) and Godinez, Schweiger, Gruver, and Ryan (1999). Roche (2004) et al’s. use of Likert scales for 67 participants
gives both a quantitative and qualitative picture of responses that indicate that empowerment is achieved with access to learning opportunities, information and communication, support with feedback and guidance and funding resources that reduced the nurse patient ratio during a 12 week preceptored orientation. The Likert scale noted that in this context most nurses (84%) found the environment conducive to learning most of the time or always.

Godinez et al. (1999) took a qualitative approach to describing the initial steps in the role transition process by collecting feedback from both graduate nurses and their preceptors, with clear objectives, and an adequate number (27) of participants using logs to identify learning. A total of 299 logs were completed (73% of the total number of possible responses) and it was found that for the participants the focus was reflected in percentages as 32% real nurse work, 28% transitional process, 18% institutional context, 16% interpersonal dynamics and 6% guidance. A significant conclusion drawn from this study was that the transitional process and real nurse work percentages combine to account for more than half of the responses and that this takes time which is in keeping with the findings of Benner’s (1984) classic work on the development of expertise and Treadwell’s (1996) notion of mastery.

Godinez et al. (1999) also noted that pre-registration education tended to focus on nursing care and not necessarily on the context in which it was delivered, whereas the feedback around institutional context and workplace culture indicates this is significant. They suggest that context could be brought to care by effective communication with nurses and other team members facilitated by the preceptor thus enhancing the transition in the categories of real nurse work, the transition process itself, the institutional context, interpersonal dynamics, and guidance. Under the most prevalent theme of real nurse work the graduate nurse feedback related strongly to clinical tasks such as intravenous pumps, drugs, types of physical assessment carried out, admission and discharges, communicating with the doctors, and beginning to do some patient teaching such as pre-operative information.

This focus on clinical tasks was reflected by McCarthy (2006) also including skills such as naso-gastric tube insertion and urinary catheterization, which were identified by the new graduate nurses as important in the transition year. In McCarthy’s study, preceptors
noted that they felt they did not have enough skill to coach all of the required clinical skills effectively, but this was not explored in detail. Both graduate nurses and preceptors felt that where there was shared responsibility in teams for learning and clinical coaching, as well as group processing of practice issues there was a positive impact on retention. Initial descriptors identified by the graduate nurses were evident in words such as ‘overwhelmed’ and ‘nervous’ initially and then words such as ‘more confident’ and ‘efficient’ emerged as they progressed through their transition period. The concern with clinical skill was reported in an earlier study by Casey et al. (2004) who surveyed graduate nurses from six acute care facilities in Denver including a variety of hospitals in the district (a teaching hospital, private for profit and not for profit / community hospitals). Of 784 surveys distributed there were 270 responses (34%) and of this only 4% were comfortable performing the required skills identified by the graduates themselves initially. Actual skills identified were similar to those noted by McCarthy, (2006) and Godinez et al. (1999). The difference with Casey et al’s. (2004) study is that the preceptor did not feature strongly as a positive support during transition, mainly because there were not consistent preceptors or allocated time structured into the transition.

In contrast to this a national United Kingdom longitudinal research project (Hardyman & Hickey, 2001) earlier surveyed one third of the 2,109 nurses qualifying in the adult branch of the nurse diploma course regarding their expectations of preceptorship. Surveys were sent to nurses in the initial period of their employment and at six months. A confirmed 1,596 nurses responded with 1,512 (87%) stating they wanted a preceptor, and that the preferred length of time was for six months. Clinical skills were also a priority for this group with 1,361 (91%) of respondents identifying them as the most important. A limitation of the study is that results reported relate only to the first questionnaire.

The literature reviewed in relation to graduate nurse experiences gives several perspectives on the value of the preceptor in the transition to the registered nurse role. The role of the preceptor was consistently viewed by the nursing leadership and teams as a facilitator of practice development not just a ‘buddy’ for orientation. Most experiences describe a positive benefit from having a preceptor (McCarthy, 2006; Gurney, 2002; Hardyman & Hickey, 2001; Godinez et al. 1999). Some reinforce the value of a dedicated preceptor where an ongoing relationship forms the basis of a
collegial teaching and learning environment (Orsini, 2005; Roche, Lamooureux, & Teehan, et al., 2004; Delaney, 2003; Gerrish, 2000). Others found that having more than one preceptor was valuable in that different perspectives and skills could be taught and learned (McCarthy, 2006; Smith & Chalker, 2005). The way that the preceptor role is organised and applied impacts on the overall effectiveness and this aspect will now be explored.

**ORGANISATION AND APPLICATION OF PRECEPTOR ROLE**

Structured transitions in the first year of practice characterised by allocation of dedicated preceptors equipped to facilitate appropriate teaching and learning, challenge organisational cultures that do not have learning and empowerment as priorities. A study by Fox, Henderson and Malko–Nyhan (2005) used focus groups to explore staff perceptions of support during transition during the first three months (16 participants) and then at six to nine months (12 participants) after commencement. This Australian study has particular relevance to this research project, as Australia and New Zealand have similarities in practice environments and share some educational context in nursing. Their findings contrast with other studies critiqued in that the data reflected a greater depth of insight into the preceptor role and the graduate nurses’ experiences dealing with the reality that preceptors, although allocated, are not always available. This is impacted by the associated reality that different teams have different dynamics. Some are positive in which case socialisation and learning occurs appropriately but in other areas overt and covert undermining is evident. Operational issues such as provision of supernumery days, rostering and skill mix impact directly on the preceptor’s ability to fulfill role requirements, however, in areas with a positive culture for facilitating a learning environment, a positive outcome was achieved and a subsequent improved rate of retention.

New graduate feedback within the mental health sector in London, England (O’Hanlon, Reynolds & Gale, 2005), also found challenges in gaining full commitment from management for the preceptor requirements, study days and release time to meet the learning and support requirements. Information gained from listening days held by the nursing directorate where nurses could come and have their say, led to the development of a structured transition programme where the preceptor was a partner, group reflection a component of the study days, and assessment of a professional portfolio profiling
competence. This has significance in that these components are very similar to those of the Lakes DHB NETP Programme (2006c). Feedback from the graduates in this programme was positive in regards to the content structure and support. Of particular value was the group sharing and learning in the study days.

A later study by Fox, Henderson and Malko-Nuyhan (2006) compared preceptor and graduate nurses’ perception of preceptor effectiveness at two to three months and six to nine months during the relationship. This differs from the 2005 work of the same authors in that it quantifies the response rate from preceptors was only 24% (n=15/29) a finding similar to that of Owens et al. (2001) who had a similar response rate to their questionnaire about behaviours. The response rate was 56% (n=33/59) from graduates at three months and 29% (n=17/59) at six to nine months. Comparison between the preceptor and graduate nurses responses were consistently positive with groups finding that managers and other staff were supportive, goals and learning needs were met, new graduates felt welcome and the overall experience was positive for both groups. Both groups reported that preceptor and preceptee meetings were not so regular at six to nine months which could possibly be linked to the need for a time of ‘weaning off’ (Gurney, 2002) and evolving independence. The discussion suggests that as time went on the preceptors felt more realistic about their own expectations and more fulfilled in the role and that preceptors had assisted in the transition of new staff with an emerging expectation of long term benefits in staff stability.

Growth and development in the way that preceptor roles have been applied was explored by Gerrish (2000) who examined the haphazard manner that nurses transition from student to registered nurse. This study also made links to the different ways of training and educating nurses. A grounded theory approach was used to bring fresh perspective to the way that preceptor roles have been applied. The data was collected in individual interviews which were subsequently transcribed. More recent study participants noted that they felt more supported with a preceptor regarding stressful aspects of the transition. These aspects related to being able to perform essential clinical skills, manage and prioritize a workload, caring for a dying patient and relatives, and clinical decision making. Many of these concerns are also reflected in the above mentioned work of Godinez et al. (1999) and McCarthy (2006). The comparison highlighted that preceptorship and use of reflection helped with these concerns in
Gerrish’s 2000 study. Reflection, as a supportive component of clinical supervision, is also noted by Hyrkas, Appelqvist-Scmidlechner and Haataja (2006) in their study about job satisfaction, burnout and quality of care. Johns (2004; 1995) and Bond and Holland (1999) also profile the use of reflection linked to action as key aspects of practice development, incorporating the way that guidance is delivered as well as the exploration of practice issues.

Preceptors facilitating action learning sets as a tool to process practice issues in the first year of practice in Ireland (McCarthy, 2006) has similarities to the Lakes DHB NETP Programme (2006c) which uses action learning sets as a tool for delivering clinical supervision to new graduates as a group. Action learning sets are a practice development tool using structured reflection in groups, based on open questioning to guide the process towards resolution and action in dealing with practice issues (Mc Gill & Brockbank, 2004). Action learning sets are also part of the Lakes DHB preceptor training which ensures that both the preceptor and graduate nurse develop similar skills for facilitation and processing practice issues (Lakes DHB, 2006d).

Group and individual support sessions were also used by Roche et al. (2004), whose earlier mentioned empowerment model was based on a twelve week partnership between the preceptor and the new graduate. This American article included different approaches in different facilities such as preceptor preparation based on Benner’s (1984) model developing expertise in nursing and stress management. Profiled outcomes included retention (which improved to 92.5%, n=67, as opposed to 25% previously), relationships, orientation satisfaction and a positive learning environment which was based on the Likert Scale (where 5 = always conducive to learning and 1 = never). A four point Likert scale measured the support (where the mean result was 3.825) confirming that the preceptor role is positive. There was a greater degree of satisfaction in relationships when there was only one preceptor, however, having one to three preceptors enabled new graduates to observe different styles of practice. In contrast to this Smith and Chalkers findings, (2005) highlighted that multiple preceptors can reflect the same benefits.

A New Zealand study by Roud, Giddings and Koziol-McLain (2005) examined self-reported performance expectations in a longitudinal study using six domains of critical
behaviours (Schwirian, cited in Roud et al., 2005), these being leadership, critical care, teaching / collaboration, planning and evaluation, interpersonal relations/ communication and professional development. The data for this quantitative study was collected at seven weeks into the programme and again at seven to nine months. These timeframes for data collection are similar to those of Fox et al. (2005; 2006) and identifies similar results. The tool for collecting data was modified in the communication and professional domain to reflect cultural and social contexts of nursing in New Zealand. Godinez et al. (1999) had referred to institution and practice contexts, but this is the only study in my literature search that had identified and given value to the cultural contexts. The study identified the nursing behaviours which would be expected and that preceptors would support, but did not relate the data to the graduate / preceptor relationship.

The work of Roud et al. (2005) complements the qualitative work of Godinez et al. (1999) and Delaney (2003). Delaney’s phenomenological study addresses the transition experience of the new graduate nurse identifying themes that can inform the graduate nurse / preceptor relationship in a developmental process. These were; mixed emotions, preceptor variability, welcome to the real world, stressed and overwhelmed, learning the system and culture shock, not ready for dying and death, dancing to their own rhythm, stepping back to see the view, the power of nursing and ready to fly solo.

Delaney’s (2003) themes are consistent with the findings of the other literature I have reviewed. While all of the themes impact on the impression the graduate has of their preceptor, the component on preceptor variability invited focused feedback indicating that a consistent and confident preceptor resulted in a positive learning experience while fragmented preceptor allocation and preceptors who lacked confidence resulted in frustration and confusion. The study looked only at the first twelve weeks of practice. Delaney links her findings to those of Godinez et al. (1999) and Bond and Holland (1999) and draws similar conclusions. Smith and Chalker (2005) extend this view to explore the impact of preceptor continuity on the graduate nurses’ transition. This descriptive retrospective study included all nurses who had commenced as graduates in a military hospital between the years 2000 and 2003; the sample size was 213 with a response rate of 93 (44%). In contrast to other studies where a dedicated preceptor is allocated, 56 (63%) noted they were assisted in improving knowledge and clinical skill and acting as a resource for questions and problem solving with multiple preceptors,
compared with 31 (35%) with the same preceptor. Whereas areas where the same preceptor had the most influence included 59 (69%) with help taking responsibility for four to six patients and 54 (62%) instilled confidence in skills and decision making suggesting that a dedicated preceptor is helpful for development of the graduates nurses way of working in practice, but that a variety of teachers is helpful in teaching skills and tasks.

This development of decision making and clinical judgment is explored by McNeish (2007) in a phenomenological study over a three month period of time. A sample of five preceptors were interviewed three times during the designated transition, at the start, midway and at three months. The findings of this study present a holistic view based on a model incorporating intrapersonal, interpersonal and integration of aspects of practice to make the whole. The function of the preceptor is to facilitate this development to incorporate context and readiness for evolving independence in practice using reflection in response to ever changing practice situations. Within this holistic framework is an emphasis on integrating what is described in the classic work of Carper (1978) as “ways of knowing” about the patient, building communication ability and understanding prioritisation. A limitation of this study is that graduate nurses were not interviewed.

**SUMMARY**

The strength of the literature reviewed is that it supports the notion that the transition from student to registered nurse is a crucial stage in a nurse’s professional journey. Meaningful support that facilitates practice development incorporating clinical judgment, technical skill and practical wisdom enables graduates to negotiate this journey. Preceptorship has positive outcomes in providing much of this support and contributes to improved retention. New graduate nurses describe similar experiences in their transition to the registered nurse role, these being associated with the practice context, feeling overwhelmed and stressed about workload, practice complexity and clinical/technical tasks. The graduate/preceptor relationship is a critical relationship addressing these needs. The way the preceptor role is applied is impacted by the way the unit and transition are organized. Management support of a learning culture, supernumery days, rostering of graduates and preceptors together and study release also impact on the quality of the transition.
Within the literature I have critiqued a variety of methodologies that have been used. Despite this variance there is consistency in reporting that a well structured entry to practice programme with dedicated preceptor support aids the transition from student to registered nurse. The phenomenological work of Delaney (2003) has close links to the aim of this project and the programmes outlined by Orsini (2005), McCarthy (2006), and O’Hanlon et al. (2005) have strong links to philosophy of the Lakes DHB NETP programme (2006c). A significant proportion of the literature is from a leadership perspective and does not include the views of graduate nurses. The literature supports the need for this study and has led to the formation of the following research question:

“How has the preceptor supported the transition of the graduate nurse to the registered nurse role?”

The method and process for this will be explored in the following chapter.
CHAPTER FOUR:

RESEARCH PROCEDURES:

The literature explored in the previous chapter confirms the value of preceptor support for the transition of the graduate nurse. Within this chapter the rationale for using the case study research method to gain greater understanding of this is explored. Recruitment of participants, data collection and analysis procedures are presented. This is followed by a review of the complex ethical issues addressed during the research project to facilitate answering the research question:

“How has the preceptor supported the transition of the graduate nurse to the registered nurse role?”

RESEARCH METHOD

Qualitative research methods are particularly useful for exploring experiences regarding phenomena or events requiring a deeper understanding or in which more needs to be known (Crotty, 1998; Appleton, 1995). The subjective and inductive nature of the qualitative methods fit the philosophy of reflection and enables the researcher to
discover, consider and make sense of the individual perspectives of those within the situation using their own words and reflection to provide information about the social experience being explored (Elo & Kyngas, 2007; Duffy, 2007; Streubert & Carpenter, 1999; Appleton, 1995). In this study the qualitative case study method has been used to gain detailed insight and describe fully the graduate nurses’ preceptored experience as they make the transition from student to registered nurse practice within the Lakes DHB NETP Programme (Creswell, 2007; Gangeness & Yurkovich, 2006; Jones & Lyons, 2004; Blaxter, Hughes and Tight, 2002; Zucker, 2001; Thomas 2000a; Cohen & Manion, 1995; Yin, 1994). This lived experience is the core of the inquiry with a focus on the dynamics of contributing factors in the transition phase as a single entity with clear boundaries (Creswell, 2007; Dempsey & Dempsey, 2000; Polit & Hungler, 1999; Holloway and Wheeler, 1997; Yin, 1994).

The case study method has its origins in sociology and underpinning it is the “methodological philosophy about how the social world links to theory and practice” (Blaxter, Hughes & Tight, 2002, p. 71). As such, it is a relevant application for studying this transition which has many links to social context in a specific case within a local setting (Creswell, 2007; Blaxter et al., 2002; Thomas, 2000a; Bell, 1997; Yin, 1994). The intention is to gain holistic understanding of the practice culture of the graduate nurse and to invite possibilities for new meaning and fresh development that can inform future application of the preceptor role (Jones & Lyons, 2004; Thomas, 2000b; Gangeness & Yurkovich, 2006; Crotty, 1998; Tellis, 1997; Bell, 1997; Burns, 1993). It enables both the voice and the perspective of the lived experience of participants to be considered with the interaction between the different forms of data within this organisation specifically (Creswell, 2007; Thomas, 2000a; Thomas 2000b; Tellis, 1997; Clifford, 1997; Yin, 1994).

**DATA COLLECTION**

Qualitative research data can be generated by a variety of strategies. The data for this exploratory study has been collected from semi-structured interviews and focus groups (Zucker, 2001; Thomas, 2000a; Tellis, 1997; Alspach, 1995). Secondary data from the 2006 preceptor / graduate nurse evaluation questionnaire has also been referred to (Creswell, 2007; Blaxter et al., 2002; Polit, Beck & Hungler, 2001; Polit & Hungler, 1999). The questionnaire design was based on the Waikato District Health Board Questionnaire (2004), Alspach (1995) and the New Zealand Nurse Educators Round Table Preceptor
A summary of the 2006 preceptor/graduate nurse questionnaire, including the actual questions and statements they were invited to comment on is included in Appendix Four.

Interviews have been based on narrative and the questions in Appendix Two have been used to provide prompts to explore the meaning of the lived experience of the preceptorated transition. Focus groups have also used the same questions with the expectation that the group process will enhance the development of understanding (Bond & Holland, 1999). This has relevance as groups of six to eight participants are used frequently in the Lakes DHB NETP Programme (2006c) to encourage nurses to develop and extend their ideas regarding practice (McCormack, Manley & Garbett, 2004; McGill & Brockbank, 2004; Bond & Holland, 1999; Mumford, 1996). This number (six to eight) was aimed for to collect data in this project as it is large enough to facilitate the group dynamic without limiting the opportunity for each participant to contribute. (Hollaway & Wheeler, 1997).

The questions for use in the semi structured interviews and focus groups were developed as prompts for the discovery of thoughts, perceptions and feelings (Holloway & Wheeler, 1997). Consultation occurred regarding these with 2006 New Graduate Nurses, CNEs, the Director of Nursing and the Associate Directors of Nursing at Lakes DHB. Feedback and suggestions were requested and this informed both the pilot and the final version (Appendix Two).

As a novice researcher, the value of carrying out a pilot was to gain confidence in the reflective process and confirm the appropriateness of the data collection methods and questions (Duffy, 2007; Appleton, 1995). The pilot included three interviews and one focus group. The nature of discussion generated in both indicated that they were appropriate ways to collect data, and that the questions were appropriate for stimulating narrative when required. The notion of finding one’s ‘own rhythm’ in practice as discussed by Delaney (2003), needed clarification for all participants in the pilot so this was extended to use words such as ‘style’ or ‘way of practicing’ or ‘organising one’s practice’ when required. The process highlighted that a similar format and agenda could be used for both the focus groups and interviews with consideration being required to facilitate the contribution of all participants within the group setting.
After approval to proceed was obtained from Unitec and Lakes DHB (Appendix One) data collection was commenced. The interviews were conducted in a private office away from interruptions, the focus groups were conducted in a conference room within the hospital setting over the lunch break of a NETP Programme study day and the duration of both was approximately one hour (Creswell, 2007; Blaxter et al., 2002; Zucker, 2001; Thomas, 2000a; Hollaway & Wheeler, 1997). For both the interviews and focus groups the participant(s) were welcomed and refreshments offered. An explanation was given of how the interview or focus group was to proceed. This included: confirmation that the session was to be tape recorded and transcribed as per the information on the information sheet and consent form; that confidentiality was assured and that identifiers will not be included; and that any matters that arose causing concern could be followed up with the research project supervisor and that professional supervision or counseling could be arranged if required. This was not requested by anyone during the process, but had it been required it would have been arranged via the Lakes DHB Clinical Supervision process (2006a) or the Employee Assistance Process (2007) depending on which process best suited the situation. There was opportunity for questions before proceeding. The participant(s) were invited to share their experience and the sample questions (Appendix Two) were used as prompts (Bond & Holland, 1997; Yin, 1994). The interview concluded with acknowledgement of the participant(s) contribution and confirmation that they were satisfied with the process.

There were delays in data collection due to availability of the graduate nurses who were impacted by shift work and the extremely heavy clinical load within the hospital over winter. Graduate nurses usually work 0.8 FTE and were often called on to work extra shifts making it difficult to arrange suitable times for focus groups in particular. For this reason, the focus groups were scheduled over the lunch break of study days when they were in attendance. It was stressed that participation was voluntary. Extra time was allocated into the study day programme to allow for the focus group and time for participants to still have a break prior to the afternoons programme.

This use of group processes in the focus groups has been valuable to build on and explore the complexity and interactions of the preceptor / graduate nurse relationship and the impact it has for the transition to the registered nurse role (McGill & Brockbank,
2004; Blaxter et al., 2002; Zucker, 2001; Tellis, 1997). As a specific single case study, no attempt has been made to generalise findings in relation to other studies; as by exploring the phenomenon of the preceptored experience, the reasons that the variance in application of the preceptor role occur in this organisation can be understood (Sharma, 2004; Jones & Lyons, 2004; Thomas, 2000a; Bell, 1997; Clifford, 1997; Yin, 1994).

Within the presentation of findings direct quotes from individual interviews are noted with a pseudonym, those from focus groups are noted with (FG1) or (FG2), and those comments where the questionnaire relates to this are noted with (Q). Where the 2007 artwork portrayal of the group evaluation is referred to this is described.

PARTICIPANTS
The population of the 2007 NETP Programme intake at Lakes DHB consisted of 14 participants. All of these nurses were invited to participate and volunteer for interviews and / or focus groups following an information session about the research (Blaxter et al., 2002; Hollaway & Wheeler, 1997; Bell, 1997; Cormack, 1997). A powerpoint presentation outlined the project and there was opportunity for discussion and for any queries to be addressed. An information sheet (Appendix One) was distributed to each programme participant. This pack included the contact details for the academic supervisors of the research at Unitec. The primary reason for the purposive sampling which invited volunteers was to limit bias, as discussed in the ethics section (Hollaway & Wheeler, 1997).

The selection criterion for inclusion was a graduate nurse participant in the 2007 Lakes DHB NETP Programme who volunteered. Purposive composition of the sample group similar to the composition of the new graduate intake group for age and ethnicity was desirable (Cormack, 1997; Holloway & Wheeler, 1997). This achieved a total population sample as all of the participants from the January 2007 intake volunteered to participate in either the focus groups or the interviews with some participating in both. Of the 14 (100%) participants, 10 (71.5%) were of European descent and four (28.5%) were Maori. Ages ranged from 21-55 years with a mean age of 40 years. Thirteen participants (92%) participated in two focus groups (six and seven in each) and six (42.8%) participated in the interviews. This resulted in both individual perspectives and ideas that were
developed in the group context. All participants had completed the Bachelor of Nursing qualification in 2006, three had previously been enrolled nurses, and the implications of this are that it could imply that their needs during the preceptored transition are different. The 2007 NETP study days also included graduate nurses from private hospital and community settings who were excluded from the study because the NETP Programme specifications were designed for hospital based nurses at the time of the project.

DATA ANALYSIS

Thematic analysis of the data has been used to identify and categorise common threads for meaning (Finlayson & Dixon, 2008; Polit et al., 2001; Crotty, 1998; Cormack, 1997; Yin, 1994). Reflection has been used to identify overall themes, note patterns and group themes, identify sub themes, contradictions and confirmations, and note suitable examples and link them to other theory / philosophical underpinnings, and what the relationships are between themes to construct new meaning (Johns, 2004 & 1994; Polit et al., 2001; Polit & Hungler, 1999; Burns, 1993).

During this process I have used an eclectic mix of content and concept analysis to become immersed in the data as I listened to the recorded interviews and focus groups while transcribing them (Baldwin, 2008; Duffy, 2007; Elo & Kyngas, 2007; Streubert, & Carpenter, 1999; Appleton, 1995; Lincoln & Guba, 1985). I have read the transcripts many times each as a whole, noting words and phrases that recur initially as overall concepts and how they are being said (Thomas, 2000a; McDonnell, Lloyd – Jones, & Read, 2000; Cormack, 1997.) I have then noted patterns and clustered the data (Creswell, 2007; Zucker, 2001; Streubert & Carpenter, 1999) by highlighting and colour coding the recurring words and phrases with a different colour for each broad concept and followed this by linking these to form broad themes (Polit et al., 2001; Zucker, 2001; Clifford, 1997). The data from these colour coded phrases was entered into electronic folders according to the alignment with each of the broad themes. The data in each folder was read and reflected on; some data aligned with more than one theme and was placed in more than one folder and then reconsidered regarding its most appropriate placement. In repeatedly reading the data in the themed folders it became apparent that a point of saturation had occurred at the last interview where no new information became apparent as much of what had been said previously was repeated and confirmed although an individual perspective was evident. From this process two categories
emerged and the folders were then assigned to these, each with three themes. Reflection was used to question and challenge the emerging themes and literature was explored to aid further analysis (Johns, 2004; 1995; Carolan, 2003; Preist, 2002).

Data source triangulation and reflexivity were used to identify links to other parts of the data. This demonstrated consistency between focus groups and the interviews, whereas there was some inconsistency between the findings of the questionnaire and the other forms of data with regard to socialisation (Creswell, 2007; Leitz, Langer & Furman, 2006; Sharma, 2004; Polit et al., 2001; McDonnell, Lloyd-Jones & Read, 2000; Thomas, 2000b). This could relate to the fact that not all graduate nurses and preceptors completed the questionnaire and that they were from a previous years participants when the preceptor expectations had been less clearly implemented.

The literature highlights a variety of strategies which contribute to the demonstration of rigor in qualitative research. Trustworthiness and rigor have been built into this research study by adhering to the ethical requirements and principles of Unitec and Lakes DHB, adherence to the processes identified in the research proposal and protocol, recruitment by invitation, linking analysis to the raw data by using verbatim quotes, participant checks with an observer, self reflection and supervisor checks (Creswell, 2007; Rolfe, 2006; Sharma, 2004; Edwards & Titchen, 2003; Polit et al., 2001; Thomas, 2000b). Creative aspects have been profiled in a way that expands the view of the data to the reader (Creswell, 2007).

Participant checking of the initial data analysis was carried out in a session that was held on each of the two NETP Programme study days so that all could attend. A powerpoint presentation outlined how the data had been processed and how the two overarching categories and the associated six themes had emerged. The presentation was interspersed with related verbatim quotes from the data to ensure that it had been interpreted as intended by participants and that identification of participant statements had been protected. There was discussion at the commencement of the session about how each person could potentially identify their own comments from interviews and also theirs and others comments from the focus group they had attended. As the study day groups were the same as the focus group participants, this was deemed appropriate.
There was opportunity for participants to give feedback to each theme and category and at the conclusion there was also further reflection, with nurses confirming the data had been interpreted correctly and also reflexivity, with nurses linking this to other experiences that had confirmed this in practice (Johns, 2004; 1995; Hope & Waterman, 2003; Carolan, 2003; Hand, 2003). Individual transcripts were available for participants to view; however, no-one took this opportunity, discussion in the group and individually noted that the presentation had confirmed the data. A CNE experienced in group processes and acting as an ‘observer’ was present in each of these sessions to record thoughts, impressions and any suggestions (Leitz et al., 2006; Polit et al, 2001; Yin, 1994).

Self–reflection and supervisor checking was linked to Johns’ model (2004; 1995) of reflection, the Lakes DHB values (2005c), the Lakes DHB NETP Programme (2006c) and the research proposal. During the process of reflection, I was trying to achieve insight into the new graduate nurse’s experience of the preceptor relationship (Bulman & Schutz, 2004; Johns, 2004; 1995; Carolan, 2003; Hand, 2003). My thoughts and feelings throughout the process have been varied as some of the disclosures around this topic have required me to consider how the systems and processes used in setting up preceptorship have not worked well in some circumstances. At this point the process of bracketing (Edwards & Titchen, 2003) was difficult as I struggled to be open to the data as observed or heard, while putting aside my own beliefs about the support a graduate nurse should receive during her transition. I have processed these thoughts with my supervisors and the Director of Nursing at Lakes DHB, developing strategies to deal with these issues whilst not being distracted from the purpose of the research project itself. This presented some challenges in that I needed to separate some of the issues and plan for better outcomes in the next intake whilst still retaining confidentiality and the integrity of the research (Carolan, 2003; Hand, 2003).

ETHICAL CONSIDERATIONS
As this study forms part of the requirements of Masters of Health Science (Nursing), approval was obtained from the Unitec Postgraduate Board of Studies and subsequently from the Chair of the School of Health Science Ethics Committee. As the participants of the study are employees of Lakes DHB and the research is a case study relating to the Lakes DHB NETP Programme, approval was also obtained from the Lakes DHB
Research and Ethics Committee. The Lakes DHB Research and Ethics Committee requested further clarification around whether the data from the questionnaire was existing data or whether new data would be collected using the same questionnaire. They requested that the consent forms state that no penalty would accrue if participants chose not to be involved in the survey and details about how participants would be selected. I clarified that the questionnaire was secondary data, added the comment about no penalty accruing if graduates chose not to participate to the consent form, and outlined that selection was to include any of the 2007 NETP group who volunteered to participate. Following this, approval was granted to proceed with the study. These letters of approval for both Unitec and Lakes DHB are profiled in Appendix One.

Access for gathering data in the form of interviews and focus groups was negotiated with the Director of Nursing at Lakes DHB so that data could be collected in ways that did not interfere with the clinical responsibilities of the participants (Appendix One). I also sought the support of Te Whakaruruhau Maori Support Team during the process of this research to ensure appropriate reflection of cultural competency and use of Maori language (Appendix One). Following research approval from Unitec and Lakes DHB, an information sheet was given to all prospective participants (Appendix One). Informed consent was obtained from all participants and a sample of the consent form is attached (Appendix One). All material has been treated as confidential. Tape recorded interviews and focus groups have been transcribed by myself as the researcher. The tapes have been destroyed and the transcripts will be kept in a secure cabinet for five years then destroyed. All participant identifiers have been removed to ensure anonymity. Pseudonyms have been used in presenting the data to retain the personal focus of the feedback.

From an ethical perspective this project aligns with the values of the Lakes DHB (2005c), who are employers of the graduate nurses and preceptors and also providers of the NETP Programme. These values are:

- Manaakitanga - Respect and acknowledgement of each other’s intrinsic value and contribution.
- Integrity - Truthfully and consistently acting collectively for the common good.
• Accountability - Collective and individual ownership for clinical and financial outcomes and sustainability.

The context of the preceptor/graduate nurse relationship incorporates these values and reflects attributes of the ethic of care which enhances traditional approaches of ethics (Glass & Cluxton, 2004). The ethic of care is based on responsibility for the relationship, it views emotions as important as they enhance reason and incorporates broader influences such as family and whanau. In contrast, traditional principles of ethics are based on rights and duties, reason and objectivity, and focus on the individual. This is significant for this research project as relational considerations constitute much of the effectiveness of the preceptored transition for graduate nurses.

Participants of the 2007 Lakes DHB NETP Programme were invited to volunteer to limit bias by myself as the researcher. Informed consent was obtained in writing from all participants. There is the potential for a conflict of interest in that I am the NETP Coordinator and as such facilitate all aspects of the NETP Programme. I also contribute to some of the teaching for preceptor study days. I facilitate the recruitment process for graduate nurses to participate in the NETP Programme, final selection is made by a panel including the CNM and the CNE for the placement area, Te Whakaruruhau Maori Service Team and myself. This process was complete and the 2007 programme underway prior to inviting graduate nurses to participate in the study. Assessments for the NETP Programme are carried out by a group of people including CNEs, the Restraint Coordinator, and myself, final programme assessments are made by qualified Lakes DHB PDRP assessors.

Preparation of preceptors includes a two day preceptor course run by Waiariki Institute of Technology (I am not involved in delivery of this programme) and two Lakes DHB study days for graduate nurse preceptors. These Lakes DHB days are facilitated by three clinical nurse educators, Te Whakaruruhau (Maori Service Development Team) and myself. I oversee the study days and contribute to some of the teaching/learning activities. The majority of the education and preparation for preceptors for the 2007 intake has been carried out by the Wairakei Institute of Technology and the CNE Group at Lakes DHB, to limit the impact of potential bias (Neuman, 1997; Yin, 1994). Preceptors for each graduate nurse were selected by the CNMs and CNEs for the areas.
I was not involved in preceptor selection. The preceptor resource manual has been developed by the Lakes DHB CNE Group. My input has related only to providing the NETP Programme requirements for preceptors and the feedback tools.

In considering my role as the NETP Coordinator and thus the potential for influence or bias, I would note that the case study method can accommodate such a relationship with the researcher as the main measurement device as the nature of the sharing of the experience requires empathy, trust and the exploration of truth as an interpretation of phenomenon or the individuals reality (Thomas, 2000a; McDonnell, et al., 2000; Hollaway & Wheeler, 1997; Bell, 1997; Burns, 1993). Application of the ethic of care (Glass & Cluxton, 2004) acknowledges that the relationship between preceptor and the graduate nurse exists and also between the graduate nurse and myself as the programme coordinator. To do this effectively requires the researcher to have knowledge and experience relating to the case being researched (Yin, 1994). The key factor is the use of bracketing to ensure the researcher’s knowledge and presuppositions to not taint the data by using semi-structured interviews and open ended questions so that the themes are not imposed on the participants (Edwards & Titchen, 2003; Crotty, 1998). The use of reflexivity identifies the personal position of the researcher (Hand, 2003; Carolan, 2003; Koch & Harrington, 1998) and takes into account the existing knowledge, values and assumptions of the researcher as part of the process (Hammersley & Atkinson, 1995; Yin, 1994).

The research process has been applied in such a way that should other researchers undertake a similar project using similar processes, comparable conclusions can be reached indicating that a similar approach in another setting could replicate results (Sharma, 2004; Jones & Lyons, 2004; Koch, 1994; Yin, 1994). Participant checking of themes identified from transcribed data, supervisor checking and self–reflection have been used to ensure the integrity of the data is maintained throughout the process (Sharma, 2004; Zucker, 2001; Hope & Waterman, 2003; Johns, 2004; 1995; Carolan, 2003; Yin, 1994).
SUMMARY

The case study method has been used to explore perceptions of the graduate nurse’s preceptor experience at Lakes DHB. This study is strong in the reality of the graduate nurse’s experience providing rich data and links to the complexity of the context of the graduate nurse in practice (Creswell, 2007; Sharma, 2004; Blaxter et al., 2002; Yin, 1994). Data was collected from individual interviews and focus groups. Secondary data from the 2006 preceptor/graduate nurse questionnaire are also included. Participants of the 2007 NETP Programme were invited to participate. One hundred per cent of the 2007 intake participated in either or both of the interviews and focus group. Data was analysed using an eclectic mix of content and concept analysis which incorporated reflection. Trustworthiness and rigor have been integrated into the study by addressing potential for bias within the study design, by clearly linking the data to the participants themselves as the source, and by using participant checks, supervisor checking and self reflection. Ethical requirements were met by obtaining approval from the Unitec and Lakes DHB Research and Ethics Committees, and applying informed consent, confidentiality and the use of pseudonyms.

The thematic analysis of the data has resulted in two categories each with three themes. These will be explored in detail in the following chapter.
CHAPTER FIVE:

PRESENTATION OF FINDINGS AND DISCUSSION

Giving Voice

Within this chapter the voice of graduate nurses that emerged through semi-structured interviews and focus groups is woven together with secondary data from the 2006 preceptor/graduate nurse evaluation questionnaire. Verbatim quotes are used to portray the voices accurately and the literature was explored again in relation to themes emerging from the analysis. Discussion regarding these themes is integrated within this chapter.

The 2006 preceptor/graduate nurse evaluation questionnaire was the catalyst for undertaking this research project as it confirmed that a deeper view of preceptorship was required to inform further development of the role. The questionnaire was adapted from the Waikato DHB Preceptor Evaluation (2004) and Alspach (1995) and the New Zealand Nurse Educator Round Table Preceptor Subgroup report (2005). It was tailored for both preceptors and graduate nurses. Both groups were asked to complete the written evaluation regarding their experience. Of the twelve graduate nurses in the intake five, (41.6%) responded and of the twelve preceptors, six (50%) responded. A summary of
the questions and answers is included as Appendix Four. The questionnaire was not developed to form part of data collection for this research, but as an evaluation and feedback tool for the programme at the time and as such is used as secondary data.

While the questionnaire links to the key aspects of the preceptor role and graduate nurse transition, it is limited in that the majority of the questions are closed and do not encourage exploration and articulation of reasons for the responses or suggestions for overcoming them. The responses were largely positive, however, it was known to me from anecdotal feedback from graduate nurses, preceptors CNMs and CNEs that there was a degree of frustration associated with the incongruence between the requirements of the role and how it was applied. Graduate nurse responses in the questionnaire were mostly positive with only one check in the ‘fair’ column relating to receiving daily feedback.

Preceptor responses were also positive and the comments gave descriptive information. These indicated that a heavy workload resulted in time restraints and reduced availability to ‘work with’ the graduate nurse and facilitate learning; that they felt adequately prepared, and that the preceptor course had been helpful; and that there had been opportunity to refresh their own knowledge. Another suggestion was that it would be useful for the CNE to co-ordinate and teach common clinical skills in the first week. This feedback aligns with some aspects of the data from the focus groups and interviews explored in the following two categories.

**SUMMARY OF THEMES**

Emerging from the thematic analysis and critical reflection were six themes divided into two main categories. The nature of the exploration of the complex concepts within these themes is that the boundaries are blurred. The themes are therefore inter-related and not exclusive of each other.

The first category of ‘**Functional Factors**’ consists of:

* **Theme 1.** Facilitation of the preceptor role by the CNE for the unit;
* **Theme 2.** Organisation within the unit including orientation, rostering, patient acuity and workload priorities;
**Theme 3.** Clinical skills.

The second category of ‘Psychosocial Considerations’ consists of:

**Theme 4.** The sense of being scared and the preceptors’ advocacy for the graduate nurse;

**Theme 5.** Socialisation and team support;

**Theme 6.** The preceptor’s experience as a registered nurse.

**FUNCTIONAL FACTORS**

**The CNE Role**

At Lakes DHB CNEs are unit based facilitators of learning within clinical settings and endeavour to do this in a way that enables development of practice and enhances clinical outcomes for nurses within that unit. A significant amount of their work relates to graduate nurses and preceptors and as such they contribute to ongoing development of the NETP Programme (Lakes DHB, 2006c; 2006d; 2006e). A practice development approach is used to consolidate the existing knowledge of graduate nurses and impart new learning relevant to the registered nurse role.

The role of CNEs in facilitating the transition of the graduate nurse to the clinical placement featured in the data collected in interviews and from the questionnaire. From the organisational orientation and the initial week of the programme, the CNE is the link person. The CNE facilitates the first day in the ward, introduces the new graduate to his or her preceptor and implements the orientation programme. There is some overlap between the CNE and preceptor roles as it is worked out in the practice setting:

….now with introducing to the ward, basically the CNE had a major role in that and when she introduced us to the ward it was like we were like her little project people sort of got the idea that, it’s really hard to explain, like she was looking after everything to do with us. (Rangi)

There is some perception by preceptors that the CNE role is the key relationship, that their job is to ‘buddy’ the new graduate and facilitating learning is the responsibility of the
CNE. This is also inferred in the questionnaire feedback from preceptors which states the following:

I think CNE involvement in the first week would be beneficial to cover the clinical tasks, i.e. IV certificates, drains; ECG’s etc. It is very difficult as a staff nurse to teach when you have five or six patients. (Q)

These comments suggest that workload allocation for the preceptor impacts on the quality of teaching and learning, and that the CNE can be supportive by providing structured sessions for these skills (Orsini, 2005; Hom, 2003; Kelly, Simpson, & Brown, 2002; Owens et al., 2001; Godinez et al., 1999). However, this can lead to confusion of the preceptors’ expectations of the role as noted in the comment from graduate nurses in the focus group:

The Clinical Nurse Educator looked after us more in the first few weeks, more than the preceptor as such and because that person (CNE) had been mainly looking after us it was understood by the other nurses that she was looking after us and they didn’t sort of step into that preceptor role. (FG1)

Another area that the CNE has been a valuable influence is to moderate the use of short cuts or over confidence when busy work loads become a time pressure:

…. you’ve got a bit of confidence they think that you’re ok. It’s not until the clinical nurse educator comes along and says hey come on slow down. (Rangi)

In contrast, some graduate nurses found that connection with the CNE was limited despite the expressed intention to be available:

… it would have been good to have more input from her ‘cos I know she’s got heaps of knowledge and skills. (Hira)

This limited connectedness was largely due to the graduate nurses’ shift work hours being worked at different times to the CNEs hours, which were often part time and did not include after hours shifts. This is unfortunate given that the CNE has identified expertise in the clinical area, and an overall view of the needs of the graduate nurse
programme applied within the units’ context. A way to ensure that there was appropriate access or that equity between graduates within a clinical area was not compromised due to roster variances would be to structure sessions for clinical coaching.

The preceptor feedback in the questionnaire suggested that the CNE could really help with the initial period of orientation for things like fire alarms, location of resources, and important processes specific to that clinical area. This would mean that the time with the preceptor could be focused on the shared clinical load and facilitating learning. This was reinforced by discussion in the focus groups:

...in the ward I would have appreciated it if someone just had taken the time to say ‘this is how we do it, this is what the routine is and this is what’s expected of you… we make sure that the fluid balance charts are added up and ... like all the drains have to emptied by eight o’clock in the morning before the Drs rounds like I wasn’t used to all that sort of stuff and had to find it out by trial and error a lot of error.

(FG1)

Clinical coaching could incorporate orientation to ward routine and be considered as a structured part of the CNE role while supporting the preceptor relationship with the graduate nurse (Chang & Daly, 2001; Hom, 2003; Kelly et al., 2002). Support by educators is essential to the preceptor role, however, it is important to provide support that empowers and enables the preceptor rather than undertaking the role themselves (Hyrkas & Shoemaker, 2007; Myrick, 2002; Chang & Daly, 2001; McGill & Brockbank, 2004). This can include structured teaching that may be delivered on a session basis to all graduate nurses in the unit, and thus provide complementary support to the preceptor (Griffen, Hanley & Saniuk, 2002).

The NETP Learning Framework (Figure One), was developed by the CNE group and articulates the transition of the graduate nurse. As the CNE has understanding of this, they have the opportunity to provide a leadership function in supporting the values of the nursing and communicating its essence as they implement it in their units (Hyrkas & Shoemaker, 2007; Chang & Daly, 2001). The framework relies strongly on the theory of practice development which also underpins the way that CNEs facilitate education in clinical areas (McCormack et al., 2004; McGill & Brockbank, 2004). The CNEs ability to facilitate problematisation (Titchen, 2003; Wright & Titchen, 2003), to bring to
consciousness and look differently at aspects of practice, with both the preceptor and the graduate nurse supports the development of both. Application of a structured experiential learning model (Stuart, 2003) which encompasses phases from preparation and observation through to experience resulting in synthesis and critical thinking, could further define the way that preceptors partner with graduate nurses as they progress from beginning practitioner to display the features of a competent nurse as defined by the NETP Programme (Lakes DHB, 2006c; Benner, 1984).

**Organisation, rostering, workload allocation and prioritisation**

Organisation, rostering, workload allocation and prioritisation featured strongly in the data collected in interviews, questionnaires and focus groups, implying it is in the forefront of the graduate nurses minds. In programmes where there is clear structure around allocation to work closely with their preceptor and with expectations and feedback about what is being achieved, there is a positive outcome (Orsini, 2005; Smith & Chalker, 2005; Crimlisk, McNulty & Francione, 2002; Kaviani & Stillwell, 2000; Godinez et al., 1999; Walker, 1998). In this research project this was also the case.

Where the rostering was carried out to facilitate the preceptor and the graduate nurses working the same shifts for the period required in the NETP Programme, the nurses noted a smooth transition. All of the CNMs and CNEs had been advised of the requirements. These requirements were that they worked alongside the preceptor with their workload allocation of patients and then gradually began a workload of their own in a shared context whilst still having access to the preceptor to check things, problem solve and discuss their practice as required with an identified person. The timeframe for this shared clinical load is four to six weeks. This occurred for only four of the participants:

I found with my preceptor it was really good ‘cos we were on the same roster for a good five to six weeks. We had the same patient load and then I gradually had my own but I still had one specific person I could go to if I had any questions. I found it really good. There wasn’t any confusion of who do I go to and she was really willing to help me and she was often coming up to make sure that I was ok. (FG2)

This is described as ‘dwelling with’ by Rummel, (2004, cited in Kavanagh & Knowliden, 2004), so that learning can occur to extend application of skills and knowledge in the
reality of the practice setting. For those four participants whose roster and allocation was applied so that the graduate nurse and preceptor could work together learning was facilitated in alignment with the NETP Learning Framework (Figure 1).

Another type of rostering experienced by the graduate nurse, was working the same shifts as the preceptor for the initial supernumery period of two weeks and then picking up a full patient load. This occurred for five of the participants. The purpose of the period where the nurse is supernumery for two to three weeks is so that the preceptor’s workload can accommodate the time it takes for the learning needs of the new graduate. There was a variety of ways this happened some worked closely in the initial two weeks only:

...for the first two weeks I worked with my preceptor in close proximity for the first two weeks in that two weeks time we basically divided the patient lot, ...after that it got harder as I often wasn’t on with my preceptor and that was for the following six weeks that I didn’t see her. (Tangi)

...but I think after that she was supposed to be rostered on the same shifts as me so then I could go back to her but she wasn’t rostered on any shifts with me I only had those first two weeks and then I never saw her for like a few months later really it was really hard actually... (FG:1)

The initial support was valued, but without the opportunity to go back and solve problems and process issues as they arose in practice, the intent of the preceptorship requirements were unable to be met.

For some, the preceptor arrangements broke down. Three were due to illness of the preceptor, in one case the preceptor was on annual leave and in one case the preceptor was not allocated. In the latter case there was expectation that the team on the ward would pick up this function overall. Each of these examples is described in the data:

the CNMs and CNE said that it was a shared thing and everyone was there to support me, that made me feel good ... until I realized that it gave everybody an excuse not to, it was quite difficult really. (Mata)
Well for the first week I worked with my preceptor then after that we were supposed to get back together again and really that hasn’t happened. It wasn’t her fault that she has been off sick. (Piki)

My preceptor was on holiday when I started …. I don’t think I met her until three weeks after, I knew it should be better than that …. It’s just the way it was I accepted it …I don’t get why they let them go on holiday, I don’t get that really. (FG:2)

The feelings of Mata and the nurse in the focus group become apparent in these statements, as they struggle to come to terms with the fact that a conscious decision has been made at some point, and that this decision has left her without a preceptor and without a plan for how this supposedly essential function can be provided. This matter of not attending to allocation and rostering is a very powerful decision leaving the graduate nurse vulnerable and exposed to workload allocation that is inappropriate for her experience and also feeling uncertain about her place in the team. It gives a strong message to the graduate nurses that the organisation has not honoured its commitment by allocating and rostering them to work with a preceptor. Also implied is that the power of such a decision rests with the manager of the unit rather than the NETP Programme and organisational policy (Lakes DHB, 2005b; 2006e). Such an overt decision impacts negatively, not only on the individual experience of Mata, but also on long term outcomes such as job satisfaction and retention (Casey, et al., 2004).

The way that the rostering was arranged was a significant factor for all participants impacting on the quality of the relationship the new graduate had with their preceptor. In some areas the rosters were developed with the new graduate and preceptor in parallel and in other areas this was not applied. In units where it did happen the orientation to the unit, socialisation with team members, sense of relationship, and a sense of being supported during the transition happened more smoothly than in areas where this was not the case. In contrast to this positive experience there was also a pragmatic sense of accepting that this was how things were, and that as a registered nurse you had needed to get on and apply yourself in the best way you could, for example as stated in a focus group:
I know it should be better than that but I didn’t have an issues around it is just the way it was and I accepted it. (FG2)

Later in the focus group this nurse acknowledged that:

...everyone was really supportive, there were no problems, there was always a senior nurse on the floor and I think that’s why I just accepted it (FG2).

The support of the other team members and the senior nurse on a shift contributed significantly to responding to the learning needs within the transition. The key to the effectiveness of this extended team support was the graduates need to learn about skills and decision making as situations presented in practice and the associated identification of learning needs. This is an attribute of adult learning (Hand, 2005) and is also explored in relation to advocacy and team support in the second category of themes.

One way of valuing the contribution made by preceptors includes modifying the patient load/acuity they are allocated allowing time for the required teaching and learning (Griffen et al., 2002; Charmley, 1999; Kinley, 1995). Both preceptors and graduate nurses in the questionnaire indicated that a reduced patient load or reduced acuity would be supportive of the learning that needs to occur during the transition period, especially during the first two weeks. Three of the fourteen 2007 preceptors went off on periods of sick leave that were more than a few days, limiting their function in the preceptor role. They were experienced registered nurses undertaking extra responsibilities such as shift coordination and patient allocations with complex high acuity care needs. The possibility of a link between illness and potential for burnout of experienced nurses taking extra responsibilities is not an objective of this project, but it is worth highlighting for future consideration.

The transition to prioritisation of workload and finding your ‘own rhythm’ (Delaney, 2003) was varied for most, and related to unique routines for the unit, acuity of the patients, other responsibilities of the preceptor such as unit coordination, and the preceptor’s own way of working. The most common view from the graduate nurses was that finding their own way was an individualistic approach to external requirements of what is to be achieved in the work day which was also influenced by team expectations (Waterworth,
2003; Gerrish, 2000). They could see strengths and weaknesses from other nurses’ ways of doing this; however, their own way was unique to them as described by Tioki, Tangi and Hira:

It takes a long time to do that for yourself….She (the preceptor) was good at that …the barriers are that these are her prioritizations …she’s going to be quicker at procedures … you’re just going to be slow and steady cos you’re learning (Tioki)

I had my own way of setting a timetable and she did pretty much the same thing although she is probably recognised that its a way to balance the workload (Tangi)

I think …they just let me find my own …never once did they say well you need to do it this way… if I was uncertain about it they were just like well its your patient you need to do it your way and then it made me feel a lot better ‘cos I was seeing outcomes that made me feel good ‘cos I had done them. (Hira)

Tioki noted that being ‘quicker’ was linked to mastery and efficiency, and that being ‘slow and steady’ is part of working towards this. Work overload becomes a constraint that can impact negatively on graduate nurses who feel they are unable to deliver appropriate care (Chang & Daly, 2001; Gerrish, 2000; Charmley, 1999). Continued exposure to work overload can lead to feelings of inadequacy and loss of confidence as even though there is a plan in place it may be difficult to adhere to:

….. its very different and I’m still struggling with it … I know how to prioritise its just go go go all the time. (Rangi)

The focus group also explored this:

She was always there and I did go to her a few times. I think there was one time I had just been IV certificated and all my patients had IV’s and some of them had doubles and she said sit down and work it out remember you’ve got a two hour window before and after so don’t ever think you’re pushed for time you don’t have to deliver everything right on time it just doesn’t happen like that….it relaxes you, you think O chill out a bit more. (FG2)
The preceptor’s ‘being there’ and available helped to bring clarity and support to graduate nurses as they worked out time management and ways of finding their own sense of rhythm and ways of managing within this busyness. Attention to rostering the preceptor on the same shifts enables functional relationships to form that can accommodate the challenges of the practice environment.

Clinical skill and related tasks
Clinical skills and tasks formed the third theme within the functional factors category. The need for support relating to practical skills was a recurring topic within the literature (McCarthy, 2006; Casey et al., 2004; Hennigan, 2003; Godinez et al., 1999;) identifying Intravenous (IV) therapy, nasogastric insertion, and catheterisation as common concerns. IV therapy was the clinical skill most mentioned as a concern in both focus groups and interviews. At Lakes DHB, IV therapy competency requirements formed the basis of a self directed learning package followed by a drug calculations test, a theory session regarding practical aspects and technical skills workshops during the first week of employment on the new graduate programme. This is followed up by supervised experience in the clinical area and sign off by a certificated IV assessor when competency is achieved for each of the three components, IV fluids, IV medication and blood products. For some, where the preceptor did not work the same shifts as the graduate nurse, this was extremely problematic and had an immense impact on their work flow. Consequently, at the end of the three months some graduates experienced the frustration of not having a full IV certificate:

If you asked somebody to take you through one thing, they never actually started and took you through the whole thing for some reason it would be broken so you’re picking up half bits of information… it took 6 lots of blood, before I got IV certified to do IV blood ‘cos I never had the same person from the start of the process to the end of the process so nobody would sign me off … (Rangi)

Within the focus groups there was discussion about how not having an IV certificate disrupts care delivery and whether having this requirement achieved as part of the student’s transition placement prior to registration would help overcome this:

There’s one thing that I reckon would be really really good and that’s that everybody was IV certificated before they went onto the ward. (Piki)
The professional and legal implications (NCNZ, 2005b) for students undertaking this clinical task prior to registration to gain the practice experience required could align to that of other clinical experience where the student carries out the task under the direct supervision of the registered nurse according to set organisational evidenced based protocols. This has been trialled as an initiative by some education providers in partnership with their local DHBs. Initial feedback is that while it does have merit in terms of streamlining the process of getting the skills signed off, the actual competency aspect of IV therapy as a clinical task requires a wide range of exposure that included assessment and problem solving rather than just the task itself.

It is a reality that the process of achieving certification in the practice environment generates unnecessary constraints and more anxiety for graduates. The tool for IV certification competency assessment (Lakes DHB, 2004b) is itemised so that each behaviour is identified and achieved. This means that the nurse at the commencement of an infusion may not be the same one at the end of an infusion; however, the critical behaviours for each component can be recognised and signed off achieving certification as a whole in a timely fashion. The problem therefore appears to be around how to use the assessment tools effectively to achieve certification within the six week timeframe.

Advanced IV skills posed some difficulty in acute areas with high acuity patients. Concerns of the graduate nurses were related to the tension between managing their workload and patient needs in a timely fashion, and remaining within their scope of practice and organisational policy (Lakes DHB, 2002). This was explored in focus group one:

Every second person has a PICC line or CVL Line and us as new grads at this stage can’t administer through it unless we are supervised or someone is supervising us administering that medication ‘cos we still haven’t had that education…so you’re finding that we’re saying ‘no I can’t have that patient because I can’t administer through it’ or ‘you’re going to have to come and watch me so I can do it’…and the seniors on the ward are just like ‘just go and do it’… (FG:1)

As well as intravenous therapy other examples of the clinical skills and technical tasks noted include catheterisation, immunisation, stomas, urostomy, drains, patient
controlled analgesia (PCAs), electrocardiographs (ECGs), dressings, nasogastric tube insertion, wound infiltrations, blood pressure and associated education, blood transfusions, plaster casting, complex infusions such as glucose, insulin and potassium (GIK), trouble shooting with equipment such as infusion pumps and telemetry. Other considerations from interviews and focus groups included use of specific equipment, some of it is technical skill and some of it is processes, thinking, decision making and communication:

Insertion of a graseby pump and how to set them up, how to put them in properly, she showed me how to use a new needless system that she had been trained in, and knew how to use it she was quite good at that whereas a lot of the other nurses I’ve found don’t use it ‘cos they don’t know how it works and how to pop it in. (Tangi)

I was going to ask about things specific to your area that are important like I made the mistake about what was expected when you took someone to theatre … and also going up to collect the patient from PACU (Post Anaesthetic Care Unit) I never realized how important it was that you get all the information and that you are happy with collecting that patient as you are responsible for them so if they start bleeding all of a sudden you got to know what to do you got to check the dressings all that sort of stuff. So it’s about understanding area specific needs. Someone just said … your patient’s ready in theatre go and pick them up so I say ok and think you’re just going to pick your patient up from theatre ( FG:1).

There is a tension between learning a task and learning a skill that incorporates critical thinking and process learning that Mumford (1996) calls “seduciveness of task” (p.4), where the graduate nurses have the expectation that by doing the specific task they will meet the requirements of care. This links to Benner’s (1984) application of skill acquisition where the beginning practitioner applies concrete thinking, and experience and intuition enhances those skills as practice develops. The focus groups developed this idea of skills including technical tasks and practical wisdom, relating it to sequencing of information. Some graduate nurses found that their preceptor was keen to teach them about more complex technical skills, as they were perceived to be very interesting and a great learning opportunity. However, the new graduates themselves identified that they
wanted a solid foundation of the basic skills to be consolidated first. This was also consistent for the enrolled nurses:

I know there’s a lot to learn and when you come on as a new grad the preceptors may think you want to learn all the … nitty gritty stuff but you just want to get the basic stuff that you want to know so you get the basic stuff right then you can move onto all the task things you need to learn... (FG1)

Attention to basic clinical skills in a structured way (Stuart, 2003) before building on the more complex, enables the cognitive and psychomotor domains of learning to be applied effectively, being enhanced by the affective domain as exposure and confidence increase (Bastable, 2003). Those who had been enrolled nurses prior to completing the bachelor of nursing and registering as a nurse also noted they would appreciate learning skills in a structured way. They felt that they were expected to know more and be able to adapt quickly to the registered nurse role but some had not worked in acute areas for many years and so their pre-existing skills were quite different. This experience was also noted by Kilstoff and Rochester in their study about the transition expectations of enrolled nurses (2004) where they note that as well as the skills being different as they now link to the clinical judgement of the registered nurse, they have a greater level of responsibility that is more than the sum of these skills. Enrolled nurses in the 2007 NETP intake at Lakes DHB described the same preceptor needs as the other participants.

As the year has progressed those graduates who have established a good rapport with their preceptor in the initial 12 weeks have continued to find it easy to approach them about new clinical skills they are coming across in practice as described by Hira:

Its interesting ‘cos throughout the year if I’m working with her, it’s a lot easier to go to her and ask her how things are done and she’s taught me a lot more later on in the year rather than just in that 12 weeks and I’ve grown. (Hira)

However, in identifying that they preferred basic skills to be established initially the graduate nurses also indicated that they would like some early teaching of advanced skills in the area of resuscitation in particular:
If we had done that Advanced Life Support earlier it would have been a huge benefit, not that we used the skills as such but just to have had that grounding. (FG:1)

You are sent on transfers and you’ve never been in the ambulance in your life. Ok, your patients stable but they could become unstable …we need to have a little in-service and probably a guided tour through the ambulance before you go, its quite big… (FG:1)

This quote infers familiarisation rather than skill, but could relate to concern about being able to recognise the signs of deterioration and initiating the appropriate action in unexpected events which is a part of the definition of a beginning or novice practitioner (Benner, 1984). Having a shared clinical load with the preceptor would mean they were present to support the development of confidence in these types of new situations. These are often where they gain knowledge and grow their practice maturity by the often uncomfortable and challenging experiences in practice as they relate to the patients in their care (Benner, 1984).

This first category has explored the functional factors that have impacted the preceptor relationship. Within the data collected significant attention has been given to organisation and facilitation of these. Without the opportunity to work together with a dedicated preceptor, there is limited opportunity for a relationship to be established (Myrick & Yonge, 2005; 2004). Applying a structured approach to the way the preceptor works with the graduate nurse ensures consistency in facilitating the cognitive, affective and technical domains of learning (Bastable, 2003; Stuart, 2003). The relational benefits of preceptorship contribute significantly to the psychosocial considerations explored in the second category of themes.

**PSYCHOSOCIAL CONSIDERATIONS**

This second category links three themes about the sense being scared and advocacy; socialisation and team support; and the preceptors experience as a RN. Within this section there are positive and negative considerations for each of the three themes with considerable overlap.
Sense of being scared, and advocacy

Graduate nurses find the transition to the registered nurse role stressful and words such as traumatic and overwhelmed are featured in much of the literature written about ‘reality shock’ as it has been described in Kramer’s influential work (1974; 1985 cited in Dochterman & Grace, 1985) and further explored by Dunham–Taylor and Pinczuk (2006). They identify the stress within their transition as awareness of the responsibility of being a registered nurse, making decisions with their limited experience, administering drugs, carrying out clinical procedures, conflicts between their own values and the reality of practice in a busy unit, and the adjustment to shift work and organisational culture (Walker, 1998; Charmley, 1999; Humm, et al, 1998; Baillie, 1999; McCormack et al., 2004; O’Shea & Kelly, 2007). There is a significant focus on feelings such as being on your own and feeling scared about carrying out a new function. These feelings align to feelings that patients describe when they are admitted to hospital and the generic nursing response to them relates to our delivery of care or caring as a fundamental value and function of practice (Watson, 1988; Rummel cited in Kavanagh and Knowlden, 2004, Schumacher, 2007). While the graduate nurse’s experience is not that of being a patient, the nursing response of caring is appropriate to support the transition to a new role and the beginning of practice as a registered nurse:

.... I felt almost like I was in the way (Rangi)

One thing that terrified me when I started was when something that went wrong with the patient and I was ringing the doctor. My preceptor just said to me ring him and I thought what do I say what do I tell him …I don’t know…I had no idea …man it used to terrify me... (FG1)

The sense of belonging or not belonging, the ability to participate in practice in a meaningful way and feelings of being valued or a hindrance to the team were evident in the focus groups and interviews. The negative aspects of not being rostered with preceptors or problems to do with organisation of orientation and teaching clinical skill have also impacted in this category. For example, when the preceptor was very busy with other responsibilities such as looking after a student as well as a graduate nurse, and/or coordinating the shift, there was the sense of being a burden that featured on several occasions:
...well no-one really wanted to know you... You were a new grad you had a lack of knowledge... (Rangi)

This added to the already present uncertainty around starting a new job and initial practice as a registered nurse (Chang & Daly, 2001). In contrast to this, where there had been well facilitated rostering and the graduate nurse worked closely with the preceptor, there was a solid foundation for this learning relationship. Having the preceptor available was also supportive to address these stressors.

...she was with me hands on for two weeks after that I went solo for a couple of weeks. She was still there on all the shifts so we had about a good four weeks together and in that time I made heaps of mistakes, and she just made sure that my landing was in the right pond. (FG2)

This metaphor of ‘landing in the right pond’ infers an advocacy function that facilitated learning and development while ensuring a positive outcome for both the patient(s) and the graduate nurse. Much of the learning occurred during the time of working on the same shift as the preceptor, but having an allocated patient load is impacted by the practice context for the graduate nurse on a particular day in a particular unit. This extends the application of knowledge and skills learned in undergraduate education and rationalised decision making to begin to make the journey towards critical thinking, based on a variety of variables for patients, the unit and in this case the graduate nurse (Benner, 1984). This advocacy function aligns with the NETP Learning Framework (Figure One) facilitation domain of critical companionship (Titchen, 2003). The preceptor as the critical companion facilitates: raising the graduate nurses’ consciousness of knowledge, intuition and behaviour that impacts on practice; helps them to see different perspectives not initially visible to them; and guides them to reflect and become aware of the reasoning that enables them to apply new understanding. By facilitating this in the practice setting, preceptors advocate not only caring for patients but also managing their practice and therefore caring for themselves as nurses which contributes to the development of coping mechanisms (Delaney, 2003; Chang & Daly, 2001. Benner, 1984). These characteristics align with the principles of adult learning where the graduate nurse participates actively in the learning process which relates to their experience, the environment reflects mutual trust and respect, and there is a sense of progress towards their own goals (Knowles, 1980).
Others also described the preceptor as advocating for and facilitating learning opportunities by negotiating time for this and for the graduate nurses presence when clinical situations were occurring that were valuable for learning:

…she came to get me if something was going on in the ward like if there was a nasogastric insertion or something like that she’d come and find me and advocate that I’d go and watch that technique and see it being done, yeah that was probably how she did it (advocacy). (Tangi)

The NETP Programme itself was also identified as a part of support and coping:

…I would never have survived without the backup of the programme and meeting with everybody else so you’ve got to have both. You need that support on the ward but you still need the programme, I’d hate to see a preceptor thing going without the programme you still need that back up for survival. (Mata)

Mata’s use of the word ‘survival’ captures some of the sense of vulnerability that accompanies the transition. The support offered by the NETP Programme reinforces the development aspect of the transition in a general way, rather than just within a particular unit. One aspect of the programme that aids this is clinical supervision, which is provided in groups using action learning sets as a tool to facilitate structured reflection on practice and to apply action strategies (Figure One; Lakes DHB, 2006c). This supervision is facilitated by the NETP Coordinator and CNEs who have undertaken training for this purpose. The action learning sets form a type of peer supervision consisting of graduate nurses as peers. The role of facilitators is to both model and facilitate the process with the aim that the graduate nurses are able to do this by the completion of the NETP Programme year. A common challenge for accessing clinical supervision is finding the time in an already busy schedule, and also having the number of supervisors available for individual supervision (Kelly et al., 2002). In previous years this had always been offered to graduate nurses individually but uptake had been poor. Whereas by scheduling the time for this (90 minutes) into the NETP study days, all nurses participated. To complement this there is provision for preceptors to meet fortnightly away from practice to reflect on and process practice issues (Forneris & Peden-McAlpine, 2007; McCormack et al., 2004; Mc Gill, & Brockbank, 2004; Titchen, 2003;
Chang & Daly, 2001; Bond & Holland 1999; McGill & Brockbank, 2004). While this preceptor/graduate nurse fortnightly meeting is not formal supervision it provides a regular opportunity to form a supportive relationship and limit cumulative stress arising from practice issues that are unresolved (Wildlake, 2002).

Advocacy for consideration of the entry level expectations of practice as a beginning practitioner (Table 1) arises from this relationship, when the preceptor makes a place for the graduate nurse acknowledging that their contribution to the overall workload of the unit is initially limited as they do not have the same experience as other team members. By acknowledging this positively and role modelling engagement in care delivery and team processes within the unit, the preceptor advocates acceptance of and support for the graduate nurse (Delaney, 2003; Chang & Daly, 2001). This is highlighted in the focus groups:

Well, because it was a new environment for me, I had never been there before, it was good because she made them aware that I had never been there and that I was a new grad, but in some ways it was like she’d made a new friend it was like a friendship environment she was giving me as well as supporting me. (FG2)

Friendship, trust, and experience are salient factors influencing the quality of both the relationship and the learning experience.

...Knowing that I trust the preceptor for advice and also the experienced nurse who has been on the unit for a long time.

I think that over the year you do choose somebody who you can trust and you can trust what they are going to say, when you ask something and you know they are not going to say you are stupid for asking that question or anything like that and I admire their nursing practice. You build a rapport with them its not a formal thing it’s more a trusting thing, a relationship thing. (Piki)

Trust is vital and incorporates openness and honesty between the preceptor and the graduate nurse within teaching and learning. As preceptors trust the graduate nurses learning and skill acquisition, they begin to increase the level of responsibility without compromising patient outcomes. Working in ways that enable the graduate nurse to
accept this responsibility for not only technical aspects but integrated clinical judgement, requires a high level of support for both the preceptor and the graduate nurse (Cardin & McNeese-Smith, 2005; Myrick & Yonge, 2005; 2004; Johns, 2004; Rummel, cited in Kavanagh & Knowlden, 2004). Development of this aspect of the relationship early in the transition contributes significantly to coping and the development of confidence. The focus group discussion about how the preceptor could make a difference to “being terrified” as stated in focus group one included the following:

Just being there, and like giving you prompts or something. (FG1)

Presence or ‘being there’ is the significant requirement for the preceptor for a graduate nurse undertaking any new action, as the potential for a serious or dangerous outcome is the underlying fear feeding their stress and anxiety. ‘Being there’ facilitates the building of trust and also integrates with reciprocity; the giving and receiving of knowledge, thoughts, care, effort, concern and satisfaction (Titchen, 2003). This is another aspect that contributes to engagement and the sense of belonging, and participation. For graduate nurses being able to make such a contribution makes a difference and results in feeling valued (O’Shea & Kelly, 2007; Chang & Daly, 2001). Reciprocity is also a component of cultural competency (Lakes DHB Te Whakaruruhau, 2005). As such it is woven throughout the NETP Programme, its context being that we each bring something to a relationship that is of value, and that this positively impacts behaviours in practice. Different levels of practice exist between the preceptor and the graduate nurse; however, they each have mutual responsibility for learning within the context of delivering care. Acknowledging this empowers graduate nurses to contribute as noted in one of the focus groups:

I find you have to have a willing attitude to help them for everything that they're doing for you … I'll always make an effort to ask them is there something that I can do for you in the meantime or just try to be there to help if they need it as well. Because otherwise you are taking all the time and not giving. (FG2)

Personal attributes and characteristics contribute to a positive relationship which fosters reciprocity:
Patience, lots of patience and willingness to change and look at themselves as well, they are asking you to not just accept that they know best. (Tioki)

It's very special to have a friendly manner, she's good at what she does, she knows what she's talking about, there's a lot of knowledge there, you felt that anything you asked her she would give you a good answer for. (Piki)

There is an expectation that appropriate attributes relating to caring behaviours, relational ability, and teaching and learning are a consideration in the selection of preceptors (Schumacher, 2007; Rummel, Cited in Kavanagh & Knowlden, 2004). CNMs and CNEs select the preceptors in the units after the graduate nurses have been appointed and both the data from the focus groups and interviews, and Kramer’s early work (1974), suggests that this is appropriate, given they have been involved in the selection of graduate nurses and also know the preceptor’s attributes and characteristics and can match both appropriately (Kaviani & Stillwell, 2000). Attributes of a practice developer, as described by McCormack, Garbett and Manley (2004), include someone with clear values and beliefs, a commitment to improving patient care, enabling not telling, facilitative skills, flexibility, sensitivity and reflexivity, knowledge and creativity and the perceptions of graduate nurses reinforce this as beneficial for preceptors and CNEs.

The work of Myrick and Yonge (2004), identifies a relational process where the preceptor holds intrinsic power, clinical expertise, and advanced knowledge, to facilitate the development of competence, applied to existing knowledge with graduate nurses at a time when they are intrinsically vulnerable (Hennigan, 2003; Kinley, 1995). The notion of power is strongly linked to knowledge (Barker, 1998) regarding not only nursing practice but the culture of the unit, organisation and related systems and processes for achieving the requirements of the both learning and the work of patients care. It is only through effective relationships that the dynamic of empowerment of, rather than power over the graduate nurse can be realised. Rummel (Cited in Kavanagh & Knowlden, 2004), reinforces the value of this relational aspect describing it as the preceptor ‘dwelling with’ the nurse and gifting time to share and to become attuned to where the nurse is in her transition journey. This relational process enables the preceptor to transmit a culture of caring. In contrast to this Schumacher, (2007) identifies both over presence and under presence as non-caring; over presence or hovering implies that there is insufficient trust
for responsibility to be imparted to the graduate nurse, and under presence leads to frustration and sometimes errors can occur because of the inability to access the preceptor.

Where there is understanding of the needs of graduate nurses in this transition appropriate preceptor allocation and supportive rostering facilitates an effective relationship based on friendship, trust, collaboration and empowerment. Such advocacy addresses the sense of being scared and alone, facilitating a caring approach and the development of coping strategies that limit the impact of reality shock and overlaps with the relational aspects of socialisation.

Socialisation and team support
Socialisation was facilitated effectively in conjunction with the organisational aspects of rostering and workload identified in theme two. The term socialisation has many complex applications. For the purpose of this research context it has been defined as:

   Facilitating relationships on the unit and with hospital personnel, acquisition of professional behaviours through role modelling, feedback and advice (Beecroft, Santer, Lacy, Kunzman & Dorey, 2006. p.740).

On arrival in the units following the week of generic orientation, there was a variety of receptions for graduate nurses. The feedback in the 2006 questionnaire was positive with all respondents noting that socialisation was excellent, very good or good. However, as this reflected only five (41%) of the 14 in the group, it may be that those who did not respond had a different experience. The data from focus groups and interviews provided insight into both negative and positive experiences. When they were introduced to their preceptor and other team members, provided with the orientation booklet and a schedule of the shifts they were rostered to work with their preceptor, they felt welcomed and had a sense that the unit was ready for their arrival and equipped to facilitate their transition. This also demonstrates that the team value the contribution the graduate nurse makes to future workforce (Chisengangtambu, Penman & White, 2005). However this positive experience did not occur for all. For several of the graduate nurses the experience indicated that the arrival of the graduate nurse was inconvenient as discussed in one of the focus groups:
...you walk into work and there this big sigh, O God no we've got a new grad. Then you feel you've got to work twice as hard to outlive that reputation of being a new grad.(FG:1)

The lack of empathy and consideration in this response is very stressful for graduate nurses to experience, as it implies that the unit is not prepared and equipped to facilitate the transition to the registered nurse role and that they are not wanted or valued. It clearly implies that the staff of the unit have the power in this situation and can use this to impact on the type of transition a graduate nurse experiences. The feeling that they need to work twice as hard to outlive a negative reputation and become accepted as part of the team has the potential to result in compliance with unit culture, rather than practice development based on modelling and sharing of professional values. From such a negative initial experience, the formation of trusting relationships and subsequent empowerment of the graduate nurse is inhibited (Beecroft et al., 2006; O’Shea & Kelly, 2007; Myrick & Yonge, 2004; Delaney, 2003). Where the arrangements for preceptorship had fallen over initially, in terms of rosters and working together, the impact on team engagement was significant as it was not actively facilitated:

I don’t know if it was smoother for them but they had somebody to talk to, they sort of weren’t left out in the cold and didn’t have to sink or swim and when you asked a question they asked it of their preceptor and they got an answer. (Mata)

Others’ experiences of socialisation were varied. Some described it as facilitated by the CNE and CNM with initial introductions, others who had worked more closely with their preceptor found that this was facilitated well, and those who had not worked closely floundered in this area. The type of support offered varied including introductions within the unit and invitations to drinks after work to meet others on the team. This attention to “hospitality; creating free space where the stranger can enter and become a friend” (Nouwen, cited in Myrick & Yonge, 2004, p.21) facilitates the type of socialisation defined by Beecroft et al. (2006) empowering both nurses and preceptors. For some this included warnings about how to succeed in the unit and survive:

... Mine gave me a sort of a warning about how busy the ward can get and watch your back how you have to make sure you’re not working outside your
This idea of needing survival skills implies how vulnerable the graduate nurse feels. Another of the negative aspects was the sense of other nurses watching to see if they would make a mistake:

There’s so much expected of us as nurses… and inside there is that terrible thing that goes on inside of nursing that they’re always waiting for you to trip up if you show a bit of confidence you just feel like you’re starting to fly its like someone’s there to snip your wings that’s how it feels. (Rangi)

This contributes significantly to the stress and anxiety discussed in theme four, where the sense of being constrained and not overstepping your place as a ‘novice’ curtails development within the affective domain of learning and consequently impacts negatively on the development of critical thinking (Beckett, Gilbertson & Greenwood, 2007; Myrick & Yonge, 2004; Bastable, 2003). It also has the potential to undervalue the graduate nurse’s ability to advocate effectively for patients if required, as it infers that the voice of a nurse with junior status may not be validated in the same way as a more senior nurse. Addressing such behaviours and working with teams to foster the actions that facilitate effective socialisation is necessary to prevent such experiences in the future. Applying the ethic of care and relational approaches within practice carries with it responsibility within the relationship (Glass & Cluxton, 2004).

A positive example in this study, of a team approach to socialisation was based on application of some of the structures described by Orsini (2005), and outlined in the literature review. The CNE for this area applied Orsini’s approach to the transition in the unit. This included identifying expectations for each of the initial six weeks, allocated sessions for teaching unit specific skills with all of the graduate nurses for that clinical area, and set times for the giving and receiving of feedback. This ensured that timeframes and assessment requirements for the NETP Programme were adhered to with clear role definition as the CNE led the process, the preceptor worked with the graduate nurse on the transition in practice and all parties were clear about what was expected of them. The person responsible for doing the roster ensured that preceptors were rostered on the same shifts as the graduate nurse they were assigned, for the
entire six week shared clinical load. This allowed for gradual and individual allocation of their own work load while still having the preceptor available for support. They articulated this in one of the focus groups:

I found with my preceptor it was really good 'cos we were on the same roster for a good 5 – 6 weeks. We had the same patient load and then I gradually had my own but I still had one specific person I could go to if I had any questions. I found it really good. ‘Cos there wasn’t any confusion of who do I go to and she was really willing to help me and she was often coming up to make sure that I was ok. (FG2)

Formal feedback was provided at the designated times (six and twelve weeks) and each nurse and preceptor were rostered time and space away from practice to process practice issues and set learning goals fortnightly. This feedback session is part of the NETP Programme, and occurred intermittently in other units. The way that it was organised in this particular unit ensured that it happened for all of the graduate nurses placed there. The effect of working consistently with the designated preceptor ensured that socialisation and engagement with the team was actively facilitated. All three of the graduate nurses from this area reflected this in their contribution to comments in focus group two:

Its almost like the preceptorship thing you've been befriended …and I think other people see that, so that if you've been accepted by one person they'll also accept you, rather than if you come in by yourself you will also be isolated then it takes a while for everyone to warm to you,. But if there is already somebody there that is, they follow that lead as well. (FG2)

An example of the support is the time you put aside with the preceptor to sit down and do your fortnightly form about how you are progressing and what you are having problems with and your aims are for the next two weeks. It just gave you time when instead of asking someone in a work situation when you are both in a rush. (FG2)

Other clinical areas in this study captured aspects of these positive outcomes; however, this unit was the only area that consistently achieved them. The value of Orsini's initiative (2005), with its small numbers (three), is that it could be reproduced in a clinical
setting with similar numbers in the study within Lakes DHB, achieving positive outcomes in terms of the transition experience.

Socialisation enables the graduate nurse to ‘fit’ within the practice environment. The preceptor has a key role in facilitating this and the best outcomes are achieved by participation of the whole team. The preceptor’s own experience as a registered nurse impacts on this as described in the next theme.

**The preceptor’s experience as a registered nurse**

The graduate nurses were preceptored by nurses with a range of experience ranging from those who had just completed their year long graduate nurse programme, (registered nurses for 13 months), to those who had been registered and practicing for 20 years or more. A positive approach to nursing practice was highly valued by the graduate nurses whether or not they had many years of experience as registered nurses or preceptors:

> …if you can see your preceptors got good job satisfaction a happy smile on her face and obviously enjoys her job, well this is great …she’s not always walking around sulking or whatever um nobody wants to be like that ………….so that’s job satisfaction…. (Piki)

There was some suggestion that those who had registered in the last year or two are ideal to preceptor new graduates as they have experienced the transition recently themselves. This also linked to relational ability and empathy.

> I had my preceptor for 2 weeks it was good, she was good, she was a new graduate last year so she knew how I felt. (FG1)

In clinical placement areas where the skill mix includes a number of nurses who have been registered for two or three years, who undertake the preceptor role, there is the sense that they are all in this together and collegial support was evident:

> The staff that I work with from our ward range from I think that two to three staff on ward that have been there for two to three years the rest of them are like new
grads from last year and ones that have moved from (a different) unit… we’re all newbie’s… so we’re all fresh on the block and help each other out (Rangi)

However, in the cases where a registered nurse with two to three years experience or less was the preceptor, the graduate nurses noted that they responded to the requests for knowledge rather than having overall awareness that certain things need to be facilitated in the learning experience and ensuring that those things were attended to:

… My preceptor is only an intermediate nurse, she’s very good but isn’t a senior nurse….I admired the way she works. Some other people … I noticed their preceptors …they could ask them more and they were sort of more directing. (Piki)

The majority of the data from this project identified more experience as being beneficial because there was a solid base of clinical decision making as well as clinical / technical skill and learning priorities could be facilitated:

I was quite lucky I think my preceptor was probably the most experienced nurse on the ward as far as (this type of) nursing goes I think she just about knows something about everything …. (FG2)

The literature has varied views about this but studies profiling the graduate nurses perspective support similar findings to this study (McCarthy, 2006; Delaney, 2003; Godinez et al., 1999; UKCC, 1994). Whether the preceptor has more experience or not there is clear expectation that they will have a degree of expertise that enables them to support the learning needs of the graduate nurse they are working with (Hennigan, 2003; Kinley, 1995; Bain, 1996). There is an alignment between this expectation of preceptors and the attributes of proficient and expert nurses (Northern Region District Health Boards, 2004; Benner, 1984) in that they demonstrate the type of expertise in practice that recognises and anticipates subtle changes in clinical situations; manages complex and unpredictable circumstances, and provides leadership by influencing the practice of others. In circumstances where the arrangements for the preceptor and the graduate nurse to work together had not continued, nurses identified someone else who they trusted to fulfil this function noting experience and expertise as a consideration in this selection:
After the initial 2 weeks there hasn’t been so much time as we haven’t really been on that many shifts together which is kind of a shame but I kind of I have kind of adopted someone else as my preceptor as I am often working the same shifts as them so its worked out quite well and she’s someone more experienced as well.

The issues of overloading experienced nurses with high acuity patients, shift coordination and preceptor responsibilities discussed in theme two (organisation, rostering and workload) are also reflected in this theme. There is a clear sense that much is expected of the experienced nurse and this is supported in the questionnaire, focus groups and interviews. Despite the challenges of a high level of diverse responsibilities many experienced nurses are providing a positive preceptored experience for nurses in their transition to the registered nurse role. Support for nurses providing preceptorship is available in the form of the preceptor course, preceptor study days/sessions and also from the CNE. However, while these measures equip nurses and provide avenues to process issues, they do not relieve the burden of the workload in the practice setting. Further exploration of ways this could be realised in practice are warranted and could include consideration of a reduced allocation for the initial days of the transition and structured sessions for clinical coaching (Hom, 2003; Griffen, Hanley & Saniuk, 2002; Kelly, Simpson & Brown, 2002; Kinley, 1995). Such initiatives contribute to the profile and subsequent valuing of the preceptors role and were raised by the graduate nurses during the participant check.

**LINKING FUNCTIONAL FACTORS AND PSYCHOLOGICAL CONSIDERATIONS**

The Lakes DHB NETP Learning Framework, (Figure One) clearly states the intention to facilitate development of a person centred practitioner with both technical and emancipatory ability. This holistic development is filtered through the Cultural Competency Framework (Figure Two) which provides a stepped approach to forming relationships, acknowledging those intrinsic and extrinsic factors that impact it, and demonstrating behaviours that reflect reciprocity and value partnership. The questionnaire has provided superficial insight prompting further and more in-depth exploration from the interviews, and focus groups have expanded this to providing insight to how preceptors support the transition.
During the final evaluation of the programme graduates complete a formal written questionnaire, and also work in groups to portray key messages from their evaluation. The artwork articulation of the transition experience (Figure Three) developed by the graduate nurse’s as part of their NETP Programme evaluation draws both categories of themes together and was prepared in groups working apart from each other.

**Figure Three: Artwork from 2007 NETP Programme Group Evaluation**
Both groups spontaneously used handprints as a dominant feature. In the graduate nurse feedback session the graduate nurses spoke of how these handprints represented those who had supported them during their transition journey. These hands also reflected the caring nature of nursing. Among the hands were also other aspects described in their verbal feedback regarding their art work. Several of these are also reflected in the themes; these included cultural input, area specific skills, support provided by the programme facilitators and the need for work life balance including recreation and family support.

Despite a complex and challenging journey all of the participants achieved the required outcome of transition from beginning practitioner to competent nurse as defined in chapter two. While not being part of the data, written consent was obtained to use this artwork as it illustrates that support was provided for the transition providing a spontaneous link to the title of this study “Will someone walk with me”? This collegial support is a picture of those who had walked with the graduate nurses. Not all of this support was as intended by the programme requirements, however the common factor impacting all aspects was a reciprocal relationship based on trust.

On reflection, I considered the data and the subsequent analysis resulting in the themes presented. Within the data there was minimal reference to the content of the Learning Framework which incorporates Cultural Competency at strategic and practice levels as outlined in Chapter Two. As part of the trustworthiness and rigor of the research I had not included questions that lead participants to articulate responses in this vein. However, I was able to make links between the data and the programme intentions. Without attention to the functional factors the psychosocial considerations cannot be facilitated. Empowerment and relational ability of graduate nurses and those who walk with them contribute to each of the themes which in turn inform the theory of practice development applied within the unique context of Lakes DHB.

**SUMMARY**

Becoming a registered nurse carries with it a wide variety of stressors. Responsibility for their own practice is something graduate nurses are often anxious about. Effective socialisation and team support role model and facilitate coping mechanisms that balance
the tension between the sometimes overwhelming responsibilities associated with the registered nurse role and achieving best patient outcomes within the graduate nurses practice context. The leadership role provided by the CNE contributes significantly to the way this is achieved. By providing structure for expected outcomes, clinical teaching, and support and feedback for both graduate nurses and preceptors the CNE can guide the transition into the practice setting and facilitate effective preceptorship. The organisation of practical aspects, such as complementary rostering and workloads to allow time for preceptor functions is pivotal to achieving the requirements of the preceptored transition. Relational ability and personal attributes such as a friendly manner, patience and enjoyment of nursing, engage graduate nurses in reciprocal learning where they both belong and participate. Time and space away from practice provide important opportunity to reflect on and process issues in a way that develops strategies for coping and affecting positive outcomes in future situations.

The perceptions of graduate nurses regarding their preceptored experience provide the opportunity to make recommendations to inform the future development of the preceptor role and the associated preparation. These recommendations will be explored in the next chapter, and conclusions drawn from the project overall will be presented.
CHAPTER SIX:

Korowai Aroha:
Recommendations and Conclusions

The purpose of this chapter is to weave together the threads of this research project and provide Korowai Aroha; a cloak of covering for the graduate nurses who will be preceptored in future at Lakes DHB. Using reflection, this cloak is constructed of the strong fibres of effective transition where the intent of the NETP preceptor and graduate nurse relationship have been realised. Woven into it are the delicate fibres of difficulty where for some, they have not transitioned effectively. Drawn from both are the associated recommendations for practice, the limitations of the study and final conclusions.

The aim of this project was to gain a deeper view of the graduate nurses’ perceptions of the preceptored experience. This was to further inform the way that preceptors are prepared and the role is applied for graduate nurses on the NETP Programme at Lakes DHB.
The study has introduced the practice context of the NETP Programme at Lakes DHB (2006c) identifying the strong links between clinical need, the learning framework (Figure One) and cultural competency (Figure Two) and that preceptorship is a pivotal role in facilitating this in practice for graduate nurses.

A critical review of the literature identified that while much has been said about preceptorship, there is limited research available profiling the perspectives of graduate nurses regarding this. Examples of preceptorship programmes and leadership perspectives provided useful insight into how it had been applied to support graduate nurses and positively impact retention.

The research design has been based on the qualitative case study method, considering the perspectives of graduate nurses at Lakes DHB as part of the NETP Programme. Data were collected in semi-structured interviews and focus groups from participants in the 2007 NETP Programme. Secondary data from the 2006 NETP preceptor/graduate nurse evaluation has also been referred to. Thematic analysis has been based on content and concept analysis resulting in two categories each with three themes.

The themes associated with the first category of functional factors include: the role of the CNE, primarily as a leader, facilitator and supporter of preceptors; organization, rostering, workload allocation and prioritisation as an absolute priority if any of the expectations of the preceptored transition are to be met; and clinical skills incorporating development of technical tasks, clinical decision making and practical wisdom. The themes associated with the second category of psychosocial considerations include: the graduate nurses’ sense of being scared and the way that preceptors have advocated caring behaviours and learning opportunities; socialisation and team support where relational ability facilitates integration and the confidence to contribute; and the preceptors experience as a registered nurse where experience, expertise and credibility are valued. When considered together these two categories present the essence of the Learning Framework (Figure One) demonstrating both the technical and emancipatory aspects of nursing. The support of well equipped preceptors to ‘walk with’ graduate nurses on this transition journey empowers them to walk in practice in their own rhythm as they develop from being acontextual and rule governed novices (Benner, 1984) to emerge as competent nurses with clarity around reflecting their own values in practice.
All nurses from the 2007 intake of the NETP Programme have achieved an effective transition to the registered nurse role measured by achievement of competent level registered nurse on the Northern Region PDRP (2004) (Table 1). The journey for several graduate nurses has been as intended by the programme (Lakes DHB, 2006c). For others, where these requirements have not been well facilitated, the journey has been frustrating and difficult, adding to the already present stress of ‘reality shock’ (Dunham-Taylor & Pinczuk, 2006; Kramer, 1974), and adjustment to a new role.

On reflecting on the voice of the graduate nurse regarding their preceptored experience (Bulman & Schutz, 2004; Johns, 1995; 2004; Schon, 1987), I began to gain more insight into myself as a researcher. I realised that I carry attributes of the expert nurse (Northern Region DHBs, 2004; Benner, 1984) within my practice as a registered nurse and educator; however, as a researcher I am a novice. As a nurse leader I was keen to use a problematisation approach to take the information from critical reflection and couch it in a positive and constructive frame in order to implement changes that would overcome the difficulties in the way that the preceptor role is applied. As a researcher I realised that I have responsibility to the source of the data. The voice of the graduate nurses was often raw and analytical statements around the content of the data do not always communicate the fullness of what the words represent. I have endeavored to address this in the presentation of the data and the following recommendations.

**THREADS OF CHANGE**

**Implications for practice**

The national standards for NETP Programmes set by the Ministry of Health (2005) have been developed to ensure a consistent level of support for graduate nurses entering the workforce. These are based on the NZNC (2005b) competency requirements for registered nurses. Preceptorship requirements are embedded in these standards with clear expectations of how they will be prepared and the role applied. The culture of preceptorship at Lakes DHB historically applies the role in a way that is incongruent with the current requirements and while there has been agreement to implement the revised approach described in the NETP Programme (Lakes DHB, 2006c), busyness and familiarity with the way things have always been done has limited effectiveness and change. The most significant implication of this is that if the role is not applied as outlined
in the Lakes DHB NETP Programme and Preceptor Manuals and the Preceptor Policy, (2006c; 2006d, 2006e) an effective transition to competent nurse will be compromised which then has the potential to impact negatively on nursing care and workforce retention.

The following recommendations suggest ways that the preceptor role can be developed and applied to address this.

Recommendations

**The allocation of a dedicated preceptor:** This allows a relationship to develop from which the expectations of the preceptored transition can be facilitated (Kaviani & Stillwell, 2000; Morton-Cooper & Palmer, 2000; Delaney, 2003). Such allocation is required to meet the requirements of the NETP Programme (Lakes DHB, 2006c; 2006d). A relieving preceptor can support this primary function but all other variations of preceptor application must be excluded as they do not meet the intention of the NETP Programme, (Lakes DHB, 2006c; NCNZ, 2005).

Non-allocation of a dedicated preceptor and rostering the preceptor on holiday at the graduate nurse’s start date gives a negative message to both the preceptor and the graduate nurse indicating that they are not valued; this is incongruent with the NETP Programme requirements and associated contract (Lakes DHB, 2006c; Nursing Council of New Zealand, 2005; Ministry of Health, 2005), and is also in conflict with the Lakes DHB values of manaakitanga and accountability (Lakes DHB, 2005c).

**Rosters:** In terms of practical matters of organisation, rostering and workload allocation were highlighted by every graduate nurse in either the focus groups or interviews indicating that attention to these details is crucial to enable the graduate nurse to access the preceptors support (Orsini, 2005; Crimlisk et al., 2002; Kiviani & Stillwell, 2000; Godinez, et al. 1998). This requires the rostering of the preceptor and graduate nurse on the same shifts during the shared clinical load period for four to six weeks to facilitate growth of the relationship, formation of trust and facilitation of learning (Griffen and Hanley, 2002; Charmley, 1999).
Workload allocations that incorporate coordinating the shift, high acuity patients, preceptoring of a student and a graduate nurse compromise all of these functions and have also undermined the value of preceptors. Ideal situations for workload allocation are not always able to be realized, however, strategies to achieve a minimum standard can be adhered to as per the preceptor policy (Appendix 5) and guidelines for safe staffing (Lakes DHB, 2006e; NZNO, 2006).

**Notifying when preceptor arrangements break down:** Until I undertook this project and began collecting the data from participants, I did not have full visibility of the situations where the preceptor arrangements had broken down. Unforeseen sickness, resignations and other circumstances unavoidably occur, however, the feedback I received from CNMs, CNEs and the graduate nurses was that ‘things were ok’. Because of this, it was not until after the shared clinical load time that I was able to address these matters. This leads to the recommendation that there is greater visibility around application of the preceptored shared clinical load time of four to six weeks. This needs to be built into the structured timeframes and reported on as part of the structured progress feedback in the programme (Lakes, DHB, 2006c).

**Preceptor selection:** Feeling ‘on your own’ and ‘being scared’ can be addressed by strategies that facilitate belonging and participating and further accommodated by the type of relational processes referred to in the Lakes DHB Learning Framework, (Figure One; Lakes DHB 2006c), and the cultural competency framework, (Figure Two; Lakes DHB Te Whakaruruhau, 2005) and Myrick (2002). Selection of a dedicated preceptor with consideration for attributes and relational ability (Schumacher, 2007), rostering a shared clinical load, and the CNE’s facilitation of the first day in the unit ensures that the process begins well. Attention to these practical details for rostering and shared clinical load means that the preceptor is with the graduate nurses for many of the experiences that cause stress or anxiety in the first weeks (Dunham–Taylor & Pinczuk, 2006; Charmley, 1999). This promotes an environment where ‘caring’ for the graduate nurse occurs, trust is cultivated and growth supported (Schumacher, 2007; Delaney, 2003; Benner, 1984; Morton-Cooper & Palmer, 2000). Such caring gives attention to socialisation; as evidenced by being welcomed and included, the sense of being part of the team, and being able to participate and contribute.
Within the NETP Programme provision is made for allocated time and space away from practice. One to one meetings between preceptors and graduate nurses fortnightly although this is not always utilised. Group clinical supervision in action learning sets is provided monthly. Both of these approaches use reflection to help avoid overload and provide an opportunity to process practice issues and challenges graduates experience between their own expectations of nursing and the reality of the workplace (Chang & Daly, 2001; Bond & Holland, 1999; McGill & Brockbank, 2004). Action learning sets are already scheduled as part of the study day so routinely occur each month. However, the allocated fortnightly one to one sessions need to be scheduled and identified as part of the roster to ensure they occur.

**The CNE role:** The CNE provides a leadership role (Chang & Daly, 2001), facilitating the application of preceptorship, using the NETP Learning Framework, (Figure 1; Lakes DHB, 2006c), and other approaches that support this, such as the Northern Region DHBs PDRP (2004) and Benner’s (1984) novice to competent nurse progression in practice. This can be applied in practice by using models such as Stuart (2003) and Orsini (2005). Such models provide clear role progression of learning and boundaries for both the CNE and preceptor. This role definition is important as there has been some overlap between the preceptor and the CNE in practice resulting in confusion based on an assumption that the other will undertake certain functions. It would also provide consistent and clear links to both the CNE and the preceptor from commencement as some graduate nurses felt that the CNE engagement had occurred later in the NETP Programme year. This confusion did not occur in areas using a structured approach.

**Clinical Coaching:** Integrating clinical coaching as part of the current practice development approach within the NETP Programme would facilitate achievement of unit specific requirements in a timely fashion. Some clinical areas already function in this way, however, consistent application as a structured part of the CNE role would support the preceptor relationship with the graduate nurse by ensuring that unit specific clinical skills and processes were taught as a structured part of orientation to the clinical area (Kelly, Simpson & Brown, 2002; Benner, 1984).

Lakes DHB assessment tools for certification are intended to be used to identify key competency behaviours as a process rather than an isolated incident for the whole task.
Further education of clinical staff regarding the use of these tools would avoid the dilemma experienced by some who did not carry out the whole process of commencing and concluding a task in the one shift, for example, IV therapy and blood transfusions.

Incorporating practical wisdom alongside technical skill and use of existing knowledge as part of clinical skills workshops and clinical coaching informs the development of critical thinking and finding their 'own rhythm in practice’ (Delaney, 2003).

**Preceptor selection and preparation:** Experienced registered nurses provide a valuable platform of skill experience and practical wisdom; however, if they have not moved into the role of preceptor as a facilitator of learning and practice development this can impair the quality of their preceptorship. An inexperienced nurse can be a very effective preceptor if these issues are attended to, the key is the ability to facilitate the relational process as described by Myrick (2002) and apply a structured approach to learning and development using the tools attached to the programme (Lakes DHB, 2006c; Stuart, 2003; Orsini, 2005).

Both experienced registered nurses and those more recently qualified can be supported to develop the skills of preceptorship by completing the revised preceptor course developed from the critical review of the programme in 2006 and delivered by Waiairiki Institute of Technology. This course meets the NETP Programme requirements and was developed as a partnership between Lakes DHB and Waiairiki Institute of Technology in 2006 following critical reflection of the way that preceptorship was applied in practice and alignment with the national standards (NZ Nurse Educators Round Table, 2005; NCNZ, 2005a). Attendance at the course during 2007 was poor due to difficulties around releasing nurses from clinical areas to attend. Given that it is a requirement of the NETP Programme and associated NETP contract that preceptors attend, this needs to be given priority.

The NETP Learning Framework (Figure One; Lakes DHB, 2006c), captures the whole of the graduate nurse transition, considering the strategic influences, theoretical principles and application of competency within the practice environment. Preceptorship is the function that links the graduate nurse to these ideals. It is apparent from the presentation of the data that further development is required to see the model fully applied in relation to this function. Within the NETP Programme there is 16 hours per year designated for
professional development of preceptors over and above the completion of the preceptor course, with the content of planned sessions relating to these aspects of the framework. Strategies to facilitate for release time for preceptors need to be worked on collaboratively with CNMs to ensure it happens. Nurse leaders within the organisation at all levels need to incorporate and role model actions and decision making that reflect the NETP Programme and the values of the organisation as they apply to this context.

STRENGTHS AND LIMITATIONS OF THE STUDY
The strength of this study is that it addresses the issue of the graduate nurses perspective of the preceptored experience in their transition to the registered nurse role at Lakes DHB. The case study method has enabled a specific view, rather than a generalised view of this to be obtained in relation to the requirements of the preceptored period as outlined in the NETP Programme Manual (Lakes DHB, 2006c).

The use of both focus groups and interviews to gather data was also a strength, as the interviews allowed for sharing of a personal journey, and discussion within the group prompted further development of ideas rather than a single perspective. Examples of this include the notion that in learning about clinical skills the group developed this concept to include consideration of practical wisdom, not merely the technical and academic aspects alone; and also exploration of reciprocity; giving and receiving, collaboration in workload and ideas.

Much of the literature is focused on management or organisational perspectives of preceptorship and the influence they have on retention and other aspects of preceptorship. A limitation of this project is that in deciding to complement the literature by gaining insight into the graduate nurses’ experience; the other voices are not heard. In particular these include the preceptor, CNE and CNM perspectives at a deeper level. Operational factors in staffing units with high occupancy and high acuity provide very real challenges for nurse leaders whose primary responsibility is to deliver the required level of care for the patients in the unit. Attention to the factors impacting on effective preceptorship can support this by having well transitioned and well supported nurses contributing positively to the units workforce needs in a timely manner with limited disruption.
FURTHER RESEARCH

Consideration of the Preceptor, CNE and CNM perspectives as further research prompted by the same issues and themes would form a holistic view of the preceptored transition of graduate nurses where operational drivers were not seen separately. A related consideration for further research could be the exploration of the potential link between the sickness of preceptors and high demands in practice and whether or not these contribute to burnout and disillusionment with nursing.

This research project did not aim to evaluate the effectiveness of the learning framework and cultural competency, however, links are made that relate to the preceptors role and function within this. A bicultural research project that addressed the application of cultural competency within the learning framework would be an appropriate next step given the practice demographics and clinical need within the Lakes District.

CONCLUSION

Lakes DHB has a NETP Programme with a learning framework that is designed to facilitate the graduate nurse transition from student to registered nurse. Both the programme and framework link strategic intention and practice ideals to care delivery for the unique needs of people requiring health care within the district. The preceptor is a key person in realising this. The case study method has enabled me to consider the situation for the research question specifically in relation to Lakes DHB and how preceptorship is applied in response to the secondary data identified in the questionnaire that was the catalyst for the study:

“How has the preceptor supported the transition of the graduate nurse to the registered nurse role?”

Graduate nurses have given voice to this question individually and collectively. All participants of the January 2007 intake participated so the voice is comprehensive. For those for whom preceptorship was applied as outlined in the NETP Programme requirements, the transition was smooth and the contribution to practice as a registered
nurse was accessible and valued early on. For those where it was not applied as required the journey was inconsistent, stressful and valued contribution to practice as a team member was delayed.

This is evident in the two categories of themes; the functional factors of the CNE role, rosters and workload allocation and clinical skills; and the psychosocial considerations of being alone and being scared, socialisation and team work and the preceptor’s experience as a registered nurse. The practical nature of functional factors often becomes overshadowed by the emancipatory context of psychosocial considerations. However, implementation of measures to address psychosocial considerations cannot be achieved without attention to the detail of the way that functional factors are applied, as they ensure there is a way for relationships to form, socialisation and team support to occur and the preceptor experience to be valued. In contrast, operational demands and tasks can take precedence over the need for caring measures, socialisation and development of relationships (Schumacher, 2007; Myrick, 2002; Delaney, 2003).

The ongoing challenge to nursing leaders such as myself as the NETP coordinator, CNMs and CNEs is to “hear all the voices” (Chang & Daly, 2001 p.327) and bring about the type of influence that values and empowers preceptors and graduate nurses by ensuring allocation of adequate resource and appropriate workload, equipping and preparation, and role modeling, so that the functions of teaching and learning, coaching, reflecting, critical thinking and support become embedded in all practice. The Lakes DHB NETP learning framework (2006), and cultural competency framework and associated preceptor requirements will result in effective and timely transitions for graduate nurses. Without such leadership preceptorship of graduate nurses during their transition will not change from the historical application in practice that has resulted in disillusionment and lengthy ineffective transitions.

Beckett and Wall’s early quote (1985) regarding preceptorship withstands the passing of time and captures the essence of how it can be applied.

Preceptors give direction by drawing upon their own experience to guide another individual along a path appropriate to the learners needs; they are
clinical facilitators, committed to ongoing education and derive strength from their own expertise, self worth and autonomy” (Beckett & Wall, 1985, p. 68).

The voice of the graduate nurse and the attributes of preceptors carry strength, self worth, and expertise belonging to them as individuals. A reciprocal relationship that values these attributes and facilitates individual learning needs within the practice context is korowai aroha; a cloak of covering. From this nurses who are able to practice in a way that aligns with their own values and professional requirements are grown.


Lakes District Health Board. (2006a). *Clinical Supervision Procedure*

Lakes District Health Board. (2004b) *Intravenous therapy policy*.


Lakes District Health Board. (2005b) *New graduate policy*.

Lakes District Health Board. (2006b). *Nursing and midwifery strategic plan*.

Lakes District Health Board. (2006c). *Nursing entry to practice programme manual*.

Lakes District Health Board. (2005c). *Organisational values*.


Northern Region District Health Boards. (2004). Professional development and recognition programme for nurses.


<table>
<thead>
<tr>
<th><strong>Glossary</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Graduate Nurse</strong></td>
</tr>
<tr>
<td><strong>Manaakitanga</strong></td>
</tr>
<tr>
<td><strong>Preceptorship</strong></td>
</tr>
<tr>
<td><strong>Problemisation</strong></td>
</tr>
<tr>
<td><strong>Korowai Aroha</strong></td>
</tr>
<tr>
<td><strong>Whanau</strong></td>
</tr>
</tbody>
</table>
Appendix One

Unitec letter of Ethics approval
Lakes DHB letter of Ethics Approval
Access & Support letter from Director of Nursing and Midwifery
Support letter from Te Whakaruruhau
Participant Information Sheet
Consent Form
17 April 2007
Cheryl Atherfold
70 Grace Crescent
TAUPO

Dear Cheryl

Thank you for submitting your research proposal "New graduates perceptions of the preceptor experience".

A subcommittee of the Postgraduate Board of Studies has considered and approved your proposal.

Your principal supervisor is Sue Gascoigne and your associate supervisor is Jill Yelder.

Please be aware that ethical approval may be required for your research once you have finalised your proposal. To determine the need for ethics application and approval, we recommend that you read the Guidelines for Ethical Approval in the Research folder on the Blackboard site Postgraduate Students Resources, to identify any ethical issues that may arise. Discussion with your supervisor or the ethics committee (email: ethics@unitec.ac.nz) may also assist in this decision process. This will help determine the need, or otherwise, for a full application for ethical approval. Ethics applications and accompanying documents should be submitted as email attachments to the above address.

Please contact me if you have any questions, or if I can assist you in your research (my extension number is 7465 and my email address biloi@unitec.ac.nz).

We wish you every success in completing your research project.

Yours sincerely,

Dr Johnnie Biloi
Postgraduate Student Research Director
Division of Postgraduate Studies
cc:

Principal Supervisor: Sue Gasquoine
Associate Supervisor & Programme Director: Associate Professor Jill Yeilder
Head of School: Maurice Drake
Programme Administrator: Anna Keall
Research Office: Portia Richmond
Postgraduate Academic Administrator: Carla Sutton
From: "Andrine Stewart" <stewart@unitec.ac.nz>
Subject: Ethics Application
Date: 12 Jan 2007 12:09:41 PM
To: <cheryl.silverford@unitec.ac.nz>
Cc: <office@unitec.ac.nz, "JJ Yelding" <jyelding@unitec.ac.nz>, "Sue Gasquoine" <sgasquoine@unitec.ac.nz>

Cheryl

Thank you for submitting your application for ethical approval regarding your Master of Health Science (Nursing) Thesis.

I have reviewed your application and am happy to approve. Please can you forward an electronic version of the application to Portia Richmond at the Research Office. Portia will then assign an identification number to your application - which you should use in any future correspondence.

Best wishes for your research.

Andy
Associate Professor Andy M. Stewart PhD
School of Health Science
Unitec
AUCKLAND
NEW ZEALAND
ph: 64-9-815-4371 ext 6306
mob: 027 740 2588
fax: 64-9-815-4328
email: stewart@unitec.ac.nz
skype: andy.stewart9105
19 April 2007

Cheryl Atherfold
PDP Coordinator
Lakes DHB
Rotorua

Dear Cheryl

New Graduates Perceptions of the Preceptor Experience (Research # REC040716)

Thank you for providing us with the necessary information regarding your research on “New Graduates Perceptions of the Preceptor”.

Your information was discussed at a previous Research and Ethics Committee meeting held on Wednesday 04th April 2007. The committee was supportive of the proposal and members were positive about the possibility of Lakes DHB becoming involved in this study.

This letter outlines the further actions required and queries raised. I would like to emphasise that our goal is to assist you with getting this work “off the ground” and not hinder the process. Our feedback is as follows:

1. Data being used
   The proposal was not clear whether the data you will evaluating is existing data or whether you will be using the same questionnaire and getting new data. Please confirm.

2. Consent Forms
   The consent forms need to state that no penalty will accrue if participants choose not to be involved in the survey.

3. Selection Criteria
   The proposal does not state how you will select participants. Can you please advise how you plan to do this.

When responding to these issues please do so either by letter addressed to the Research and Ethics Committee, Lakes DHB, Private Bag 3023, Rotorua or via email to our committee Secretary sophie.minerapa@lakesdhb.govt.nz.

Our committee representatives Suzanne Gower and Erina Morrison have advised that they will assist you with any queries you may have. Please contact Suzanne on x8562 or Erina on x8663.

Healthy Communities - Mauriora!
We look forward to receiving an update on progress with your research proposal.

Kind Regards

[Signature]

Dr Barry Smith  
Chair Research and Ethics Committee

Cc: Suzanne Gower, Portfolio Manager Personal Health  
Etna Morrison, Area Director Mental Health Services
22 July 2007

Cheryl Atherfold
PDRP Coordinator
LAKES DISTRICT HEALTH BOARD

Dear Cheryl

RE: New Graduate Perceptions of the Preceptor Experience REC940716

Thank you for the extra information supplied as requested. The Research & Ethics Committee is happy to approve this project.

All the best for your research project. Please contact us if we can be of any assistance.

Yours sincerely

Barry Smith
Chairperson, Research & Ethics Committee
6 June 2007

Cheryl Aherfold  
PDRP Co-ordinator  
LAKE DHB

Dear Cheryl,

**WILL SOMEONE WALK WITH ME? A CASE STUDY EXPLORATION OF GRADUATE NURSE PERCEPTIONS OF THE PRECEPTORED EXPERIENCE DURING TRANSITION TO THE REGISTERED NURSE ROLE**

I am happy to support this research project to be undertaken as part of the requirements of the Masters of Health Science (Nursing) as a case study of graduate nurses in the 2007 intake at Lakes District Health Board.

I am aware that access for interviews and focus groups has been arranged so that clinical responsibilities of the graduates are not compromised.

I wish you well in this project and I look forward to reading your research in due course, particularly your recommendations on any improvements we can make to "our" NETP programme more successful for our new graduate nurses.

Yours sincerely,

Gary Lees  
Director of Nursing and Midwifery
18 June 2008

Cheryl Atherfold
ADON – Professional Development
Lakes District Health Board

Tēnā Koe Cheryl!

Tērei te mihi atu ki a koe i runga i ngā tini ahuatanga o te wā

Re: Will someone walk with me? A case study exploration of Graduate Nurses' perceptions of the preceptorship experience during transition to the registered nurse role.

This letter is to confirm support of this project at Lakes DHB, and that use of Maori language and principles referred to are applied appropriately.

The project integrates the principles of the Treaty of Waitangi Te Tiriti o Waitangi into practice to promote equity of outcomes for Maori. This is identified via the cultural competency framework.

If you have any questions, please make contact.

Naku noa

Ngahara Grant
Tumuaki
Te Whakaruruhau
Lakes DHB
DDI: 07 3497829
Information Sheet for Participants

**Research Title:** New Graduate Perceptions of the Preceptor Experience  
**Researcher:** Cheryl Atherfold  
**Educational Institution:** Unitec; Auckland New Zealand

**Invitation:**
You have received this information sheet following a presentation to new graduate nurses about the project. If you would like to participate in the project please contact me on 07 3497955 x 7859 or by email cheryl.atherfold@lakesdhb.govt.nz.

Preceptorship has been described the New Zealand Nurse Educators Round Table Group (2005) as a positive contributor to the graduate nurse transition to practice. The purpose of the study is to explore how the preceptor/preceptee relationship has supported the transition of a new graduate nurse to the registered nurse role.

The study will include 5 – 10 participants and by using individual interviews and focus groups will gather information that can be used to inform future preceptorship development and allocation.

The interviews will be 60 – 90 minutes in duration and be semi-structured. The focus groups will also be 60 – 90 minutes in duration and use open questions and narrative, participants may be involved with either interviews or a focus group.

Both will be tape recorded and transcribed. After the tapes have been transcribed they will be destroyed and the transcripts kept for five years then destroyed.

The data from interviews and focus groups will be analysed to identify common themes to from the basis of recommendations for the future. These will form the basis of a Masters thesis and also be presented to the Lakes District Health Board.

Selection of participants will be made from those who volunteer to closely reflect the population composition of the 2007 intake of new graduates.

**Benefits, Costs and Risks:**
The main benefit from participating in this project is that the information will be used to develop the way we preceptor new graduates in the future.

To date we have a large amount of feedback that looks at the surface components of preceptorship, however deeper information is required to develop the role in a meaningful way.

The main cost to you is your time and willingness to share your experiences.

One of the main risks is that you may find the telling of your story distressing and that it raises issues for you that are complex and difficult to resolve. Should this be the case professional supervision or counselling can be arranged.
**Participant Concerns**
Should you have any concerns regarding any aspect of the project and its progresses please contact the project supervisor as below.

Sue Gasquoine, School of Health Sciences, Unitec. New Zealand.
Phone: 09 8154321 x 5104 email sgasquoine@unitec.ac.nz
Thank you for considering this project.

If you would like to be a participant please contact me at the above phone number or email address.

Cheryl Atherfold
Consent for Participation in Research

Research Title: New Graduate Perceptions of the Preceptor Experience
Researcher: Cheryl Atherfold
Educational Institution: Unitec; Auckland New Zealand

I, __________________ (name) voluntarily agree to participate in the research regarding the new graduate perceptions of the preceptor experience. I understand that this research is being undertaken by Cheryl Atherfold and will form the basis of her Masters thesis. I understand that the research methods involved include participation in a 60 – 90 minute interview and/ or a 60 – 90 minute focus group (delete the one that does not apply).

I grant permission for the interview or focus group to be tape recorded and transcribed to be used only by Cheryl Atherfold for analysis of the interview and focus group content. I grant permission for the research information generated to be published in a report to Lakes District Health Board and in the thesis and future publications.

I understand that any identifiable information will not be included in the report, the Thesis or any future publications.

No penalty will accrue if I choose not to be involved.

Signed _______________ (Research Participant)       Date ______________
Appendix Two

Sample Questions
Sample questions to be used in focus groups and interviews to guide narrative responses.

- Can you describe how you worked with your preceptor in the first 12 weeks of practice?
- How was support and advocacy facilitated during your transition to the Registered Nurse role? Do you have some examples?
- How did this facilitate your socialization into the unit/ team?
- What types of clinical skills were taught during this period of time?
- What aspects of the preceptor relationship aided your own workload prioritization?
- How did the preceptor relationship help you to find your own rhythm of practice (style or way of practicing or organising ones practice) and how did this impact on job satisfaction?
- What were the barriers to this?
- Can you describe what have been the most positive aspects of the preceptor relationship?
- Can you describe what have been the least positive aspects of the preceptor relationship?
Appendix Three

Preceptor Policy

New Graduate Policy
TITLE:  Preceptorship

Statement/Purpose/Description
Nurses, Midwives who are new to the clinical area, are provided with the opportunity to work with experienced clinical staff who provide orientation, supervision, and guidance in order to facilitate the integration into the clinical area.

Preceptorship is a formal educational relationship intended to provide staff new to the clinical area with:
- Access to an experienced and competent role model
- A supportive one to one teaching and learning relationship
- A smooth transition to practice in a clinical area
- The ability to critically analyse clinical practice
- An opportunity to cultivate practical wisdom and facilitate clinical competence

Scope
Lakes District Health Board Registered Nurses and Midwives who are designated and trained to provide preceptorship.

Registered Nurses and Midwives who are new to a clinical area.

Definitions
Preceptor  Experienced Registered Nurse or Midwife who provides Critical Companionship for transitional role support, learning experiences, supervision and role modeling for a specified timeframe. The preceptor performs a dual role that includes continuing with some or all of the responsibilities of their position while providing an orientation process to the preceptee.

Preceptee  A Registered Nurse or Midwife who is either a new graduate, returning to the workforce, or changing clinical areas.
Preceptorship is a process to assist Registered Nurses, Midwives, in partnership with an experienced colleague, to effectively begin to integrate their skills and knowledge to the clinical setting for a fixed time period.

Critical Companionship is a holistic, person-centred helping relationship in a healthcare context, in which an experienced facilitator accompanies a co-learner on an experiential learning journey (Titchen, 2003).

**Process**

The selection of the preceptor is based on them having the skills outlined in the Preceptor Role Description, available in the Preceptor Manual. They are also able to meet the ongoing professional development requirements of being a preceptor.

The length of the orientation period for the new staff member will be decided by the CNE and CNL in conjunction with the preceptee, dependent on the person's previous experience. For new graduates, this period is six weeks, which may be delivered as:

- Three-four weeks at the commencement of clinical placement (this may differ for those who are undertaking two separate clinical placements).
- The rest of the time being regular weekly or fortnightly sessions.

During the period of Preceptorship, the new staff member will be provided with:

- Access to an experienced and competent role model
- A supportive one to one teaching and learning relationship
- A smooth transition to practice in a clinical area
- The ability to critically analyse clinical practice
- An opportunity to cultivate practical wisdom and expand clinical competence
- Professional socialization to the work environment
- How knowledge and evidence can be used for patient care
- The ability to find ways to overcome internal and external obstacles to person-centred, evidence-based practice.
- The ability to create new knowledge in and from practice (Titchen, 2003, Morton-Cooper, 1993, Myrick, 2005)

This period of critical companionship between the preceptor and the preceptee may last up to four months in a formal capacity.

The preceptee will be achieving specific objectives and competencies, set in conjunction with the preceptor/CNE/CNL, with the aim of becoming progressively independent in their position. It is the responsibility of the preceptee to ensure that they have met the objectives agreed upon, by the end of the orientation period.
This relationship will be formally terminated by mutual agreement following the attainment of the set objectives.

Points to Note

While on orientation the preceptee is supernumery to normal staff numbers.

Preceptorship requires rostered time and workloads that are suited to the preceptee's experience level, to enable effective outcomes.

Regular weekly/fortnightly sessions in the form of a debrief/action learning set/tutorial should be scheduled for each new graduate and on an as needed basis for other new staff.

The preceptee will follow the preceptors rostered shifts so to best facilitate critical companionship and a safe learning experience.

The preceptee is expected to complete the unit specific orientation manual by the end of the formal preceptorship time, and Completion of Orientation form sent to Human Resources to be kept in the preceptee's file.

Related Documentation

New Graduate Program: Document no. 55922
Undergraduate Clinical Experience: Document No. 39187
Preceptor Manual:
Lakes District Health Board Nursing Entry to Practice Program manual
Nurse Educators Round Table Preceptor Subgroup Report (2005)
Completion of Orientation

References


Prepared by:
Lakes District Health Board CNE Group

Endorsed by:

Authorised by:
Gary Lees   Director of Nursing and Midwifery
TITLE: New Graduate Programme

1. Purpose

The first year of clinical nursing practice has long been identified both nationally and internationally as a key aspect of the development of professional nursing practice (Ministry of Health 2004). The aim of a New Graduate Programme is to provide an environment where knowledge and clinical skills can be consolidated and skills in decision-making and priority setting can be developed (Lakeland Health 2000).

2. Scope

All Lakes District Health Board staff who work with New Graduate Nurses.

3. Related Documentation

1. Preceptorship NME-CSS.S02.
2. Lakes DHB Nursing & Midwifery Professional Development & Recognition Programme.

4. References


5. Process

1. New Graduate Nurses employed at Lakes DHB will enter their employment through the New Graduate Programme at 0.8FTE. The aim will be for two intakes per year. Commencement of the programme outside of these intakes can be negotiated on a case by case basis.

2. Selection onto the New Graduate Programme will be through interview process coordinated by the New Graduate Coordinator.
1.5.3 Employment on the New Graduate Programme is for a period of 13 months. During this period it is expected that the New Graduates will complete ‘Competent Nurse’ level on the Lakes DHB Professional Development & Recognition Programme.

1.5.4 New Graduates will undertake one or two rotations - in Mental Health one rotation is the norm.

1.5.5 Each New Graduate is expected to attend all scheduled study days and to complete all associated learning requirements.

1.5.6 The Clinical Nurse Leader in consultation with the Clinical Nurse Educator in each clinical area with New Graduates will:

1.5.6.1 Identify a staff member to preceptor the New Graduate during the clinical placement.

1.5.6.2 Facilitate attendance at the designated study days.

1.5.6.3 Complete a Performance Review at the completion of each six monthly period.

6. Points to Note

6.1 New Graduates should not be assigned to precept or student nurses or new staff in their first three months.

6.2 New Graduates should not be left in-charge of any acute area.

6.3 New Graduates for the first three months should be the ‘3rd RN or extra when working nights.

6.4 New Graduates require orientation time in both placements.

6.5 Where possible New Graduates should not be moved to another clinical area during their first six months. If New Graduates are to be moved within this time it must be negotiated on a case by case basis between the Nurse, CNL and Duty Manager.

Prepared by: Cheryl Atherfold
PDRP / CTA Coordinator

Authorised by: Cathy Taylor
Director of Nursing and Midwifery
Appendix Four

Summary of 2006 Preceptor and Graduate Nurse Evaluation Questionnaire
Summary of 2006 Preceptee and Graduate Nurse Evaluation Questionnaire

New Graduates evaluation of their preceptor(s)
5 of the 12 nurses who started in the general hospital in January 2005 responded (41.6% response rate)

<table>
<thead>
<tr>
<th>Function</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Model</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration with nursing staff</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaboration with health care team</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional role, i.e. use of standards, policy and procedures, giving report, etc</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistance with Socialization</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction to other staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Made to feel welcome and accepted as part of the team</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistance with identifying learning needs</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognised past experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validated learning needs</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistance with planning learning experiences</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient acuity appropriate for capability level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support available for more complex patient acuity</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range of experiences offered</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunities for increasingly more autonomous function as ability and confidence is gained</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunity to work a range of shifts with preceptor</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistance with meeting goals set as part of identified learning needs</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear organised clinical instruction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunity to carry our clinical tasks with support</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence based explanations of</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
physiology, pathophysiology, and interventions

Accessibility and availability of preceptor when needed  

| 3 | 1 | 1 |

**Evaluation of learning**
Daily feedback review (clear, timely, and constructive)  

| 2 | 1 | 1 | 1 |

Assistance with completing are specific competencies checklist for beginning practitioner  

| 1 | 2 | 2 |

Comments:
A great preceptor, great knowledge and has a rationale for everything
Willing to help
Takes time out to teach when needed
Excellent preceptors
Support offered during and outside of shifts worked
Strong support during transition
Always asks if I would like to do or take over procedure
Gives feedback about work & advice where needed

**Preceptor Evaluation of New Graduate Preceptorship**
6 of the 12 preceptors allocated to nurses who started in the general hospital intake in January 2005 responded (50% response rate)

If you choose 'no' please comment on how this could be improved

<table>
<thead>
<tr>
<th>Function</th>
<th>Yes</th>
<th>No</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you satisfied with the New Grad Orientation Programme provided (what you provided and how you delivered it)?</td>
<td>4</td>
<td>2</td>
<td>Would like more input from CNE Would have been better to have a lighter patient load</td>
</tr>
<tr>
<td>Did you have sufficient time to meet the requirements?</td>
<td>2</td>
<td>4</td>
<td>replied yes / no due to workload</td>
</tr>
<tr>
<td>Did your workload allocation give sufficient time to work with your New Grad?</td>
<td>3</td>
<td>2</td>
<td>replied sometimes due to workload</td>
</tr>
<tr>
<td>Were you able to be immediately available to you new graduate when needed?</td>
<td>4</td>
<td>2</td>
<td>Tried to be, not always possible due to workload. Mostly</td>
</tr>
<tr>
<td>Did you feel adequately prepared for the responsibilities as a preceptor?</td>
<td>6</td>
<td></td>
<td>Preceptor Course excellent</td>
</tr>
<tr>
<td>Did you receive adequate support form the CNL and CNE?</td>
<td>5</td>
<td>1</td>
<td>in between response</td>
</tr>
<tr>
<td>Did you receive adequate support form other nursing staff in the unit?</td>
<td>5</td>
<td>1</td>
<td>in between ward very busy</td>
</tr>
<tr>
<td>Did you receive adequate feedback about the education and support you provided for the New Grad?</td>
<td>2</td>
<td>3</td>
<td>1 sometimes</td>
</tr>
<tr>
<td>Did you encounter any learning / teaching</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
problems working with the New Grad?

| Were you able to identify / access the appropriate patients and clinical situations to enhance the New Grad’s learning experience and assist with further learning? | 5 | 1 in between |
| Were you able to plan goals and objectives that were attainable and then achieved? | 5 | Sometimes. Ongoing process. Most of the time 1 in between |

Comments
I really enjoyed my role as a preceptor. This was an opportunity for me to refresh my knowledge and experience. Patient allocation needed to decrease so that preceptor can work properly with the new graduate and the new graduate be able to feel more comfortable working with their preceptor. New Graduate needs to be specific about what needs to be achieved by the end of each week of their work. I think CNE involvement in the first week would be beneficial to cover the clinical tasks, i.e. IV Certificates, Drains; ECG’s etc. It is very difficult as a staff nurse to teach when you have 5 – 6 patients. I enjoy my role as a preceptor and hope to carry on in the future.