What are the Elements of Work Readiness of New Graduate Nurses in the New Zealand Context? A Professional Consensus.

Diana Fergusson

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School of Clinical Sciences

Faculty of Health & Environmental Sciences

Abstract

Background: Preparation for practice as a Registered Nurse (RN) is an age-old concern, and the tension between nursing education and practice has been well described. There is increasing interest in work readiness of new graduate nurses in New Zealand due to a number of factors; the aging population, increased chronic/long-term conditions, health inequities for Māori and Pacific people, increased demand for mental health services, sicker hospital patients with shorter lengths of stay, increased demand for community health services, expanding use of technology and drug therapy, new infections, antibiotic resistance, migration, and the impact of climate change on health. This is the complex and ever-changing context in which new graduate nurses orientate, socialise, and learn to practice as an RN.

Aim: To gain consensus across the nursing sector on the elements of work readiness of new graduate nurses in New Zealand and explore the work readiness framework in relation to the Western Institute of Technology Bachelor of Nursing Modern Apprenticeship degree.

Methodology: The study used a modified Delphi methodology with a scoping literature review, focus group interviews, and two survey rounds. Participants were presented with 167 items and given YES and NO fixed answers to facilitate convergence to agreement and consensus on work readiness items. Participants were also asked to make judgement on expected levels of performance for each of the work readiness items, using an adapted professional tool. The resulting work readiness framework was explored, and judgements made by a focus group as to whether the work readiness items were 'taught, practised and assessed' in the Western Institute of Technology nursing programme.

Results: Sixty-seven nurses working in tertiary education, district health boards, primary health care, aged care, community health, and professional bodies participated. Consensus levels were set at 70% and level of agreement was found in 85% of items presented. Four items met a NO consensus. No leadership items reached a YES consensus. The WR framework demonstrates that the highest expectations of WR element performance aligns with the knowledge component (knowledge/knows to), suggesting that NZ nurses view the main purpose of preparing NGNs for beginning professional practice is knowledge for practice acquisition. The lowest scoring component was found in proficiency (accomplished and well-practised) and in over three-quarters of the WR elements NGNs are not expected to be accomplished and well-practised.

Ninety-two percent of the work readiness items were judged by the focus group informants to meet each of the criteria of 'taught, practised and assessed' in the Western Institute of Technology nursing programme, although the informants agreed that most of the expected levels of performance had been set at a low level; that Western Institute of Technology graduates performed at a higher level.

Conclusion: A New Zealand new graduate nurse work readiness framework comprises 143 items with associated expected levels of performance. A transformational nursing degree model, such as the Modern Apprenticeship, can achieve work ready new graduate nurses. A 4th year internship is recommended for the nurse to develop proficiency in the workplace and achieve work readiness. The WR framework proffers an evidence base for articulating a national, curriculum mission, vision, framework, and programme outcomes and the nursing profession needs to re-claim nursing education to ensure a consistent contribution to the wellbeing of the citizens of Aotearoa New Zealand.

Table of Contents

List of Figures

List of Tables

Glossary

Aged Residential Care Nurse Entry to Practice (ARC NEtP)

A supported first year of RN aged care practice programme funded by the Ministry of Health

Hapori Māori   Māori language word for kinship

Hapū   Māori language word for extended family

Iwi   Māori language word for tribe

Nurse Entry to Practice (NEtP) A supported first year of RN practice programme funded by the Ministry of Health

Nurse Entry to Speciality Practice (NEtSP)

A supported first year of RN aged care practice programme funded by the Ministry of Health

Tangata whenua   Māori language word for people of the land

Whānau   Māori language word for family

Kawawhakaruru hau   Māori language phrase for cultural safety within the Māori context and contributes to health outcomes

Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

23 November 2019

Diana Fergusson   Date

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This study was approved by the Auckland University of Technology Ethics Committee (16/116, 18/73 and 19/90).

Chapter 1 Introduction

1. Introduction

The purpose of this chapter is to introduce the topic of interest; that of work readiness of new graduate nurses. The chapter begins with the impetus for the study, which is followed by a background examination of the nursing regulatory, health, professional, and education perspectives. A broad overview of the study design is presented, followed by a description locating me, as the researcher in the research project. Finally, an overview of each of the chapters completes the chapter.

2. Impetus for the study

The majority of New Zealand (NZ) educated Registered Nurses (RNs) complete their pre-registration nursing qualification at undergraduate degree level (a small number at graduate level) to prepare them for practice in a range of settings (acute, community, and mental health care). Underpinning their preparation is the assumption they are 'work ready' for employment. Within the small rural region where I work, a local healthcare provider increasingly questioned and challenged this assumption. They expressed concerns of knowledge and skill deficit when employing new graduate nurses (NGNs) who had successfully completed their Bachelor of Nursing (BN) degree from the local tertiary education provider and completed registration with the Nursing Council of New Zealand (NCNZ). Their view is shared across the country. Nurse leaders have expressed disquietude at the preparedness of nurses to meet health care demands and variability in undergraduate educational outcomes (Cook, 2009; New Zealand Nurses Organisation, 2013); views that reflect the intention of Health Workforce Directorate (formerly Health Workforce New Zealand) (HWD) to increase their degree of influence on undergraduate education (Ministry of Health, 2014c).

Work readiness (WR) has been defined "as the extent to which graduates are perceived to possess the attitudes and attributes that make them prepared or ready for success in the work environment" (Walker et al., 2013, p. 116). Yet, this definition raises questions: whose 'perception'? what is the 'extent'? what are the 'attitudes and attributes'? and by whose standard? There is also a need to agree what constitutes 'success in the work environment', particularly between education and practice. Calls for collaborative decision-making in nursing education (Cook, 2009; KPMG Consulting & NCNZ, 2001), support the need for consensus-reaching methodology. Using a Delphi methodology, the

aim of the research project was to identify the elements of WR of NGNs in NZ, whereby nursing, across the sector, agree the attributes and levels of performance.

The increasing interest in WR of NGNs in contemporary health care is due to a number of factors. The NZ health environment is experiencing growth of its aging population, an increase in chronic/long-term conditions, population diversity, and inequities in health outcomes for Māori and Pacific people (Ministry of Health, 2014d, 2018a). There is greater need for some services and significant change required in others. Demand for mental health services (Ministry of Health, 2018b; New Zealand Government, 2018) is increasing. Patients in hospital have higher acuity; yet, stay for shorter periods of time. There is increased demand for community health services and expanding use of technology and drug therapy (Ministry of Health, 2013). New infections, antibiotic resistance, migration, and the impact of climate change on health add to the complexity of the challenging health environment (Ministry of Health, 2016b). Furthermore, the continually changing and increasingly complex nature of the workplace is occurring alongside current and foreseeable financial constraints (Ministry of Health, 2014a). NGNs orientate, socialise, and learn to practice as a RN in this complex and ever-changing context.

In my new role of Head of School of Nursing, it became evident that dialogue between the District Health Board (DHB) and the School of Nursing highlighted different perspectives on the meaning of WR, forcing a search for the opportunity to collaborate more closely in revision of the nursing degree programme. In 2012, the Western Institute of Technology (WITT) School of Nursing commenced a revised BN programme developed in partnership with nursing leaders from around the province. The purpose behind a collaborative approach to the curriculum review was to take common issues, wisdom, and aims, and merge them into a jointly developed curriculum, incorporating key elements that many believed were missing from the previous curriculum. A key part of the development was the conversations between the health and education sectors, wherein we discovered the distance between the two sectors, its causes, and how they could be broached in a meaningful way. There was free flowing conversation, beginning with a 'green field' (starting afresh) discussion on the key elements of preparation believed necessary for NGNs' WR. The aim was to create a curriculum whereby learning opportunities incrementally built students' professional profile so graduates were work ready and able to nurse competently in a changing healthcare environment when entering the workforce (WITT, 2011). Within this context, WR refers to the capacity of

new graduates to successfully orientate and work safely within a variety of practice contexts when first entering professional employment.

Given the increasingly complex nature of health care, the nursing leaders were adamant that clinical practice learning was central to the development of WR. Hence, the programme used a 'Modern Apprenticeship' (MA) (Benner, Sutphen, Leonard, & Day, 2010) framework; a framework that centres learning on clinical practice. There is some evidence to support the Taranaki nursing leaders' view that clinical learning is pivotal to WR; however, this has not been found with all models of undergraduate clinical practice learning (Patterson, Boyd, & Mnatzaganian, 2017). The unpredictable nature of the clinical learning environment, increasing patient acuity, variable student learning support, expected outcomes, and the clinical attendance pattern (length of placement, shifts work) all have a significant impact on NGNs' readiness to practice (Stayt & Merriman, 2012). Therefore, it cannot be assumed that clinical practice learning equates to WR. The more fundamental question posed was: what does the capacity to work safely as a beginning RN look like?

3. Background

The search for WR descriptors within the NZ context began with a background examination of the nursing regulatory, health, professional, and education perspectives. Given the key roles of these bodies in the regulation, education, and employment of NGNs, I expected some congruence or at least complementary frames of reference of WR for this professional role.

3.1 New graduate nurses fit to practise and fit for purpose

The NCNZ's purpose and existence is driven by the Health Practitioners Competence Assurance (HPCA) Act (2003). Its role relates directly to protecting the health and safety of the public by ensuring nurses' 'fitness to practise'. The Oxford Dictionary defines 'fitness' in conjunction with 'for' or 'to do' as "the quality of being suitable to fulfil a particular role or task" ("Oxford English Dictionary," 2000). The NCNZ ensures this 'quality of being suitable' is met through:

- "Successful completion of a degree in nursing accredited by the NCNZ
- demonstration of competency against the Nursing Council's Competencies for the registered nurse scope of practice
- being fit for registration in terms of section 16 of the HPCA Act. This refers to:
  - the ability to communicate effectively within scope of practice;

- o possession of English language skills sufficient to protect the health and safety of the public;
- o a review of any criminal convictions whereby time lapse since conviction and imprisonment punishment may adversely affect fitness to practice;
- o possession of mental and physical health sufficient to perform the role;
- o a review of any professional disciplinary proceedings that may impact on fitness to practice (in NZ or overseas);
- o and any other reasons that may compromise public health and safety. (NZ Government, 2003)
- being of good standing with the institute's school of nursing at which they have studied, in terms of section 19 of the HPCA Act. This refers to:
  - o competence to practice;
  - o sufficient English to protect public health and safety;
  - o and any other issue that may impact on fitness to practice (HPCA, 2003).
- passing the NCNZ State Final Examination for registered nurses" (NCNZ, 2014).

However, the NCNZ does not provide any further information that describes a NGN's level of practice; how it may be different from a nurse with nursing experience. The New Zealand Nurses' Organisation (NZNO, 2013) has defined the NGNs' level of practice, a framework that can be found in regional DHB) Professional Development and Recognition Programmes (PDRP) (Taranaki DHB, 2016). The NGN's level of practice is compared with the competent RN level of practice in Table 1 (p. 5).

Table 1. NZNO Level of practice for a new graduate nurse compared to a 'competent RN'

New Graduate Nurse	Competent RN
• Is a newly RN with a practising certificate • Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe • Is a multi-skilled beginner nurse with theoretical and practical student experiences • Is able to manage and prioritise assigned client care/workload with some guidance • Is reliant on learning from the experience of other nurses and her/his own experience • Learns and is developing confidence from practical situations • Is guided by procedures, policies, and protocols	• Develops partnerships with clients that implement Te Tiriti o Waitangi in a manner which the client determines is culturally safe • Effectively applies knowledge and skills to practice and has consolidated nursing knowledge in their practice setting • Is able to manage and prioritise assigned client care/workload • Confident in familiar situations • Has developed a holistic overview of the client, demonstrates increasing efficiency and effectiveness in practice, is able to anticipate likely outcomes for the client with predictable health needs, is able to identify unpredictable situations, act appropriately and make appropriate referrals

The framework suggests that new graduate RNs are not yet competent when entering professional practice. It recognises that it can take time and experience as an RN to meet competence levels of practice. Having met competence in the NCNZ Competencies for the RN Scope of Practice (SoP), as part of their final practice placement as a student, congruence with the NGNs level described above is questionable.

The Committee on University Programmes (CUAP) (New Zealand Vice-Chancellors' Committee, 2015) and the New Zealand Qualifications Authority (NZQA) have directives based on the 1989 Education Act to ensure that degree programmes are 'fit for purpose' (New Zealand Qualifications Authority, 2018), defined by the Oxford Dictionary (2000) as "suitable for the intended use; fully capable of performing the required task". Graduate suitability and capability is demonstrated by virtue of possessing a number of generic graduate abilities, including:

- "Demonstrate intellectual independence, critical thinking and analytic rigour;
- engage in self-directed learning;

- demonstrate knowledge and skills related to the ideas, principles, concepts, chief research methods and problem-solving techniques of a recognised major subject;
- demonstrate the skills needed to acquire, understand and assess information from a range of sources;
- and demonstrate communication and collaborative skills". (NZQA, 2018)

There are a number of problems with the above statements. First, their purpose and nature are not clear. Second, they do not identify a standard of achievement or performance that is required. Third, it is not well defined how they should be interpreted in the context of the nursing discipline. Finally, each outcome can be disparately perceived and widely interpreted by different bodies, potentially leading to the demonstration of different graduate abilities (Barrie, 2006). Given the increasing interest in WR, the extent to which the rhetoric of graduate ability statements actually represent WR is a matter of conjecture. Furthermore, the extent to which each nursing programme teaching and learning processes develop these outcomes is questionable.

3.2 Education and practice tension

If it can be reasonably assumed that the role of the nursing education sector is to produce graduates for the health sector to employ, it could also be reasonably assumed that education would collaborate with the health sector to produce work ready graduates. However, the tension between nursing education, located in the education sector, and practice, situated in the health sector, has been well described (Greenwood, 2000; KPMG Consulting & NCNZ, 2001), with drivers for the two government departments, education and health, claimed to be differently affecting the direction of nursing education. Despite attempts, over a period of time, to encourage collaborative working, a number of NZ reports reflect the tension.

1. In 2001, the NCNZ commissioned KPMG Consulting to undertake a strategic assessment of undergraduate nursing education and identify a set of recommendations to NCNZ for the preparation of the comprehensive nurse for 2010 (KPMG Consulting & NCNZ, 2001). The review undertaking was based on the premise that in order to decide on future nursing education, both the context and nature of practice needed to be articulated, including "key attributes and skills required" (KPMG Consulting & NCNZ, 2001, p. 2). It was argued that the skills and attributes required of the future nurse should be the drivers for education programmes, with greater focus on practice skills rather than higher order

6

thinking skills. It was further suggested that these skills should be informed by the health care needs of the community. Education and practice collaboration is highly recommended in this report and the directive was strengthened within the NCNZ education standards. How the directive is enabled and monitored is not clear.

2. In 2003, the Health Workforce Advisory Committee (HWAC) published a report on health care workforce development (HWAC, 2003). Considerable attention was given to improving relationships between DHBs, the health and disability sector, Tertiary Education Commission (TEC), and tertiary education providers. Recommendations to review governance mechanisms, performance management, contracting and monitoring, and funding mechanisms were proposed in order to improve integration.

3. The NZ Minister for Health identified "strengthening the health workforce" as one of the ministry's key priorities (National Health Board, n.d.). To accomplish this, in 2009, the minister established two bodies; a committee on Strategic Oversight for Nursing Education and the National Health Board (NHB). Chaired by Len Cook, the committee explored whether a formal Nurse Education and Training Board would benefit the oversight and improvement of the leadership and responsiveness to, and quality of, nursing education at undergraduate, graduate and post-graduate level in NZ (Cook, 2009). Despite the 2003 HWAC report recommending professional collaboration and integration, the review still identified highly decentralised health and education systems with little national governance on key issues of health workforce planning and education, and that collaborative action to achieve change is difficult (Ministry of Health, 2014c). The HWD now has overall responsibility for planning and development of the health workforce, ensuring that staffing issues are aligned with planning on delivery of services and that NZ's health care workforce is 'fit for purpose'. The main focus, to date, has been on the medical rather than the nursing profession.

4. HWNZ (2014c), now known as the HWD, argued that the current regulated health workforce roles (including nursing) restrict the ability to successfully deliver health targets, bearing out the perception that NGNs are not work ready for contemporary health care provision. HWD, planned to work with the TEC to investigate the considerable influences on undergraduate education outcomes; recognising concerns in the sector about factors impacting on variability in educational outcomes such as inconsistency of selection and entry criteria, variable content emphasis, grading criteria and attrition rates between the tertiary

education institutes, resulting in varying capability amongst NGNs. There is no mention of determining WR skills and attributes.

5. The NZNO education policy framework states that the provision of effective nurse education is dependent on strong relationships between and amongst the nurse education and clinical sectors, and that these arrangements have the potential for improved student outcomes, amongst other advantages (NZNO, 2013). Further, the framework notes that the current quality of the undergraduate student experience differs across the country, suggesting that not all graduates have the same capability; and, therefore, WR differs throughout the country. The proposed solution for this WR inequality is to reduce the number of curricula in NZ by half despite lack of supporting evidence (NZNO, 2013). A national programme providing consistent outcomes has been proposed earlier (Cook, 2009).

6. In 2007, Nurse Education in the Tertiary Sector (NETS) and Nurse Executives of New Zealand (NENZ) published a joint position statement (Nurse Education in the Tertiary Sector & Nurse Executives of New Zealand, 2007) that recognised an agreed understanding of what comprises work ready NGNs. A set of principles and actions demonstrated an attempt for practice and education to work together at a regional level, including profiling the work ready graduate that fits the local strategic plan. Unsupported by any literature, the behaviours described in the statement reflect the NCNZ competencies for the RN SoP except for the last two; managing an increasing realistic workload and understanding shift work, both of which could be found in any orientation and induction programme. This would suggest that WR, for each of these national professional bodies, equates to meeting the regulatory body SoP and associated competencies. It is not known how the education and practice sector commit to this statement; nor is it clear whether the NZQA/CUAP graduate attributes were considered.

Preparation for practice as a RN is an age-old concern; the discourse is not new. Nurse training moved into the education sector because the previous apprenticeship model, in which there was insufficient theory (El Haddad, 2016), was no longer meeting health service requirements (Papps, 2002). Despite concerns about the quality of teaching and learning, as well as the lack of academic parity with other health care professional education and the acknowledgement that reform was needed, it took the publication of the 1971 Carpenter Report (Ministry of Health, 2008) for the eventual transfer of nursing education into the tertiary education sector; firstly at diploma (in the 1980s) and then at degree level (from the 1990s).

There are now reports of a reversed situation with a concern of too much theory and insufficient clinical practice learning (El Haddad, 2016). The ongoing debate of the 'theory-practice' gap is indicative of the differences of opinion between nurses in practice and education regarding WR (Greenwood, 2000; Watt & Pascoe, 2012; Wolff, Pesut, & Regan, 2010). The International Council of Nurses (ICN) (World Health Organization, 2009) also contended that the new graduates are not prepared for the practice world nor do they possess the capabilities for current health care services. They warned that the persistent lack of appropriate clinician role models, overcrowded clinical learning environments and ineffective clinical teaching models continue to impact on the NGN's WR.

The background has identified that despite a plethora of perspectives and investigations into the education of nurses, there are still several issues being debated and some anxieties expressed regarding nursing education and how nursing education is being delivered, regardless of the accreditation regulations in place. Notwithstanding a number of recommendations for collaborative sector work to determine the shape of nursing education, there appears to be limited progress. Regardless of changes to nursing education programmes, the concern regarding the variability of graduate outcomes and WR could be due to the ability for disparate interpretation of degree outcomes, what their meaning and standards are for nursing education, and/or a lack of understanding of how these attributes support preparation or readiness for beginning professional practice. Before the nursing sector collaborates to determine the educational preparation of the beginning nurse, it must first agree on the attributes of WR. This study will work towards achieving consensus on the elements of WR for NGNs in a NZ context.

4. The study design

This section provides a high-level overview of the study design. The purpose of this study is to gain a consensus from nurses working in education, practice, professional and regulatory bodies about the elements of WR of NGNs. The elements will be identified using a national consensus process and explored in relation to the BN MA model. The specific question posed is: 'What are the elements of work readiness of new graduate nurses in the New Zealand health care context?'

The aims of the research are:

- To gain consensus about the elements of WR of NGNs from nurses working in education, practice, professional and regulatory bodies.
- To explore the co-constructed consensus of the WR construct in relation to the WITT BN MA model.

This study used a modified Delphi methodology (McKenna, 1994) to seek consensus from nurses working across the sector on the essential elements of NGNs' WR within the NZ context. A Delphi methodology aims to gather a consensus of expert opinion that is more informed and developed than any previous inception (Keeney, Hasson, & McKenna, 2001); and thus, contributes to advancing the knowledge base of WR (Hasson, Keeney, & McKenna, 2000). The main premise of the Delphi methodology is based on the assumption that group opinion is more valid than individual views (Keeney, Hasson, & McKenna, 2011). Individuals are equal and have disparate but equally important views; and so collaboratively, truth and knowledge are uncovered. Philosophically, it has been posited that the Delphi builds on the Lockean notion that human experience and agreement provides the basis for truth (Mitroff & Turoff, 1975; Powell, 2003). This philosophical position suggests alignment with a constructivist paradigm which will be further explored in Chapter 3. The study comprised three phases:

Phase one: gathering all pertinent information

This phase gathered together all the pertinent information to develop the first survey questionnaire. It comprised three parts. First, information was gathered by identification and analysis of the available national and international literature on WR. Secondly, the results and analysis of key participant perspectives from a focus group interview on WR of NGNs was determined. Finally, the results of the literature and the participant findings were melded to acknowledge what is currently known about the elements and expected levels of NGNs' performance of WR.

Phase two: identification of the construct elements of work readiness

The resulting elements from phase one, along with a modified professional tool determining expected levels of performance of those elements, were then presented to nurses working across the sector in NZ to gain consensus. Two survey rounds were undertaken to reach consensus.

Phase three: exploring the consensus of elements of WR in relation to the WITT BN 'MA' model

The resulting WR framework from phase two was explored by a focus group of tutors teaching on the WITT BN programme. The informants were asked to examine the WR framework and make a judgement on whether each of the elements are 'taught', 'practised' by undergraduate nursing students, and 'assessed' within the programme.

5. Locating the researcher in the study

El Haddad (2016) argued that nurses in education and practice work in agencies requiring the achievement of different organisational outcomes. As a leader in tertiary nursing education, the necessity to meet organisational outcomes, whilst managing a nursing programme that produces work ready graduates for an industry with different outcome requirements, is challenging. However, working in partnership with the regional clinical nursing leaders to co-construct the BN MA programme, focused on developing WR, provided an opportunity and indeed a mandate to ensure industry outcomes were met; that is, a safe practice and positive health outcomes approach. In embarking on this research project, I have developed substantial knowledge and understanding of different perspectives through undertaking the 'curriculum developer' role of the undergraduate programme. It provided an opportunity to examine the literature, listen to and survey the perspectives of nurses across the sector, as well as other stakeholders.

This 'consultation' process was highly commended in the programme accreditation process (New Zealand Qualifications Authority & Nursing Council New Zealand, 2011). Achievement of curriculum consensus at a local level meant working in different ways, deploying different strategies as needed; a role also known as a *bricoleur* (Warne & McAndrew, 2009). Performing as a *bricoleur* was also needed in this research project when deciding to use a Delphi methodology and locating the research mostly within a constructivist paradigm; a philosophical stance debated in the literature (Keeney et al., 2011) and discussed in Chapter 3. However, when operating as a *bricoleur,* the research must not be de-valued through any ill-considered judgement. Instead, the work must be accompanied by critical self-analysis (Finlay, 2002), requiring regular revisiting of my own thinking and decision-making.

Bringing together various professional perspectives, interpreting/synthesising these, and presenting them back to participants for further consideration, situates me centrally within

the research project. The final *bricolage* represents the bringing together of an agreement or consensus that represents the profession as a whole. Furthermore, implementing a collaborative approach that emulates and builds from that used for the BN programme development concurs with my professional values (Denzin & Lincoln, 2011). My choice of research topic reflects a personal aspiration and motivation for sector collaboration in, ultimately, the formation of work ready NGNs delivering the best health outcomes for society.

Given my role as curriculum developer, it may be viewed that in undertaking this study, I had an interest in ensuring that the WITT BN MA programme did indeed meet WR outcomes. This potential conflict of interest was discussed with my supervisor. A key event in mitigating this potential risk was my secondment from the Head of Nursing role and the nursing school at the time of data collection. Secondly, engaging in reflexivity was undertaken.

Reflexivity can be described as the researcher continually examining and then explaining how they may have impacted on the research project (Dowling, 2008). The researcher must make their position in the research transparent (Denzin & Lincoln, 2011). Recognising, acknowledging, and taking responsibility for better understanding my own role, perspectives, beliefs and values, meant exposing a significant level of self-awareness (Houghton, Casey, Shaw, & Murphy, 2013) throughout the research process; and, in doing so, recognising the influences I have had on the research. I needed to take an unambiguous approach to the actual practice of reflexivity as I strove to work towards as true an interpretation of the data as possible. An advanced level of self-reflection was achieved through the keeping of a research diary, examination of supervisor feedback, and clearly articulating decision-making processes (Jootun, McGhee, & Marland, 2009).

Self-awareness was further required in my researcher position, identifying as non- Māori, and the relationship with Māori colleagues; that the research will benefit the Māori community through a respectful engagement (Denzin & Lincoln, 2011). Given the significant health disparities for Māori in NZ (Ministry of Health, 2016b), the Māori community will have an interest in WR of NGNs to address these. In a Delphi methodology, the consensus must reflect the participants' perspectives, including an opportunity for a bi-cultural outcome. This is further explained in Chapter 3.

As a nursing education leader, the following assumptions shaped my thinking for this study:
    1. The innovative co-constructed MA BN programme would strongly influence WR

2. Nurses across the sector desire an opportunity to work collaboratively

3. Nurses across the sector desire an opportunity to consider and agree a framework of WR

4. This work will make a positive contribution to the discipline of nursing in NZ

5. Developing a consensus will provide a framework for the whole-of-profession to collaboratively develop future nursing workforce

6. Evaluation of undergraduate nursing programme outcomes may be able to have the use of an agreed model

7. There is an opportunity to advise and shape standards for undergraduate nursing education within the education sector as well as the regulatory body

6. Overview of chapters

The thesis is presented in nine chapters and is now briefly outlined.

Chapter 1 – Introduction

Chapter 1 has introduced the intent of the research project and explored the background for the study. The role of the nursing degree approval and accreditation bodies, as well as health reports examining nursing education, were presented to set the scene whereby the call for collaborative work has been largely unfulfilled. A brief synopsis of the study design and identification of the three phases of the project was presented, along with how I situated myself within the research project.

Chapter 2 – Literature Review

Chapter 2 presents the literature on WR of NGNs. A scoping methodology, using a five-step process, was used to map what is known about WR of NGNs. The purpose of this methodology is to develop semi-structured questions for the focus group interview in phase one of the study; and to identify elements, as well as a tool measuring expected levels of performance, for the survey questionnaire for phase two of the research project.

Chapter 3 – Research Methodology

Chapter 3 explicates the underpinning rationale and argument for the study, along with the research methodology and design of the project. The research design framework connects the research question with the underpinning paradigm, the methodological approach, and associated methods of the inquiry including data analysis methods. A Delphi methodology was used for this research project; a methodology that is flexible

and consequently requires detailed rationale for each stage of the research to attain adequate rigour. The ethical considerations of the study are also detailed for the reader.

Chapter 4 – Phase One

Chapter 4 provides details of phase one of the study. First, the nursing leader focus group interview data collection and results, yielding 77 WR elements, are presented. The second part of the chapter describes the development of the first Delphi survey. The survey comprises three parts. The first section requests demographic data and offers guidance on completing the survey. Combining the results of the literature review and the focus group interview created a list of WR elements in the second section. Finally, how the literature was used to create a professional tool for judging the level of performance is elucidated.

Chapter 5 – Phase Two

This chapter presents the largest component of the Delphi where convergence to consensus and agreement is achieved. Two survey rounds and the creation of a WR framework are described. Data collection, results, and analysis outcomes, and the associated performance levels of consensus of the first survey are presented. The decision-making process for the second survey creation is detailed, along with the results and analysis outcomes giving rise to the co-constructed WR framework.

Chapter 6 – Phase Three

This chapter presents the final phase of the study. The WR framework co-created by nurses across the sector is explored in relation to the WITT BN MA model. Following phase three ethical approval, the undertaking of a focus group interview of the tutors teaching on the programme is presented. The results of the tutors making judgements on the WR elements being 'taught', 'practised' (by nursing students), and 'assessed' are presented and examined.

Chapter 7 – Discussion: Setting the scene and polarised expected levels of performance

Chapter seven presents part one of the discussion of findings from the three phases of the study. The context of the WR framework is presented with a discussion of the MA framework and the NCNZ Education Programme Standards for the RN SoP along with the NCNZ Competencies for the RN SoP. Those WR elements achieving the highest and lowest expected levels of performance are explored.

Chapter 8 – Discussion: Performing as a NGN in the health care system

This chapter presents part two of the discussion on the results of the research project. The cornerstone of the RN role, that of clinical decision-making is explored within the context of workload along with time management and working as a team member. Leadership, quality, organisational and health care system WR elements are examined and pertain particularly to the future with changing health care models. Finally, a review of the overall expected levels of performance is articulated with narrative focussed on the role of the undergraduate degree.

Chapter 9 - Conclusion and Recommendations

This final chapter proffers a concluding statement from the research project and makes recommendations for undergraduate nursing education in New Zealand. Recommendations for further research are also proffered. Limitations of the study are identified and described. Finally, concluding remarks are made.

7. Summary

A high level of education and practice sector collaboration enabled the development of an innovative new undergraduate nursing degree with a core aim of increasing NGNs' WR in a rural NZ region. In the NZ context, there is little direction on what WR of NGNs actually looks like. Various reports suggest that even with ongoing developments and reviews of nursing education programmes, concerns persist about NGNs' readiness to practice in the contemporary health environment (Ministry of Health, 2014b; NZNO, 2013). Further, there is tension between nurses in education and practice about the preparation of NGNs (Greenwood, 2000; KPMG Consulting & NCNZ, 2001). Given the differing roles of the NCNZ, quality agencies such as the NZQA, professional bodies, and education and practice environments, there appears to be no formal process by which the whole-of-the-nursing profession works together to agree upon or ensure WR of NGNs now and for the future (Cook, 2009; HWAC, 2003; KPMG Consulting & NCNZ, 2001; NZNO, 2013).

This research project will contribute evidence on WR of NGNs by collating the findings from nurses across education, practice, the regulatory and professional bodies to reach consensus on the elements of WR and thus heed repeated calls to do so. Identifying and analysing extant literature on NGNs' WR for the purpose of presenting findings for the whole-of-the-nursing profession to make judgement is presented in the following chapter.

Chapter 2: Literature Review

1. Introduction

Chapter 1 provided an overview and background to the study. This chapter examines the literature on WR of NGNs. The purpose of the literature review was to search for, and identify, the existing knowledge base of the topic (Polit & Beck, 2017) ensuring comprehensive familiarity with what is currently known about WR of NGNs (Rumrill, Fitzgerald, & Merchant, 2010). Given the disparate types of literature reviews available (Paré, Cameron, Poba-Nzaou, & Templier, 2013), I selected a scoping review methodology congruent with the aim of the research project (Paré et al., 2013); that is, to co-construct a consensus of the elements of WR. In discerning WR elements, I searched widely to capture all that existed, for it would be the survey participants, known as 'expert panel members' in a Delphi methodology, who decided what was important, rather than me.

2. Scoping review

A scoping review is a form of knowledge synthesis (Colquhoun et al., 2014) that can provide a rigorous method for mapping and elucidating the extent, range, and nature of the area of research (Arksey & O'Malley, 2005). Such scoping uses a non-systematic, comprehensive range of sources of information, regardless of study design, focussing on a broad examination rather than depth of coverage (Levac, Colquhoun, & O'Brien, 2010; Paré et al., 2013). In other words, the quality of the studies is not analysed; rather, the current information that is available on a broad topic of interest is mapped out (Arksey & O'Malley, 2005). Like a systematic review, a scoping review must maintain methodological rigour (Anderson, Allen, Peckham, & Goodwin, 2008; Davis, Drey, & Gould, 2009). To that end, the Arksey and O'Malley (2005) framework, further developed by Levac et al. (2010) was used to illustrate the decision-making details, thereby strengthening reliability; an approach that provides sufficient detail that it may be replicated by others (Arksey & O'Malley, 2005). The framework is detailed in Table 2 (p. 17).

Table 2. Scoping review framework (Arksey & O'Malley, 2005; Levac et al., 2010)

	Scoping review framework	
STEP 1	Identifying the research question	The research question is clearly articulated
STEP 2	Identify relevant studies	Determine the scope of the study based on the research question and purpose
STEP 3	Study selection	Using an iterative process, search of the literature and refine the strategy as needed Develop inclusion and exclusion criteria Subject abstracts to inclusion and exclusion criteria Identify exclusions Remaining articles fully examined to ensure they continue to meet the inclusion and exclusion criteria
STEP 4	Charting the data	Develop data charting form Determine the variables to extract that will answer the research question An iterative process, whereby data is continually extracted, and data charting form updated Revise process after approximately five article reviews to determine extraction is consistent with the research question and purpose
STEP 5	Collating, summarising, and reporting the results	Three steps 1. Analysis (qualitative and quantitative) 2. Reporting of the results, referring to the research question 3. Examine the findings in relation to the study purpose and discuss implications
STEP 6	Consultation	Not used

The six-step process was reduced to five steps for this review of the literature. Step six involves consultation, which was not undertaken. This was because the purpose of the scoping review was to create a framework for presenting to the NZ nursing sector; in other words, the Delphi survey rounds replaced this step of the scoping review process. The overall aim of the review was to examine the extant knowledge of WR of NGNs. The purpose was to firstly use the literature to develop semi-structured questions for the focus group interview in phase one of the study; and secondly, to identify elements for the survey questionnaire for phase two of the research project. The specific objectives were to:

1. Identify the extent (number of studies/documents) and nature (definitions, other terminology) of WR; the context and the participants
2. Discern the underpinning concerns or nature of the questions being asked of WR
3. Identify the elements (an essential or characteristic part) of WR

4. Determine the level of consensus existing regarding WR

The literature review steps using the Arksey and O'Malley (2005) scoping literature review framework, further developed by Levac et al. (2010) are now presented.

Step 1: The literature review question is determined

Prior to conducting the search, the search question was established.

What is known about work readiness of new graduate nurses?

Step 2: Relevant studies/documents are identified

To ensure breadth of the review, identifying key words and relevant databases was required. Initially, the key words 'work readiness', 'nurse', and 'new graduate' were selected because they reflected the purpose of the scoping review. They were used in combinations in each of the following databases:

- ProQuest
- EBSCO (for CINHAL and MEDLINE)
- Science Direct
- Scopus
- Google Scholar (to ensure no further studies could be located)

Step 3: Study selection

Inclusion and exclusion criteria were developed to ensure relevant studies were identified whilst aiming to achieve comprehensiveness.

Inclusion criteria:

1. All works (qualitative and quantitative research, reports and expert opinions, as well as literature reviews) where NGNs' WR was the key focus
2. Literature since the mid-1990s to reflect the NZ all-graduate entry to practice education programmes
3. Nursing graduates rather than diplomats to reflect local academic level (i.e., undergraduate degree)
4. Perceptions of nurses working across the sector including academic staff, professional and regulatory bodies, as well as clinical staff

5. Nurse graduates rather than other professional graduates (e.g., engineers, lawyers)
6. Literature from the western world where health and education systems, although not the same, may be considered similar

Exclusion criteria:

1. Non-English language work
2. Literature reporting on the practice environment culture alone (e.g., level of graduate support, bullying)
3. Debate on the academic level of nursing education
4. The role of employment in the health field prior to or during the nursing programme, to ensure focus on WR attributes could be achieved

The scoping review methodology is an iterative process (Arksey & O'Malley, 2005) meaning that researchers engage in a reflexive manner. Steps may be repeated to ensure the literature is examined in a comprehensive manner. The search strategy was further refined to include key words 'practice readiness', 'capability', 'practice preparation', 'work preparedness', 'generic attributes', 'degree graduates', 'graduate employability', and 'fitness to practise'; along with 'nurse', 'new graduate', and 'newly qualified' in combinations because these terms appeared in the literature alongside WR (Walker, Storey, Costa, & Leung, 2015; Watt & Pascoe, 2012). The same aforementioned databases were used.

A total of 1061 studies were located. Articles were eliminated where:

- Duplication occurred
- Studies were not related to the undergraduate nursing degree programme
- WR was focussed on a specialty area of nursing rather than professional practice in general
- Other irrelevant articles

Forty-two articles remained. The abstracts were read and subjected to the inclusion and exclusion criteria resulting in no articles being excluded. The 42 articles were read fully and examined to ensure they still met inclusion criteria, following which eight articles were excluded for the following reasons:

- Explored scope of practice of registered and enrolled nurses (one article)

- A literature review whereby literature cited was already included in the scoping review (two articles)

- Focus on supporting new graduates in time of staff shortages (one article)

- Examined the role of the preceptor (one article)

- Evaluated employment processes (one article)

- Studied the health and good character requirements for regulatory body (one article)

- Literature review of the transition experiences of NGNs (one article)

All articles had their reference lists/bibliographies hand searched to identify further relevant studies not routinely included in the electronic databases. Only one article was identified and added due to its reference across many of the studies examined. A total of 35 remained for analysis. A flow diagram of the literature review method is detailed in Figure 1 (p. 21).

Step 4: Charting the data

A data charting form was developed to use as an analytical framework. This technique provides a framework for interpreting and synthesising data by grouping material according to the key issues (Arksey & O'Malley, 2005). The key issues or data extraction variables matched the objectives of the scoping review. An iterative process whereby data is continually extracted, and the data chart updated accordingly was applied. After the first five articles had data extraction completed, the approach was reviewed to ensure the process aligned with the research question and purpose (Levac et al., 2010).

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┌─────────────────────┐
│ Potentially relevant │
│ documents identified │
│      (n=1061)        │
└─────────────────────┘
           │                    ┌──────────────────────────┐
           │                    │ Studies excluded for:     │
           │                    │ -  Duplication            │
           │───────────────────▶│ -  Unrelated to           │
           │                    │    undergraduate          │
           │                    │    qualification          │
           │                    │ -  Speciality focus only  │
           │                    │ -  Irrelevance            │
           ▼                    │        (n=1039)           │
┌─────────────────────┐        └──────────────────────────┘
│ Abstracts reviewed and │
│ subjected to inclusion │
│ and exclusion criteria │
└─────────────────────┘
           │                    ┌──────────────────────────┐
           │                    │ Studies excluded for:     │
           │                    │ -  Irrelevant focus       │
           │───────────────────▶│ -  Literature review where│
           │                    │    literature already     │
           │                    │    included in scoping    │
           │                    │    review                 │
           ▼                    │        (n=8)              │
┌─────────────────────┐        └──────────────────────────┘
│ Reference lists/     │
│ bibliographies hand  │
│ searched             │
└─────────────────────┘
           │                    ┌──────────────────────────┐
           │                    │ Studies included for:     │
           │───────────────────▶│ -  Extensive citation     │
           │                    │        (n=1)              │
           ▼                    └──────────────────────────┘
┌─────────────────────┐
│ Documents and studies │
│ with usable information│
│ and for review        │
│      (n=35)           │
└─────────────────────┘
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Figure 1. Flow diagram of literature review method

At this point, the issue of identifying the participants and location of the research was deemed important to include, with a view to capturing the context of the study. Further, the literature identified that 'levels' of new graduate *performance* added complexity to WR, and this variable was also included. The final analytical data charting framework included:

- Author(s), study title, origin of study
- The underpinning concern (may be expressed as purpose, aim, question, rationale, background) giving rise to the research question/document
- The participants and setting
- WR definitions, terminology
- Elements of WR
- Levels of NGNs' performance
- Consensus issues

Step 5: Collating, summarising and reporting the results

Three distinct steps are recommended to present a narrative account of the extant literature (Levac et al., 2010): analysis, reporting results, and examining the meaning of the findings. Each step is presented now.

5.1 Analysis

Each of the analytical framework headings are used to present the results in this step.

5.1.1 Author(s), study title, origin of study

The first variable analysed was the origin and year of publication of the studies. Thirty-five studies were analysed using frequency distributions and reported as percentages for country of origin (see Table 3, p. 23); year timeframe of publication (see Table 4, p. 23) and country of origin for the year timeframe (see Table 5, p. 23). Percentages have been rounded to the nearest 1%. The purpose of rounding is to remove the least significant digits, making it easier to interpret; yet, keeping close to the original value (Moore, McCabe, & Craig, 2014).

Eighteen of the thirty-five (51%) publications were Australian. Eight studies (23%) were by American authors, four studies were Canadian (11%), NZ and the United Kingdom (UK) each had two studies (6%) and one study (3%) was Swedish. Over two-thirds of studies (n=24, 69%) were published in the last seven years. Eight studies were published between 2001 and 2009, and three studies from 1995-2000.

Table 3. Country of origin

Country	Number of studies	Percentage of studies
Australia	18	51
US	8	23
Canada	4	11
NZ	2	6
UK	2	6
Sweden	1	3

Table 4. Publications

Year timeframe	Number of studies	Percentage of studies
2010 – October 2017	24	69
2001 – 2009	8	23
1995 – 2000	3	9

An analysis combining the frequency of studies and the year of publication demonstrated that two-thirds (67%) of studies (n=16) undertaken in the past seven years originated from Australia. Four studies originated from the United States (US) (17%), three from Canada (12%) and one from the UK (3%) in this timeframe.

In the 2001-2009 timeframe, four studies (50%) originated from the US, with one study (12%) each from Sweden, Australia, the UK, and Canada. Two (67%) NZ studies and one (33%) Australian study were published in the 1995-2000 timeframe.

Table 5. Countries by year of publication

Year timeframe	Countries of origin	Percentage of country of origin
2010 – October 2017	Australia 16 studies	67
	US 4 studies	17
	Canada 3 studies	12
	UK 1 study	3
2001-2009	US 4 studies	50
	Australia 1 study	12
	Canada 1 study	12
	UK 1 study	12
	Sweden 1 study	12
1995-2000	NZ 2 studies	67
	Australia 1 study	33

5.1.2 The underpinning concerns or nature of the questions being asked of WR

The second variable analysed the underpinning concerns of WR; what the reasons were for asking the question and conducting the research. The qualitative data analysis

method of 'in vivo' coding identified six main codes. 'In vivo' coding refers to the method of using the actual language of the participants (Saldana, 2014). These codes represent and summarise the underpinning concerns of the authors, giving rise to their research. The six codes identified are presented.

1. *Nurses across the sector have different views, opinions and perceptions of WR* (Bork, 2003; El Haddad, 2016; El Haddad, Moxham, & Broadbent, 2017; Wolf, Pesut, & Regan, 2010; Wolsky, 2014). The long-standing debate on how well-prepared NGNs are continues (El Haddad, 2016; Greenwood, 2000; Hegney, Eley, & Francis, 2013; Walker, 1998). Clarke and Holmes (2007) claimed that there is no agreement on what competence means for new nurses. Further, there is growing disconnect between practice and education (Shingler-Peters, 2016), and lack of consensus on what comprised readiness for practice (Brown & Crookes, 2016; Romyn et al., 2009).

2. *There are disparate elements underpinning WR* (Bembridge, Levett-Jones, & Yeun-Sim Jeong, 2010; Diatta, 2015; Romyn et al., 2009; Walker et al., 2013). The term 'theory-practice' gap continues its use (Patterson et al., 2017); the inability to connect theory to practice precludes NGNs' ability to work as independent practitioners (Missen, McKenna, Beauchamp, & Larkins, 2016). In the rapidly changing healthcare environment, there is little information on which competencies (Utley-Smith, 2004) and capabilities (Rochester, Kilstoff, & Scott, 2005) are most important and NGNs do not possess the appropriate skills (Brown & Crookes, 2016). Woods et al. (2015) stated that although competency is met, this is different from being work ready. New graduates themselves feel inadequate in terms of providing care, a view shared by their managers (Otoo, 2016). NGNs having insufficient clinical and client care skills has been reported for nearly two decades (Greenwood, 2000). Critical thinking is not well taught (Diatta, 2015) and Casey et al. (2011) based their work on the belief that NGNs must be ready to competently care for patients. The integration of 'ICT'; the use of information and communication technologies is essential (Bembridge et al., 2010). Degree outcomes should support performance in clinical practice (Walker, 1998).

3. *Judging the standard of the elements of WR.* NGNs are perceived as not fully or adequately prepared (Missen, McKenna, & Beauchamp, 2015; Missen, McKenna, & Beauchamp, 2018; Missen et al., 2016; Watt & Pascoe, 2012), nor do they feel prepared (Otoo, 2016). Their education programme has not furnished them with the knowledge, skills, or confidence necessary for independent

practice; nor is there a standard whereby nurses can judge knowledge levels and what they still need to learn (Clark & Holmes, 2007). Holland et al. (2003) stated there is a lack of clarity on what success means and the extent to which fitness to practise has been achieved. NGNs are not practice or work ready (Brown & Crookes, 2016; El Haddad, Moxham, & Broadbent, 2013).

4. *Judging successful transition to the workplace.* There is increasing expectation of practice readiness in an industry with growing demands of an aging population, a predicted nursing shortage, constrained finances and growing workplace complexity (El Haddad et al., 2017). In a rapidly changing and complex health care system, many nurses state that NGNs need to function safely and independently and "hit the ground running" (Woods et al., 2015, p. 360) in providing nursing care. Without requisite skills, patients are at risk (Otoo, 2016); errors causing morbidity and mortality can occur (Diatta, 2015). There is a need to identify what is most important for success in new graduate nursing practice (Rochester et al., 2005). Expectations of the education and practice sector have gaps (Romyn et al., 2009). Students must acquire essential skills to improve patient outcomes and workplace satisfaction (Bembridge et al., 2010); providing safe and effective care (Berkow, Virkstis, Stewart, & Conway, 2009). It is unclear what competencies are useful in various work settings (Utley-Smith, 2004).

5. *What are the graduates meant to be ready for*? (El Haddad et al., 2013; Wolff, Regan, Pesut, & Black, 2010b). With a lack of clarity regarding the level of NGNs' WR needed, it raises the issue of how WR is measured and by whom (Wolff, Regan, et al., 2010b). Furthermore, the link between NGNs being competent entry-level nurses and demonstrating WR is debated (Wolff, Regan, et al., 2010b).

6. *WR known as other terms.* Twenty studies identified WR using various terminology. Although the most common term is *WR, as* identified in six studies (El Haddad et al., 2017; Freer & Penman, 2016; Hegney et al., 2013; Patterson et al*., 2017; Walker & Campbell, 2013; Walker et al., 2015), 10 other terms were found:

   - Readiness to enter the workforce (Shingler-Peters, 2016)
   - Readiness for practice (Hickey, 2009)
   - Practice ready/readiness (El Haddad, 2016; El Haddad et al., 2017; Wolff, Regan, et al., 2010b)
   - Job readiness (Wolf et al., 2010)
   - Prepared/preparation (Hegney et al., 2013; Missen et al., 2016)

- Prepared to enter the practice environment (Casey et al., 2011)
- Preparation/preparedness for practice (Watt & Pascoe, 2012; Wolsky, 2014)
- Fitness for practice (Holland et al., 2010)
- Competence (Lofmark, Smide, & Wikblad, 2006)
- Degree outcomes (Walker, 1998)

5.1.3 The participants and setting.

This section is divided further into two parts; first, the research participants and second, the research settings. Thirty-five articles were analysed using frequency distributions and reported as percentages and percentages have been rounded to the nearest 1%, making it easier to interpret yet keeping close to the original value (Moore et al., 2014).

a) *Participants*

The participants identified in the studies were clustered into 12 groups (see Table 6, p. 27). NGNs were defined as those who had been employed in practice for two years or less and were the biggest group studied. Fourteen studies (40%) included NGNs as participants. RNs identified as experienced practitioners participated in the second largest number of studies (n=12, 34%). The next largest group were those nurses working as practice leaders in the capacity of managers, administrators or Directors of Nursing (n=11, 31%). Academic staff comprised those working in the education sector and included lecturers and programme managers (n=10, 35%). Clinical practice educators and those managing NGNs' transition placements were identified as participants in nine studies (26%). Undergraduate nursing students themselves participated in seven studies (20%). RNs working in NGNs' preceptorship/supervising or peer support roles were identified as participants in six studies (17%). Where the studies (n=4, 11%) used a literature review or scholarly opinion framework, this group were named researchers. Carers were included as participants in two studies (6%). The nursing regulatory body were invited participants in two studies (6%). Enrolled nurses and service users were each identified as participants in one study only (3%).

Table 6. Participant groups

Participant Group	Number of studies using this group	Percentage of studies using this group
New graduate nurses	14	40
RNs	12	34
Practice leaders/managers	11	31
Academic staff	10	35
Practice educators/ transition facilitators	9	26
Students	7	20
RNs in supervising/ preceptor/peer roles	6	17
Researcher	4	11
Carers	2	6
Regulatory body	2	6
Enrolled nurse	1	3
Users	1	3

The number of participant groups identified in each study can be seen in Table 7 below. Most studies (n=20, 57%) used only one participant group. Six studies (17%) recruited two participant groups and only one study (3%) used three groups. Four and five participant groups were each identified in two studies (6%). Only one study (3%) used six participant groups, and two studies (6%) used eight participant groups. No studies included all participant groups.

Table 7. Number of participant groups in each study

Number of participant groups	Number of studies	Percentage number of studies
1	20	57
2	6	17
3	1	3
4	2	6
5	2	6
6	1	3
8	2	6
all	0	0

b) The research setting

The type of research setting was not always clear, and classification of settings was described generically in some of the studies (e.g., 'small to large institutions' and 'health organisations'). Given the disparity of setting descriptions, there is likely to be some overlap in the analysis; for example, mental health may be one of the settings in the 'small to large institution' but was not captured as such. Likewise, community care may include mental health or aged care. However, the data were not captured in this manner. Finally, some terms required interpretation for classification (e.g., 'city medical centre' was determined to be the same as a hospital setting given its North American origin).

The main research setting was overwhelmingly the hospital/acute care sector. Even where other clinical settings were used within a study, the numbers of participants in these settings were in the minority compared with the acute care setting. Twenty-five studies (71%) were set within a hospital/acute care setting. Nine studies (26%) comprised participants from the community/medical centre setting, eight studies (23%) from the aged care sector, and four studies (11%) in the mental health setting.

In six studies (17%) it was unclear or not stated where the setting was and four studies (11%) did not disclose a setting due to emphasis on the scholarly/literature review nature of the article. The university setting was identified in 10 studies (29%). Other clinical settings (independent practice, government policy, and hospice) were each identified in only one study (3%). The types of research setting can be seen in Table 8.

Table 8. Type of research setting

Type of study setting	Number of studies	Percentage of studies
Hospitals/acute	25	71
University	10	29
Medical centre/community	9	26
Aged care	8	23
Not clear/not stated	6	17
Literature review/scholarly work	4	11
Mental health	4	11
Independent practice	1	3
Government policy	1	3
Hospice	1	3

The number of research settings identified in the studies can be found in Table 9 below. Twelve studies (34%) only used one setting to gather data—the acute care/hospital setting. Six studies (17%) involved two settings, whilst eight studies (23%) recruited participants from three settings. Only one study (3%) identified participants from four settings, two studies (6%) from five settings, and the largest number of settings (n=7) were found in only one study (3%).

Table 9. Number of research settings in each study

Number of research settings	Number of studies	Percentage of studies
1	12	34
2	6	17
3	8	23
4	1	3
5	2	6
7	1	3

5.1.4 Work readiness definitions and terminology

Using the qualitative data analysis method of 'in vivo' coding (Saldana, 2014), 15 studies (42.8%) were identified and examined seeking perspectives on how WR was defined, and the terminology used. These studies all identified WR to varying degrees. The key statements reflecting this discussion can be found in Table 10 (p. 30). Of the 15 studies, five authors (El Haddad, 2016; Patterson et al., 2017; Shingler-Peters, 2016; Walker et al., 2015; Walker et al., 2013) used or examined the definition by Caballero et al. (2011); "The extent to which graduates possess the attributes that prepare them for success in the workplace" (p. 42). One study argued that WR has not yet been defined (Brown & Crookes, 2016).

WR was linked with 'competence' (Brown & Crookes, 2016; Clark & Holmes, 2007; Lofmark et al., 2006), 'fitness to practice' (El Haddad et al., 2017), and 'capability' (Rochester et al., 2005; Romyn et al., 2009). Two studies (Clark & Holmes, 2007; Romyn et al., 2009) referred to NGNs as being 'independent' and 'unsupervised' in practice. Wolfe et al. (2010b) described a transition process for the new graduate who can move seamlessly into practice. Those researchers working with Caballero et al.'s (2011) definition identified and linked WR with 'attributes' (El Haddad, 2016; Patterson et al., 2017; Shingler-Peters, 2016; Walker et al., 2015; Walker et al., 2013).

Table 10. Meaning of work readiness statements

Key statements relating to the meaning of work readiness	Author
The extent to which graduates possess the attributes that prepare them for success in the workplace. Multi-dimensional construct that extends beyond technical competence and clinical knowledge	Patterson et al., 2017; El Haddad, 2016; Shingler-Peters, 2016; Walker et al., 2015; Walker et al., 2013
Moving seamlessly into practice	Wolfe et al., 2010
Fitness to practice	El Haddad, 2017
Successful graduate practice is underpinned by the ability to integrate and consistently apply a number of capabilities	Rochester et al., 2005
Competence: ready to enter the nursing profession defined by … ability to perform nursing care through the integration of cognitive, affective and psychomotor skills	Lofmark et al., 2006
Qualified nurses are expected to be competent and able to practice independently without direct supervision	Clark & Holmes, 2007
Capable of competent, unsupervised nursing practice at the start of their career	Romyn et al., 2012
Generalist foundation and some job specific capabilities, providing safe client care, keeping up with the current realities of nursing practice, being well equipped with the tools needed to adapt to the future needs of clients and possessing a balance of doing, knowing, and thinking	Wolfe et al., 2010
Nurses in practice – "hit the ground running" Nurses in education – "beginning practitioner"	Greenwood, 2000
Work readiness linked to competence	Brown and Crookes, 2016

5.1.5 Elements of work readiness

All studies were examined to identify elements of WR. The Oxford Dictionary (2000) defines elements as "An essential or characteristic part of something abstract". Therefore, all parts or skills, competencies, attributes, capabilities were extracted. Thirty of the thirty-five articles (86%) had elements extracted.

Fifteen (50%) of the articles used a developed model, scale, or framework composed of varying numbers of WR items or elements. Of these, two studies were excluded as the tool being used had been further refined and validated (Patterson et al., 2017; Walker et al., 2013). Two other studies were eliminated as the tools used were replicated (Wolsky, 2014; Woods et al., 2015) and no new information from the studies emerged.

Of those 15 articles, whereby researchers were not using a tool, the authors concluded aspects of WR in terms of key issues. One study was reported in two publications (Brown & Crookes, 2016). One study combined a tool and other key issues (Shingler-Peters,

2016). All items or elements and key issues were extracted and listed verbatim. The final number of articles identifying elements of WR was 26. The 11 developed models, scales, and frameworks are listed below.

1. Nursing skills in the 'Evaluation of Graduates' questionnaire, with the addition of 'displays self-direction' (Walker & Bailey, 1999)
2. Adapted version of the Virginia Hospital Association Health Manpower Resource Centre. The survey composes 6 factors with 25 skills (Utley-Smith, 2004)
3. Professional capability scale with 38 items (Rochester et al., 2005)
4. Competence questionnaire based on an evaluation form used previously in clinical nursing education with 18 items (Lofmark et al., 2006)
5. New graduate nurse performance survey with 36 competencies divided into 6 categories (Berkow et al., 2009)
6. Clinical instructional experience questionnaire (Hickey, 2009)
7. Casey-Fink readiness for practice tool including 20 items (Casey et al., 2011)
8. Work Readiness scale with 4 categories and 46 items (Walker et al., 2015)
9. Eight key skill area model developed with 51 items; one skill area was preparedness to practice with 10 items (Missen et al., 2016)
10. Readiness of a Bachelor of Science Registered Nurse to Practice on Graduation Scale with 15 items AND Nursing Professional Behaviours/Competencies (Sub-scale [16 items] of the Self- Assessment Clinical Competence Questionnaire (Otoo, 2016)
11. Work readiness scale PLUS other key issues – see below (Shingler-Peters, 2016)

The key issues identified in the remaining 15 articles are now presented.

- "Critical thinking, problem-solving, reflection on practice, research, independent learning, using cultural safety knowledge" (Walker, 1998, p. 36)
- Lifelong learning, information management, research, decision-making, priority setting, critical analysis, judgement (Greenwood, 2000)
- Eager to learn, communication skills, flexible, determined, positive attitude, asks questions (Bork, 2003)
- Confidence, ability to transfer skills, knowledge underpinning actions (Clark & Holmes, 2007)

- Basic ICT skills and nursing software including: electronic documentation, medication control, patient records (Bembridge et al., 2010)
- Confidence in ability, clinical skills and underpinning knowledge, "working in a diverse and multi-cultural community, working with other professionals" (Holland et al., 2010, p. 464)
- "Generalist foundation and some job specific capabilities, providing safe client care, keeping up with current realities and future possibilities, …possessing a balance of doing, knowing, thinking" (Wolff, Regan, et al., 2010b, p. 1)
- Knowledge of the environment, knowing how and where to access clinical resources and information, understanding rules, hierarchy and place in the organisation (Watt & Pascoe, 2012)
- Time management, cope with shift work, clinical experience (Hegney et al., 2013)
- Research skills, IT skills, "pro-active and keen to learn and a strong theoretical knowledge base especially in anatomy and physiology" (Missen et al., 2015, p. 31), basic clinical skills, time management, medication administration, had experience at providing nursing care, communication skills (written and verbal), professional behaviour, critical thinking (Missen et al., 2015)
- Skills competence/clinical experience, self-directed ability, ability to ask questions, critical thinking, time management, delegation, priority setting (Diatta, 2015)
- "Communication and documentation, privacy and dignity, efficient and effective communication, professional nursing behaviours, includes collaborative approaches to care, medications and IV products, team working and multi-disciplinary team working, planning of nursing care, personal care—ability to assess, plan, implement and evaluate care of clients across a range of settings using a holistic, comprehensive nursing model, knowledge of key nursing implications of common medical/surgical patient presentations, cultural competence, clinical intervention; preparing, assisting after care (investigations /surgery/diagnostic), preventing risk and promoting safety—duty of care, clinical monitoring and management—use of assessment tools, therapeutic nursing behaviours/respectful of personal space, critical analysis and reflective thinking, dealing with emotional and bereaved people, learner/evidence based practitioner, demonstrates behaviour conducive to learning, promotes self-care, dementia related skills, learning and developmental culture—learning environment, mental health nursing care, coordinating skills regarding nursing process—uses a range of appropriate assessment strategies and skills across a

range of settings, understanding the different roles of RNs in different treatment or care settings, technology and informatics, demonstrates teaching/ educator skills, act as a resource, case manager, supervisory skills, leadership skills" (Brown & Crookes, 2016, p. 5)

- Organisation and time management, familiar with the organisation, keep calm, ask questions if unsure, knowledge and open to learn, sufficient confidence, self-efficacy, assertive, communication with patients, families and colleagues, able to get on/social skills, professionalism, life-long learning, recognise problems/prioritise and problem solve, be humble/learn from others/learn from mistakes, self-starters, manage a work load, manage the balance between patient want and need (Shingler-Peters, 2016)

- Challenging, varied and high-quality clinical practice experience (Freer & Penman, 2016)

- Professional enculturation: "critical thinker, reflective practitioner, life-long learner, good communicator, team player, and someone who is safe, caring [compassionate], and able to perform basic clinical skills" (El Haddad, 2016, p. 154). Contextual enculturation: knowledge of organisation, ward settings, procedures and ways of doings things (El Haddad, 2016)

Content analysis (Graneheim & Lundman, 2004) was used to further analyse the WR elements identified from the literature, the purpose being to establish a comprehensive list. Content analysis is usually "associated with the study of inscription contained in published reports, newspapers, adverts, books, web pages, journals and other forms of documentation" (Prior, 2014, p. 360). In this study, the focus was on manifest content (Graneheim & Lundman, 2004); capturing the actual words used in the identified WR elements as much as possible. It is not the role of the researcher using a Delphi methodology to determine the meaning of the data in the unit of analysis; rather, to present the data for others to judge. All WR elements were brought together and the number of similarities was established. Where actual duplication existed, only one version of the element was retained, and the remainder eliminated, leaving 201 elements.

5.1.6 Levels of new graduate performance

Using the qualitative data analysis method of 'in vivo' coding (Saldana, 2014), five studies were identified and examined seeking discussion on levels of performance (Brown & Crookes, 2016; Clark & Holmes, 2007; El Haddad, 2016; Greenwood, 2000; Walker, 1998). Clark and Holmes (2007) found no agreement on the level of skill

required. Although independent practice was expected of NGNs, a level of supervision was required. This may be due to a lack of confidence by the NGNs, as well as a lack of autonomy permitted by RNs. NGNs possessed beginning skills in applying theoretical knowledge but needed further development and intellectual effort within the clinical arena to develop these (Greenwood, 2000). It is unclear what these beginning skills are.

Walker and Bailey (1999) used a 4-point Likert scale (later reduced to 3) for graduates to judge the level of their expectations of 40 nursing skill elements within the Evaluation of Graduates adapted questionnaire. NGNs were surveyed at 3 and 7 months. The Likert scales were identified as:

- Requires frequent direction (eliminated in the analysis due to only one response in this category)
- Requires some direction
- Expected level
- Above expected level

For nursing skills across four categories (assessment and planning/teaching/client care/cognitive abilities), NGNs reported:

- Requires some direction (4-42% at 3 months; 7-29% at 7 months)
- Expected level (46-83% at 3 months; 57-86% at 7 months)
- Above expected level (0-25% at 3 months; 7-29% at 7 months)

For communication skills:

- Requires some direction (0-38% at 3 months; 0-14% at 7 months)
- Expected level (38-79% at 3 months; 57-93% at 7 months)
- Above expected level (4-25% at 3 months; 7-21% at 7 months)

For leadership skills across 2 categories (related to *client care*/unit management):

- Requires some direction (*0-25*/4-17% at 3 months; *7-21*/7-14% at 7 months)
- Expected level (*58–83*/21-62% at 3 months; *57-93*/14-71% at 7 months)
- Above expected level (*0-4*/0-4% at 3 months; *0-21*/0-7% at 7 months)

For professionalism:

- Requires some direction (0-12.5% at 3 months; 0-7% at 7 months)

- Expected level (67-92% at 3 months; 71-79% at 7 months)
- Above expected level (4-25% at 3 months; 21-29% at 7 months)

Brown and Crookes (2016) used modified Bondy criteria for classification of NGNs' performance across 30 competencies. Eight skills were judged at independent level, the level at which NGNs were considered to be competent. Independent refers to "being safe and knowledgeable; proficient and coordinated and appropriately confident and timely. Does not require supporting cues" (Brown & Crookes, 2016, p. 4-5). Fourteen skills were judged at supervised level which refers to "being safe and knowledgeable; efficient and coordinated; displays some confidence and undertakes activities within a reasonably timely manner. Requires occasional supporting cues" (Brown & Crookes, 2016, p. 3). The assisted level refers to "being safe and knowledgeable most of the time; skilful in parts however is inefficient with some skill areas and takes longer than would be expected to complete the task. Requires frequent verbal and some physical cues" (Brown & Crookes, 2016, p. 3) represented where seven skills were judged.

The final skill, that of 'Case Manager', was judged at marginal level and refers to "being safe when closely supervised and supported; unskilled and inefficient; uses excess energy and takes a prolonged time period. Continuous verbal and physical cues" (Brown & Crookes, 2016, p. 3). No skills were judged at the dependent level "concerns about being unsafe and being unable to demonstrate behaviour or articulate intention; lacking in confidence, coordination and efficiency. Continuous verbal and physical cues/ interventions necessary" (Brown & Crookes, p. 3).

Benner's 'novice to expert' framework was discussed in El Haddad's (2016) research. Participants suggested that NGNs, as beginning practitioners, could be described as novices within this framework. However, the novice or beginner

> has no experience in the situations in which they are expected to perform. The Novice lacks confidence to demonstrate safe practice and requires continual verbal and physical cues. Practice is within a prolonged time period and he/she is unable to use discretionary judgement. (Benner, 1984, p. 13)

These participants identified a low expectation of NGNs' performance. The second stage of Benner's framework reflects the expectation of other participants. The advanced beginner will

> demonstrate marginally acceptable performance because the nurse has had prior experience in actual situations. He/she is efficient and skilful in parts of the practice area, requiring occasional supportive cues. May/may not be within a delayed time period. Knowledge is developing. (Benner, 1984, p. 13)

The next stage of the framework that of the 'competent' nurse, requires two-three years of experience.

5.1.7 Consensus

All articles were analysed for commentary on consensus of WR; a level of agreement, or lack thereof, between nurses in education and practice. Fifteen (42.8%) documents were included, and data extraction used the 'in vivo' method (Saldana, 2014) to ensure the author's meaning was captured as close to the actual wording as possible. In a well-known and oft referenced scholarly article, Greenwood (2000) claimed "differences of opinion exist between nurses 'in service' and nurses 'in education' in all Westernised democracies with respect to their expectations of new graduate and diplomate Registered Nurses" (p. 17). Greenwood reported nurses in practice stating that NGNs are not adequately prepared for service provision in that they are deficient in numeracy, time management and prioritisation skills, critical thinking, clinical skills, and reporting (charting) ability. Further, they are unable to process medical instructions and consult appropriately with other nurses and doctors. RNs do, however, recognise new graduate skills in critical thinking (ironically), theoretical knowledge, holistic focus to care, and being research orientated. Service providers have clearly described new colleagues' competence level differently to those in education who claim to prepare beginning practitioners possessing critical reflection skills and whom are focussed on engaging in lifelong learning, skills that although valuable are not useful to "hit the ground running" (Greenwood, 2000, p. 21).

The literature reviewed, and data extracted, reports a level of consensus from nurses working across education and practice, albeit to varying levels (Bork, 2003; Brown, Crookes, & Iverson, 2015; El Haddad, 2016; El Haddad et al., 2013; Utley-Smith, 2004; Wolff, Pesut, et al., 2010; Wolsky, 2014). Bork (2003) reported a level of agreement between nurse educators, nurse managers, and NGNs on the importance of competencies but some significant differences emerged in what each thought the most important ones were. Nurse educators rated oral communication skills, cognitive function and psychosocial assessment, incorporating standards of care, developing plan of care, history and physical exam, evaluating and modifying care to meet outcomes. Nurse managers rated oral communication skills, history and physical exam, group communication skills, written communication skills, health promotion and risk reduction, multi-disciplinary team collaboration, interdisciplinary case management, clinical decision-making, and developing plans of care. However, NGNs rated prioritisation, nursing team work, education patient and family, multi-disciplinary team collaboration,

and patient advocacy as most important. All agreed that the most desirable personal characteristic was eagerness to learn, with nurse educators adding communication skills and flexibility. NGNs added determination and flexibility; whilst nurse managers identified determination, positive attitude, and asking questions.

This variance of opinion is also reported by Utley-Smith (2004), who found nurses in different clinical settings did not agree on rating of work ready elements. Nurses in disparate practice settings perceive WR from their own working perspective. Different perspectives were found to be shaped by individual education backgrounds, generational factors, and current practice environments (Greenwood, 2000; Wolff, Pesut, et al., 2010; Wolff, Regan, et al., 2010b). Likewise, the health and education worlds have different systems drivers and view WR through different lens (El Haddad, 2016). In this study, nurse managers expected desired graduate attributes to be fully developed when commencing employment while those in academia thought these could develop with time.

Disagreement was more evident when elements within concepts were examined (Wolff, Regan, et al., 2010b). Although a general consensus on the meaning of readiness to practice was found in four general categories in this study, disagreement was evident within three of these. Wolff et al.'s (2010b) concept of "having generalist foundation and some job-specific capabilities" (p. 6) revealed disagreement on whether or not NGNs were ready for specific jobs or nursing units; that after an orientation the NGN can work independently, not only in familiar situations but for some participants, also in specialty contexts. Whilst agreement was found with "keeping up with current realities and future possibilities" (Wolff, Regan, et al., 2010a, p. 7), that NGNs should be able to function in current realities and have the tools to adapt, less agreement was found on what counted as reasonable to expect of NGNs and their levels of performance. Some purported NGNs needed to "hit the floor running" (Wolff, Regan, et al., 2010a, p. 7) whilst others viewed NGNs providing care at only a beginning level. Finally, although agreeing in principle, the concept of "possessing a balance of doing, knowing and thinking" (Wolff, Regan, et al., 2010a, p. 9), there was little agreement on the distinction between foundation clinical skills and specific unit-level advanced skills required. All agreed the concept of being safe when delivering care, including the elements of having reasonable confidence and ability to provide ethical, caring practice, along with the ability to prioritise and organise work. Finally, all agreed that critical thinking, that is to say the ability to judge a client's health status and any changes, is a key component.

Similar findings were reported by Wolsky (2014), where overall rankings were similar between education and practice. Differences were generally minimal except for 3 of the 36 competencies. All agreed NGNs met the acceptable level of practice competency, but nurse educators had higher expectations regarding critical thinking (recognition of changes to patient status, recognition of unsafe practices) and professionalism (ability to accept constructive criticism) than those in practice. They also had higher expectations regarding communication (conflict resolution) and management of responsibilities (ability to organise and keep track of multiple responsibilities) than those in practice, whereas there were significantly lower expectations of technical skills (conducting patient assessments).

In contrast, Romyn et al. (2009) found consensus among NGNs, RNs, managers and educators, who all agreed that a crucial and problematic gap exists between being a student and beginning professional practice as an NGN. But they also questioned whether expectations of a NGN were realistic. Agreement was found on clinical experience and repetition of skills contributing to greater NGN confidence and supporting the development of critical thinking, because less anxiety is experienced with well-practised skill performance.

NGNs themselves perceive a higher level of competence in performing nursing care than their RN colleagues (Clark & Holmes, 2007; Lofmark et al., 2006) or their nurse managers (Clark & Holmes, 2007). However, Holland et al. (2010) found agreement that NGNs are generally fit for practice; they just lack confidence.

Wolff et al. (2010) identified the lack of an agreed set of foundation skills for NGNs. Then, in 2016, using a Delphi methodology, Brown and Crookes gained consensus on 30 most important skills NGNs need to perform in practice. However, they reported that 4 of the 30 skills areas could not be agreed upon in terms of the *level* of competence. In these skills areas, the NGN was judged not to be working independently; therefore, not competently, consequently supporting the perspective they are not work ready. Differences in opinion regarding working independently or needing supervision were found in the use of assessment tools and medication administration.

Finally, there appears to be a lack of consensus about whether or not NGNs should have pre-knowledge of the working environment linked to WR (El Haddad, 2016; El Haddad et al., 2017; Wolf et al., 2010). Learning about the organisation and specific unit area is debated as being important by those in practice, for example, NGNs should know specific surgeon's preferences. This is contradicted by those in education who assert this is

something learned post-employment; thereby furthering the lack of clarity about where the responsibility and accountability for nurse education lies. Those in practice expect a finished product while those in education produce a beginning practitioner who requires a transition process.

5.2 Reporting the results and producing the outcome that refers to the overall research question: what is known about work readiness of new graduate nurses?

This section overviews what is known about WR in relation to the research project. The majority of studies examined in this scoping review are Australian and published within the last seven years (Bembridge et al., 2010; Brown & Crookes, 2016; Brown et al., 2015; El Haddad, 2016; El Haddad et al., 2013; El Haddad et al., 2017; Freer & Penman, 2016; Hegney et al., 2013; Missen et al., 2015; Missen, McKenna, et al., 2018; Missen et al., 2016; Patterson et al., 2017; Walker et al., 2015; Walker et al., 2013; Watt & Pascoe, 2012; Woods et al., 2015), indicating a recent and increasing interest in the topic. This is significant in the NZ context because the two countries have a reciprocal agreement with respect to nurses' ability to register and practice in each country, under the Trans-Tasman Mutual Recognition Act (1997) (NCNZ, 2010). It suggests that the nursing education programme outcomes are interchangeable and recognised by both countries' regulatory bodies. Australian research on WR of NGNs is, therefore, pertinent to the NZ context.

The increased interest in WR is due to several educational outcome concerns. Nurses across the sector have different views and perceptions of WR (Bork, 2003; El Haddad, 2016; El Haddad et al., 2017; Wolff, Pesut, et al., 2010; Wolsky, 2014) underpinned by a view of a growing disconnect between education and practice (Romyn et al., 2009; Shingler-Peters, 2016); and indeed, between disparate practice settings (Utley-Smith, 2004). Contextual influences and varying organisational systems drivers (El Haddad, 2016) may be partly responsible for this disconnect. In a rapidly changing and complex health care environment (El Haddad et al., 2017; Wolff, Regan, et al., 2010b), there is little consensus on what competence (Utley-Smith, 2004), capabilities (Rochester et al., 2005), or attributes (El Haddad, 2016; Patterson et al., 2017; Shingler-Peters, 2016; Walker & Campbell, 2013; Walker et al., 2015) are required. It is not clear if the underpinning claims relate to the NGN requirement to be capable of adapting to unfamiliar circumstances and contexts, particularly given the view that NGNs should be able to work independently and unsupervised (Missen et al., 2016). The changing skill mix within the health care environment means NGNs may be required to care for more

complex and acutely ill clients (Wolff, Regan, et al., 2010b) giving rise to concerns that, without requisite skills (Otoo, 2016), patient outcomes may be impacted by a lack of preparation for practice (Diatta, 2015).

Few studies included a comprehensive range of nurse-sector participant groups (Brown & Crookes, 2016; Wolff, Regan, et al., 2010b); a finding that may be perpetuating the ongoing WR debate. Underpinning this debate is the requirement for articulating assumptions and determining clarity of terminology used. Attaining consensus means using an inclusive approach within the profession; providing an opportunity for all those nurses who have a vested interest in NGNs' WR.

Much of the literature reported findings undertaken within the acute care sector (Bork, 2003; Brown & Crookes, 2016; Brown et al., 2015; Casey et al., 2011; Clark & Holmes, 2007; Diatta, 2015; El Haddad, 2016; El Haddad et al., 2017; Hickey, 2009; Lofmark et al., 2006; Missen et al., 2015; Missen et al., 2016; Otoo, 2016; Patterson et al., 2017; Rochester et al., 2005; Shingler-Peters, 2016; Utley-Smith, 2004; Walker & Campbell, 2013; Walker et al., 2015; Walker, 1998; Walker & Bailey, 1999; Wolff, Pesut, et al., 2010; Wolff, Regan, et al., 2010b; Wolsky, 2014; Woods et al., 2015). Given that the NZ undergraduate nursing programme must prepare graduates to work across the sector—including primary, community, Māori health and aged care—these settings must be included in gaining WR consensus. This is particularly relevant given the Ministry of Health (2016b) refreshed strategy driving a vision for more preventive health care, and care in the community where increasing numbers of nurses are projected to be working.

The most common definition of WR alluded to in the literature refers to a series of studies culminating in the refinement and validation of a WR scale for NGNs (El Haddad, 2016; Patterson et al., 2017; Shingler-Peters, 2016; Walker et al., 2015; Walker et al., 2013). The scale bases WR on a definition as "the degree to which graduates possess the attitudes and attributes that prepare them for success in the work environment" (Caballero et al., 2011, p. 42). Yet, the meaning of 'attitude' is not explicated. 'Attitude' is defined by the Oxford Dictionary (2000) as a "settled way of thinking". Likewise, the term 'attributes' is not defined. The Oxford Dictionary (2000) defines an attribute as a "quality or feature regarded as a characteristic or inherent part of someone or something". In combining these terms with 'professional', which is associated with being an *expert* ("Oxford English Dictionary," 2000), a professional attitude suggests an *expert settled way of thinking* and a professional attribute *an expert quality*, and that these are required to 'succeed' in the workplace. That WR is explained as a multi-dimensional

construct and extends beyond discipline–specific competence demonstrates the complexity of the term WR and suggests that although a NGN may have met all requirements to attain registration with NCNZ, it does not assume WR.

A construct can be defined as "an abstraction or concept that is invented (constructed) by researchers based on inferences from human behaviour or human traits" (Polit & Beck, 2017, p. 723). The conceptual nature of the meaning of WR described here may not help those in practice and education. It is more likely to be the 'elements' – "an essential or characteristic part of something abstract" ("Oxford English Dictionary," 2000), a level more descriptive and meaningful and where consensus is more likely to be achieved.

Eleven tools, models, or frameworks (Berkow et al., 2009; Casey et al., 2011; Hickey, 2009; Lofmark et al., 2006; Missen et al., 2016; Otoo, 2016; Rochester et al., 2005; Shingler-Peters, 2016; Utley-Smith, 2004; Walker et al., 2015; Walker, 1998), with a further 15 studies (Bembridge et al., 2010; Bork, 2003; Brown & Crookes, 2016; Brown et al., 2015; Clark & Holmes, 2007; Diatta, 2015; El Haddad, 2016; Freer & Penman, 2016; Greenwood, 2000; Hegney et al., 2013; Holland et al., 2010; Missen et al., 2015; Shingler-Peters, 2016; Walker, 1998; Watt & Pascoe, 2012; Wolff, Regan, et al., 2010b) using qualitative methods have attempted to explore WR. The higher the conceptual level of WR discussion, the more consensus was found. Less consensus was found at the 'element' or 'item' level (Bork, 2003; Wolff, Regan, et al., 2010b; Wolsky, 2014). Consensus at conceptual level yet disparity of opinion at the elements level may reflect divergent perspectives of the meaning of different terminology. This highlights the importance of the careful use of language; conceptual language will mean different things for different nurses.

One's sense of self-efficacy can significantly impact on how one addresses goals, tasks, and challenges. There is a clear debate on the impact of confidence (Clark & Holmes, 2007; Lofmark et al., 2006; Romyn et al., 2009) on competence and, therefore, perception of WR. Nurses may be advantaged by having undertaken their final student transition placement in the work placement they have been employed as NGNs, and this placement could be viewed as an orientation, giving rise to increased confidence when employed as a RN.

There are questions being asked about the standard of performance or level of achievement that should be demonstrated by NGNs (Brown & Crookes, 2016; Clark & Holmes, 2007; El Haddad, 2016; Greenwood, 2000; Walker, 1998), what their practice

looks like when beginning practice and what needs post-employment support to develop. Three frameworks were identified—the Bondy (1983) scales measuring levels of competence, Benner's (1984) 'novice to expert' describing progressing proficiency of RN nursing practice, and a Likert-scale measurement (Walker & Bailey, 1999) ascertaining the level of direction NGNs required when first entering professional practice. These measures attempted to explicate NGNs' expectations of professional practice.

Walker and Bailey (1999) found that at both 3 and 7 months, the NGN required direction in assessment and planning, teaching, client care and cognitive abilities. Some aspects of communication skills, as well as leadership skills, with few aspects of professionalism also required supportive direction in clinical practice. There was evidence of inconsistency of NGNs practising independently.

Similarly, only eight skills were determined as being performed at the independent level (Bondy scale) in Brown and Crookes (2016) study. There is a need for clarity on what the NGN needs to be ready for (El Haddad et al., 2013; Wolff, Regan, et al., 2010b) or what successful NGN nursing practice looks like (Holland et al., 2010; Rochester et al., 2005).

5.3 Examine the meaning of the findings as they relate to the overall study purpose; discuss implications and present outcomes for the remainder of phase one and phase two of the research project.

One purpose of the scoping review was to use the literature to develop semi-structured questions for the focus group interview in phase one of the study. The literature review and extraction of data related to the identified variable 'the underpinning concerns or nature of the questions being asked of WR' provides an appropriate resource for construction of the semi-structured questionnaire. Ten questions were constructed from the analysis of the data, which resulted in the following six codes:

1. Nurses across the sector have different views, opinions, and perceptions of WR
2. There are disparate elements underpinning WR
3. Judging the standard of the elements of WR
4. Judging successful transition to the workplace
5. What are the graduates meant to be ready for?
6. WR known as other terms

The list of formulated questions from the analysis is presented in Table 11 (p. 43).

Table 11. Focus group questions

Focus Group Questions

1. How do you perceive the term 'work readiness'? [Overall perception]
2. Is this a view of your organisation/managers? [Whose perception?]
3. What are the attitudes, attributes and skills required? [Attributes]
4. How would you define that attribute/attitude/skill? Can you give an example? [The standard]
5. Who is responsible for judging that these attribute/attitude/skills meet the standard? [Where does the responsibility lie?]
6. How do you judge that a graduate nurse has successfully transitioned into the work environment? [What is 'success in the work environment'/]
7. What are the graduates are meant to be ready for?
8. What else is work readiness known as?
9. What criteria does your organisation use to recruit new graduates [Does the perspective match the practice]?
10. Are there any other comments or statements you would like to make? [Ensure all perspectives are captured]

Another purpose of the scoping review was to identify elements for the survey questionnaire for phase two of the research project to seek consensus of WR. The literature review and extraction of the data related to identified variable 'elements (an essential or characteristic part) of WR' provides an appropriate resource for construction of the survey questionnaire and initially identified 201 elements.

The literature has provided items for measuring the level of performance of NGNs. The questionnaire measuring scale included expectations of:

- Knowledge base
- Independent safe practice
- Level of appropriate confidence
- Proficiency (accomplished/well practised) in a timely manner
- Any further development requirement
- Level of direction and supporting cue requirement

At the fundamental core of the arguments, there appears to be two opposing perspectives based on the disparate outcomes of education and practice. Practice settings, although acknowledging the neophyte status of NGNs, need their new colleagues to practice in a manner that at least does not impose a burden and contributes to the workload; a workload that is increasingly complex. WR means being job ready; the NGN doing the job, in other words, expectation of a finished product.

However, education, although acknowledging the need for competent practice, sees the role of nurse education as preparing the NGN for entry to the profession. The acquisition of a range of higher order thinking skills, such as reflection and lifelong learning, as well as the 'soft' skills including communication and team work, means that NGNs are beginning their professional practice with a requirement for time and a transition process to complete the finished product (if this can ever be such an expectation).

It could be argued that there is insufficient time and meaningful, authentic clinical practice learning to serve both of these sectors in the current nursing education framework. The WR literature has provided evidence of a lack of consensus, shown a dearth of NZ research, demonstrated a lack of inclusive participation across the nursing sector, and that work readiness was the most commonly used term. This means that there needs to be some agreement or consensus on what the elements of WR are. Therefore, the justification for undertaking this research project includes:

- There is considerable interest in the topic of work readiness
- There is little consensus on what work readiness of the NGN looks like
- There is little NZ research on the topic
- There is no tool available to facilitate determination of the achievement of WR by the WITT BN MA programme

3. Summary

This chapter has presented the literature on WR, providing the background for, and supporting the significance of, this research project. Although there is little contemporary NZ literature, there is relevant international literature, particularly from Australia, to provide context for the study design. There is increasing interest in WR of NGNs, particularly given the changing health care environment and increasing complexity of health care. Given the lack of consensus on WR and the potential risk to patient outcomes, agreement on what constitutes WR between the different nurse sectors is imperative. In this way, nurses across the sector can begin to agree on the notion of WR and each play their part in ensuring new graduates are safe and effective to begin professional practice. The research methodology will be presented in Chapter 3, with a full description of the framework that connects the research question; first with the underpinning paradigm, then the methodological approach, associated methods of the inquiry including data analysis methods.

Chapter 3: Research Methodology

1. Introduction

This chapter presents an overview of the research methodology employed to answer the research question. The question sought to gain consensus on the elements of WR of NGNs in the NZ health care context. The research design provides a framework that connects the research question first with the underpinning paradigm, then the methodological approach, associated methods of the inquiry, as well as data analysis methods (Denzin & Lincoln, 2011). The literature review has situated the research question in the context of an international as well as national concern on WR of NGNs; not only whether or not NGNs are adequately prepared for professional practice but also the disparate views on what WR means. This lack of consensus may account for claims that NGNs are not always work ready.

The literature examined in Chapter 2, and in several NZ national reports described in Chapter 1, revealed that underpinning the debate was the lack of a cohesive agreement on the elements of WR and that it was timely to seek a consensus. The research question, therefore, needed further development to reflect a desire for consensus. After much deliberation it became: 'What are the elements of work readiness of new graduate nurses in the New Zealand health care context? A professional consensus'. A Delphi methodology was chosen for the purpose of gaining consensus. The rationale, underpinning paradigm informing the study, as well as the consonant methodology, methods, and tools are presented.

2. Research design rationale

The focus of the inquiry is agreement on WR of NGNs. There are several approaches that could be undertaken to contribute knowledge to this topic. Exploring the perceptions and views of nurses working across the sector through interviews or focus groups would provide useful information from a NZ perspective but may not assist with gaining a consensus. Given the current lack of consensus, it is appropriate to use a consensus–gaining methodology; the Delphi. The purpose of the Delphi methodology is to achieve a level of agreement from a group of experts on a particular issue. The Delphi is used when exploration, generation, and correlation of differing views is sought (Keeney et al., 2011). It is particularly appropriate to use the Delphi when the topic would benefit from establishing subjective statements made on a collective basis; that is, there is benefit to

having consensus on WR so that the profession can understand and support transition of NGNs to professional practice. The Delphi methodology is also useful when geographically diverse groups of participants are logistically challenged to attend a focus group or interview, disagreements would benefit from a facilitator, and when it is desirable to avoid domination of particular individuals or sectors of the profession (Green, Jones, Hughes, & Williams, 1999).

3. The study structure

The research study is based on the premise that all knowledge and understandings are socially constructed (Leavy, 2014). All participants in the study will have their own perspectives based on their own educational backgrounds, generational factors and work environment (Greenwood, 2000; Wolff, Pesut, et al., 2010; Wolff, Regan, et al., 2010b), contextual influences and varying organisational systems drivers (El Haddad, 2016). An overview of the key features of the research design (i.e., the paradigm, methodology, data collection methods and analysis tools) used to undertake this study is summarised in Table 12 (p. 47). Each feature is further discussed in the following section.

3.1 Paradigm

The initial step in designing a research project is to think theoretically; that is to say, give thought to the topic in a conceptual manner (Patterson & Krouse, 2016), fostering research integrity (Guzys, Dickson-Swift, Kenny, & Threlkeld, 2015) and consider how the research should proceed. The theoretical position can be viewed in terms of a paradigm; an overarching set of beliefs, regulation, or way of researching that guides "what can be known, who can be the knower and how we come to know" (Leavy, 2014, p. 3). There is debate about the underpinning theoretical basis of the Delphi methodology technique. As previously mentioned, a philosophical link has been made to the work of Locke (Mitroff & Turoff, 1975; Powell, 2003). However, others have proposed that the Delphi methodology emerged from a time when the importance of a theoretical basis or underpinning philosophy was less significant (Guzys et al., 2015).

Table 12. Research design key features

Framework feature	Description	Application to this study
Paradigm	This study is mostly informed by the interpretivist, particularly the social constructivism framework (Denzin & Lincoln, 2011); and constructionism epistemology (Crotty, 1998). However, there are elements identified within an objectivism lens (Keeney et al., 2011)	Knowledge is about establishing agreement on WR elements constructed from nurses' realities across the sector.
Methodology	A Delphi consensus research plan allows a dialectical process incorporating stages that inform each other and develop expert opinion that is more informed than current evidence (Keeney, Hasson, & McKenna, 2006).	The study combines literature review, interview data, and surveys to facilitate a consensus of the elements of WR within a NZ context.
Methods	1. Literature, using a scoping methodology and document review, as well as focus group interview. Gaining key informant perspectives engages the sector from the beginning, acknowledges their views as well as the literature rather than obliging them to accept the literature only (Keeney et al., 2011).	Analysis of the literature combined with in-depth information elicited from a group of nursing leaders who have an interest in and knowledge of the topic through their contribution to the development of the WITT undergraduate nursing programme.
	2. Multi-stage survey A series of survey questionnaires are developed and used, each one informing the next. A multi-stage survey design and follows a stipulated set of procedures (Powell, 2003).	The literature and key informant perspectives generate a set of items for the first questionnaire round of the Delphi survey. A second round is required to determine the consensus.
Data analysis	1. Frequency distributions reported as percentages. Qualitative content analysis techniques including 'in vivo' coding (Saldana, 2014) and to group statements into similar areas	1. Decisions made on whether collapsing statements changed the meaning (through changing the wording) of the participant views, ensuring that perspectives can be integrated with the literature.
	2. Descriptive statistics, specifically frequencies measured by percentages (Keeney et al., 2011).	2. Agreement on the elements of WR and level of performance expected of the NGN.

Given that the Delphi has not been well established with a specific theoretical framework (Guzys et al., 2015), others have attempted to retrospectively rationalise the issue with a view to increasing the rigour of the research. The Delphi methodology has been argued as sitting in both a positivist and an interpretivist paradigm, particularly a social constructivism framework (Green et al., 1999; Keeney et al., 2011). Considering that the findings of a Delphi are based on the constructed views of participants and that

perspectives may change following feedback, this research study can claim to align with a social constructivism paradigm (Hanafin, 2004), albeit collecting qualitative as well as quantitative data (Green et al., 1999). This type of research uses a quantitative approach to analysing qualitative data (James & Warren-Forward, 2015).

The argument for an underpinning constructivism stance postulating the interaction of the research participants in the convergence to consensus within a Delphi methodology, signifies a constructionism epistemology (Crotty, 1998). Through the use of WR language, participants are socially engaging, interacting, and constructing a new reality; it is a combination of their own knowledge and the social (language) interaction that develops this new knowledge (Neimeyer & Torres, 2015; Young & Collin, 2004). The WR knowledge being constructed is culturally and historically specific (Crotty, 1998; Neimeyer & Torres, 2015; Young & Collin, 2004). That is to say, nurses have their own frame of reference and language constituting WR, depending on their social, educational, and professional backgrounds (Wolff, Pesut, et al., 2010). We create our own reality through social networks, life experiences, and our relationships all interpreted in relation to feelings and understanding. Many realities co-exist; they can be multiple, are subjective, contextual, and can alter with societal changes and accompanying beliefs and attitudes. A Delphi methodology aims to capture these realities and work to achieve a shared view through reaching a consensus. The 'experts' identified within a Delphi approach will provide their own perspective on the problem being researched. Their views may change as they share ideas, stimulate thinking, and widen their knowledge (Powell, 2003); thereby changing their perspectives and the way they view the problem.

However, the Delphi can be argued to align with positivist principles (Keeney et al., 2011) whereby, in using a reductionist approach the experts achieve agreement on a single measured entity, that the single entity is discovered and represents one true reality (Polit & Beck, 2017).

One key question is who the knower can be (Leavy, 2014) and, in particular, what the relationship is between the researcher and what is to be known. The constructivism paradigm acknowledges the interaction between the researcher and that being researched. The findings are a creation of the interaction between the two (Polit & Beck, 2017) in order to understand the situation. However, the Delphi methodology is dependent on the knowledge of the expert panel. The researcher, although having a view, is not considered an expert on the panel and his/her influences on the findings should be minimalised. The role of the researcher is to facilitate the processes and not

to make judgements on the views of the participants and expert panel members (Jünger, Payne, Brine, Radbruch, & Brearley, 2017; Keeney et al., 2011). The epistemological position taken in the Delphi seeks to decrease the effects of personal bias (Grisham, 2009). Providing anonymity, in this context, means capturing all perspectives and opinions of the experts without interpersonal influences.

Herein lies a key aspect of the debate about the underpinning paradigm of the Delphi methodology. The notion that I must distance myself from the findings, as much as possible, contradicts the constructivism stance, and a claim may be made that it lays more favourably within the positivist paradigm. Nonetheless, the research is not seeking prediction or deduction. The subjectivity of the participants' reality does not fit well with reliability and validity criteria used within a positivist paradigm. Instead, trustworthiness criteria can be applied, substantiated by an accurate trail of theoretical and methodological decision-making (Skulmoski, Hartman, & Krahn, 2007). My researcher role of collation, deciding on and providing feedback, iteration, analysis, reiteration, and reanalysis results in construction of a consensus that is more informed and refined than that known before (Keeney et al., 2011) and thus is congruent with a constructionism epistemology and constructivism paradigm.

Despite this debate, a specific underpinning philosophy for the Delphi may not exist (Mitroff & Turoff, 2002). Furthermore, it may be argued that to insist on locating the methodology within one theoretical framework entirely is unproductive when trying to answer a research question (Wahyuni, 2012; Weaver & Olson, 2006), even though conventional wisdom would disagree (Houghton, Hunter, & Meske, 2012). Moreover, the knowledge construction may be limited by the top-down application of the beliefs or regulations of specific paradigms (Weaver & Olson, 2006). There may instead, be value in first determining the research question and framework (Wahyuni, 2012) and then clarifying the contribution of each paradigm utilised.

3.2 Methodology

A discussion of the methodology provides information about how I went about discovering what can be known. It provides a broad philosophical and theoretical underpinning including assumptions and principles (Grant & Giddings, 2002), relevance and logic, with a view to deciding methods to use. A Delphi methodology aims to gather a consensus of expert opinion that is more informed and developed than any previous creation (Keeney et al., 2001), and contributes to developing the knowledge base of the problem (Hasson et al., 2000). The technique was originally named, developed, and

used by the Rand Corporation in the US where they found that a more accurate business prediction could be made with consensus. The name Delphi comes from the Greek Delphi oracle, who had a network of informants and was consequently considered wise (Kennedy, 2004). There are no formally agreed or universal guidelines on its use, nor any standardisation of the methodology (Guzys et al., 2015; Wilkes, 2015); hence, the technique has become very flexible and used in different ways, leading to considerable debate on the methodological rigour (Green et al., 1999; Hasson et al., 2000; Keeney et al., 2011). However, a lack of standardisation can create flexibility and strength (Green et al., 1999) for the *bricoleur* to identify appropriate strategies to answer the research question.

Determining the elements of WR of NGNs in NZ requires an iterative multi-stage process across the profession to ensure heterogeneity. Nurses work across diverse clinical settings, including education, research, policy, professional and regulatory bodies. The constructivism paradigm sets the framework for using both qualitative and quantitative approaches, capturing the perspectives of a diverse population (Green et al., 1999), and is appropriate for this study.

Qualitative approaches uncover highly contextual data that may be interpreted differently. Qualitative information is carefully reasoned, described, and organised to uncover the experience of a particular group, not for the purpose of generalisation and prediction (Denzin & Lincoln, 1994). It is an inductive process interpreting a phenomenon grounded in participants' experiences. Deductive processes align with quantitative approaches whereby objective data is subjected to statistical methods (Polit & Beck, 2017). Numeric information is gathered from formal measurement of variables and used to make predictions in the world.

Linstone and Turoff's (1975) seminal Delphi work, purported that this approach is useful when there is a scarce body of knowledge on the topic; insufficient to undertake a scientific study and the research topic does not require precise analytical techniques. Since these early days of Delphi use, the methodology has diversified in its approach and been increasingly used within health care, despite a number of criticisms regarding its rigour (Keeney et al., 2011).

Due to the number of different forms of Delphi and continual modifications, the process of testing rigour is problematic. The design adopted is directed by the research question rather than the requirements of a methodology (Hasson & Keeney, 2011). For example, this study used a *modified* Delphi. The term 'modified' can mean different things,

50

including use of a focus group, interview, or literature review, questioning the legitimacy of comparison with other research (Jünger et al., 2017); yet, there are justifications for modifying the technique (Paré et al., 2013). The first Delphi round may generate unambiguous, broad statements which could establish bias from inception. Hence, to verify the content and face validity, the use of a *modified* Delphi is recommended. However, the researcher needs to understand the implications of modifying the approach in this manner (e.g., limiting available participant options) (Keeney et al., 2001). Furthermore, generalisability to different settings may be affected by bypassing the researcher's interpretation and categorisation of the first-round data, normally fed back to the experts to check their definitions are correct. Moreover, the classical Delphi is assumed to achieve construct validity because the parameters are established and validated by the items given by the experts.

The modification of the Delphi for this study takes two forms. First, techniques were utilised whereby the research participants were surveyed with a pre-determined list of items, developed from a small focus group and the literature, rather than creating the list themselves (McKenna, 1994). The literature review identified significant data on the elements of WR, but it was agreement on these elements that was lacking. In this study, the expert panel members also had data elicited from a focus group comprised of those who co-constructed the new WITT undergraduate nursing curriculum. Expert panellists, therefore, were less likely to feel pressured to alter views based on the literature alone, thereby reducing bias (Keeney et al., 2006). Moreover, the use of multiple data collection methods provides methodological triangulation (Denzin & Lincoln, 2011; Polit & Beck, 2017). More than one data source supports the context of the phenomena of WR, without over-reliance on just one source.

Second, the Delphi has been further modified for this study with the use of electronic communication rather than 'pen and paper'. Using online survey tools can be an efficient and effective method in consensus development (Holloway, 2012). Advantages include convenience, in that participants can receive and complete the survey at a time and place suitable for them; rapid and timely data collection; cost-effectiveness due to no requirement for paper supplies or postage; easier follow-up and reminder to participants (Rea & Parker, 2014); data analysis support, whereby software often has collation capability (Jones, Murphy, Edwards, & James, 2008); and ease of recruitment via email contact (Cantrell & Lupinacci, 2007). However, I was mindful of disadvantages, including a response rate that may be lower than that for mail questionnaires (Jones et al., 2008).

Thus, establishing strategies to achieve and maintain participation is crucial. These are discussed further below.

3.2.1 Establishing methodological rigour

Establishing methodological rigour has been described as "the holy grail of research" (Hasson & Keeney, 2011, p. 1695). Maximising integrity and producing dependable results is the cornerstone of good research. Traditionally, rigour is aligned with validity and reliability in the objectivism/positivist paradigm or quantitative approach whilst interpretive approaches and other forms of qualitative research are associated with attaining trustworthiness (Denzin & Lincoln, 2011). The debate about the Delphi methodology sitting between different paradigms gives rise to criticism of rigour, that transferring measures between the paradigms with different underpinning philosophies produces different types of knowledge (Hasson & Keeney, 2011) because one seeks prediction and the other to explore and understand situations.

So, which criteria should be adopted? Some early literature has focussed on demonstrating rigour from quantitative perspective with few giving credence to the qualitative paradigm (Hasson & Keeney, 2011). Day and Bobeva (2004) suggested that both perspectives should be applied. The Delphi methodological literature examined distinguishes four major issues relating to rigour: the panel, consensus, iteration, and attrition. The reliability/validity and trustworthiness issues, as well as the decision-making processes designed to enhance rigour (Diamond et al., 2014; Hasson et al., 2000; Jünger et al., 2017; Keeney et al., 2001; Paré et al., 2013; Skulmoski et al., 2007; Wilson, Koziol-McLain, Garrett, & Sharma, 2010), will now be presented.

i.   Expert panel: Identifying who the experts are, their level of 'expertise', what 'expertise' means and the selection/size of the expert panel

Determining the formation of the expert panel is considered the first stage of the research process and "the linchpin of the method" (Green et al., 1999, p. 200). Crucial to enhancing the stability of the data, a number of factors must be carefully reasoned. The first issue is clearly articulating 'expertise' (Baker, Lovell, & Harris, 2006; Hasson et al., 2000). The experts must have contemporary knowledge of the topic (Jairath & Weinstein, 1994) and be seen as experts (Trevelyan & Robinson, 2015; Walker, Barker, & Pearson, 2000). The word 'expert' is defined by the Oxford English Dictionary (2000) as "a person who is very knowledgeable about or skilful in a particular area". However, it may be beneficial to avoid labelling participants as 'experts' because there is debate about

further defining the 'expert' knowledge and skills (Trevelyan & Robinson, 2015). A professional qualification or experience does not guarantee expertise. In this study, the experts are, therefore, known as 'participants' and their 'expertise' is defined as those nurses who 'have a critical or vested interest in professional, beginning practitioner workforce performance when employing NGNs.

Identifying participants using pre-determined inclusion criteria and qualifications, such as education, profession, experience and employment (Foth et al., 2016; Jünger et al., 2017; Keeney et al., 2006), can support dependability. However, there are no guidelines for determining the qualifications of experts (Falzarano & Pinto, 2013; Keeney et al., 2006; Keeney et al., 2001; Okoli & Pawlowski, 2004; Paré et al., 2013; Worrell, Di Gangi, & Bush, 2013), raising issues regarding the level of 'evidence' produced (Foth et al., 2016; Keeney et al., 2001). Therefore, with a focus on the purpose of the study (Keeney et al., 2011), inclusion criteria were developed for this study and include:

- Participants being willing to participate, able to commit to two rounds of questionnaires, having access to a computer, computer literacy to complete online surveys, as well as having met one of the following criteria:
    o Responsible for undergraduate curriculum design
    o Responsible for undergraduate programme accreditation and monitoring
    o Responsible for employing/supporting NGNs
    o Responsible for examining/advising on professional/cultural nursing issues
    o Recent completion of the Nurse Entry to Practice (NEtP),
    o Recent completion of Nurse Entry to Specialty Practice (NEtSP)
    o Recent completion of Aged Residential Care Nurse Entry to Practice programmes (ARC NEtP)
    o Recent completion of one year of professional practice without a NEtP programme

Dependability can be achieved by encompassing both a range and representative sample of experts, either as homogenous or heterogeneous groups (Keeney et al., 2001). Representation of opinion is more important than representation for statistical purposes (Powell, 2003). However, because it is usual to use non-probability sampling, such as purposive sampling (Baker et al., 2006; Hardy et al., 2004; Rowe, Wright, & Bolger, 1991) or criterion sampling (Hasson et al., 2000), selection of the panel members (Foth et al., 2016) based on their knowledge of the topic may not be representative

(Falzarano & Pinto, 2013; Hasson et al., 2000). Participants who may be affected by the outcome may have increased interest and involvement. Balancing this with current knowledge and perspectives can be challenging. Participants need guidance to understand they must be relatively impartial and provide a true opinion, one that may or may not be evidence-based (Keeney et al., 2011) and this guidance was stipulated within the survey document. A Delphi does not provide right or wrong answers but a valid expert opinion at a fixed point in time.

A purposive sampling method, based on the aforementioned inclusion criteria, was used. Representativeness (Powell, 2003) was based on these criteria and aimed for a membership that represented the range of nurses working across the profession wherein the WR of NGNs is relevant. Given that there are over 50,000 nurses registered with NCNZ (2017), only a representative group, rather than all nurses, can be selected for the panel. Moreover, the fact that 50% of nurses now work outside the acute hospital settings (Ministry of Health, 2014b) provides rationale for selecting nurses working across both acute and primary care settings.

Participants in this study were identified to achieve professional heterogeneity across the country and comprised nurses from: NCNZ; primary, secondary, and community health care; tertiary education Schools of Nursing; NGNs, and nurses working in a regulatory and professional body capacity. Furthermore, to enable a bi-cultural approach, organisations with Māori kaupapa (e.g., Te Kaunihera o Ngā Neehi Māori – National Council of Māori Nurses) and primary health care organisations with a Māuri kaupapa or whānau ora model of care were included. A truly representative panel better supports the achievement of content validity (Goodman, 1987; Green et al., 1999).

Although there is no consensus on numbers of participants (Diamond et al., 2014; Hsu & Sandford, 2007; Keeney et al., 2006; Keeney et al., 2001), reliability is enhanced with larger panels. However, this can also result in greater variance, decreasing the level of accuracy and generalisability (Hasson & Keeney, 2011). Regardless of size, if the same information was given to two or more panels, there is no guarantee the same results would be obtained (Hasson et al., 2000; Keeney et al., 2001). Further impacting on reliability, there are expected changes to participant responses as rounds progress (Keeney et al., 2011). Moreover, personal and situational differences can also influence reliability (Hasson & Keeney, 2011); for example, the expert member's level of experience, qualifications, and extant knowledge of the topic. It is perhaps more realistic

to accept that the Delphi is a "snapshot of expert opinion in time" (Hasson & Keeney, 2011, p. 1701), rather than indisputable fact (Powell, 2003).

A small size may limit representation and a large size may limit response rates (Foth et al., 2016; Hsu & Sandford, 2007; Paré et al., 2013), impacting on stability of results. Fifteen to thirty-five participants is a common panel size (Rowe & Wright, 1999), though smaller (n=4) and much larger (n=over 1000) has been reported. There appears to be no rules on the number of participants, suffice to say that it is suggested that the more, the better (Keeney et al., 2011). However, managing a large number greater than 30 may be administratively challenging and impact on retention of participants. The size should be indicated through identifying how many varieties of expertise are required and balancing this with consideration of final numbers. Thus, participant selection is appropriate for the research question and to ensure inclusivity yet manageability. A total of 109 participants were identified for this study.

The Delphi provides evidence of external validity based on assumptions that results derive from group opinion, assumed to be more valid than a single person, and that expert opinion from the nursing world provides confirmatory judgements on the subject (Keeney et al., 2011). Generalisability of findings is influenced by the number of experts recruited and the level of expertise as well as agreement/consensus which the experts possess.

ii.   Consensus: definitions, levels, outcomes

The objective of this Delphi study was to co-construct and present a list of WR elements reflecting consensus of the participant group. There is confusion on the meaning of some of the terminology used in a Delphi study such as consensus, stability/reliability, and agreement (Trevelyan & Robinson, 2015). Reliability/stability is purported as measuring level of change between rounds (Murphy et al., 1998). Agreement measures the extent to which the experts agree with the statements, and consensus measures the extent to which experts agree with each other (Keeney et al., 2006). To support dependability, clarity about such measures is necessary. Diamond et al. (2014) also purported the requirement for explicit quality indicators such as the study objective, consensus definition, threshold values for stopping the study, and criteria for dropping items or retaining them when they fall below pre-set consensus level.

Consensus

The definition of consensus is critical to the rigour of Delphi research (Butterworth & Bishop, 1995; Falzarano & Pinto, 2013; Powell, 2003) and yet no established definition exists (Falzarano & Pinto, 2013; Foth et al., 2016; Hasson et al., 2000). Based on the aims and objectives of the study, the definition of consensus was developed as 'participant agreement with each other on elements of WR of NGNs'. Again, although there are no guidelines, the consensus level measure needs to be pre-determined (Falzarano & Pinto, 2013; Jünger et al., 2017), supporting transferability of findings because inappropriate measures produce non-valid results.

The literature describes two main methods for describing when this level of consensus has been reached. Measuring frequency by calculating percentages to establish majority agreement is common (McKenna, 1994; Wengstrom & Häggmark, 1998) but this method has previously been criticised (Dajani, Sincoff, & Talley, 1979). For some researchers, 60% (Donohoe & Needham, 2009) and 80% (Falzarano & Pinto, 2013) is sufficient; the stricter the level, the less consensus likely to be achieved. The second method involves employing descriptive and inferential statistics to measure consensus and convergence, such as measures of central tendency (median, mean), dispersion (interquartile range, standard deviation), and frequency distributions (frequency polygons, histograms) (von der Gracht, 2012).

In the first round of this study, consensus was measured by the participants' level of agreement with the closed-ended statements, providing data on how much the participants agreed with each other (Trevelyan & Robinson, 2015). Nominal measures, reported as percentages, were used in this study and the level of agreement was set at 80%. This level ensures that one nursing sector alone could not determine consensus, aiming to gain agreement across sectors. Participants were asked to first answer 'YES' or 'NO' to the statements, rating whether or not they agreed these elements composed WR. Despite frequent use (Beech, 1997; Gibson, 1998; Hasson et al., 2000; Kennedy, 2000; Pelletier, Duffield, & Adams, 1997), Likert scales were not used as I wanted to achieve definitive results, funnelling the result towards determining WR elements. I was, however, mindful of the possibility of inducing convergence (Linstone & Turoff, 1975).

It must be remembered that achieving consensus does not mean the right answer has necessarily been found (Keeney et al., 2011). It has been proposed that extreme or isolated views may be excluded; that this is reasonable to do so when striving for a consensus. However, opinions omitted due to not achieving the established threshold may reveal important perspectives that can challenge the validity of the result. All

elements not meeting the consensus level were examined for professional, cultural, or minority perspectives. Although support for a more robust consensus may be achieved by not reducing the number of statements before iteration (Greatorex & Dexter, 2000; Hasson et al., 2000), participants in this study only received feedback in the second round on those elements that did not achieve consensus in the first survey. This strategy aimed to maximise retention of participants for the second round.

Agreement

Where 'YES' was indicated, participants were then asked to judge the level of ability the NGN would be expected to demonstrate for each WR element. The level of agreement with the performance criteria was measured with percentages but there was no threshold consensus level determined. Participants were able to revise their judgements in the second round. The use of an adapted professional tool, reflecting nursing performance, enabled the participants to identify with, recognise their contributions, and glean meaning from the feedback (Okoli & Pawlowski, 2004; Rowe, Wright, & McColl, 2005); thus increasing the rigour of the iteration.

Level of change

Determination of an acceptable level of change between rounds (Crisp, Pelletier, & Duffield, 1997; Dajani et al., 1979; Duffield, 1993; von der Gracht, 2012) has been suggested as a more dependable measure than the level of consensus. This measure provides data about whether consensus existed throughout or whether it developed between rounds (Trevelyan & Robinson, 2015). Stability can be measured by including measures of dispersion (Fiander & Burns, 2000; Walters, 2009). Trevelynan and Robinson (2015) recommended providing interpretable data using medians and inter-quartile ranges (IQR) across the rounds. In this study, median measurement was not considered appropriate because of the minimal variation of scores with a two-option (YES/NO) response. With only two rounds being conducted, the level of change between the two survey rounds was measured with percentages.

iii. Iteration: number and purpose of rounds, when to stop

The multi-stage survey design follows a stipulated set of procedures (Powell, 2003). The structured questionnaires, commonly known as 'rounds', were sent to participants (Hasson et al., 2000) and separated by controlled feedback that sought to gain the most reliable consensus possible. The feedback is controlled in that the researcher decides what data and how feedback is provided (von der Gracht, 2012). The number of rounds

required (Falzarano & Pinto, 2013; Foth et al., 2016) and purpose of each round (Jünger et al., 2017) needs to be clarified. Two to three appear to be the most common (Foth et al., 2016), and it is considered usual for a minimum of two rounds to be required to instil confidence. However, occasionally, consensus can be found after one round (Keeney et al., 2011). Two rounds were conducted in this study. The purpose of the first round was to gain consensus on which elements were deemed to comprise WR and measure agreement on the level of performance for each of these elements. The purpose of the second round was for participants to review their perspectives in light of feedback from their colleagues. The Delphi contributes to concurrent validity due to successive rounds as participants have identified and agreed the components (Arthurs, 2015). Ongoing iteration and feedback given to the expert panel members can be viewed as participant confirmation, enhancing credibility of the study.

This study limited the rounds to two because it can be difficult to retain high response rate with many rounds (Keeney et al., 2001), and further rounds were limited by the timeframe of the Doctor of Health Science qualification. Maintaining interest so that all participants complete their commitments to the study further supports rigour. Normally, the number of rounds is determined by the ability to achieve consensus or 'until law of diminishing returns', whereby convergence is not achieved (McKenna, 1994). It also needs to be acknowledged that there may not be consensus on some things; this, in its own right, is equally important information for the topic being studied.

Internal validity can be influenced by the composition of the participant group. Where homogenous panels are employed, dominant thinking can result (Grisham, 2009). In this study, this potential band wagon effect was mitigated somewhat by establishing heterogeneous groups of participants; different nursing groups from across the sector.

Some participants may be swayed. However, subject bias may be eliminated because each participant's contribution is given equal weight and importance, further enhanced if anonymity is achieved. Open and truthful responses provide good data. However, it is not known whether participants change opinions based on new information or, despite anonymity, feel pressured to acquiesce to the group's view. Complete anonymity cannot be guaranteed when the researcher knows the experts and their responses (Keeney et al., 2001). Participants may also know each other, just not their responses; a situation known as 'quasi-anonymity' (McKenna, 1994). Further, anonymity can produce a lack of accountability for responses; thus, invalid responses may be made (Keeney et al., 2011). Anonymity is further discussed in the methods section below.

The timing of rounds can further impact on rigour; for example, where delays occur between rounds, sample attrition may result, reducing validity of consensus (Keeney et al., 2001). A turn-around time of two weeks was identified as ideal (Trevelyan & Robinson, 2015).

iv.   Attrition: maintaining participant interest, minimising attrition

The Delphi invites participants to commit time on more than one occasion to the study, asking more than a simple survey (Keeney et al., 2006). High drop-out rates have been reported (Fan & Yan, 2010) due to fatigue, distractions, disenchantment with the study (Donohoe & Needham, 2009), or the size of the questionnaire. A response rate of 70% across rounds has been suggested as the minimum to maintain rigour (Hasson et al., 2000). Supporting participation and good response rates increases validity of the results (Hasson et al., 2000), reduces sampling bias, and supports generalisability of findings. Those participants affected more by the study are more likely to become and remain involved, but they need to understand they must be relatively impartial and provide a valid opinion; one that may or may not be evidence-based (Keeney et al., 2011).

Strategies to maintain participation in this study included:

- Minimise time between rounds (Keeney et al., 2001) to retain interest
- Piloting the survey to ensure ease of use and clarity (Fan & Yan, 2010)
- Pre-notification of the study to stimulate interest (Keeney et al., 2006)
- Reminders if responses not received (Keeney et al., 2006)
- All information provided and any other opportunities, remind participants that their responses are important in contributing to the end result (Keeney et al., 2006) to encourage interest
- All information provided and any other opportunities, use language so participants feel like they are partners (Keeney et al., 2006)

v.   The use of 'pilots' to maximise robustness

Although the literature does not provide exact guidance on how often pilots within the study should be undertaken (Keeney et al., 2001), there is clear indication they should be considered to examine the effect on participants' judgements and to reduce bias. The range of pilot testing has been recommended for the instrument (Hasson et al., 2000; Jünger et al., 2017; Paré et al., 2013), checking for any ambiguity, the adequacy of recruitment strategy (Clibbens, Walters, & Baird, 2012), to check pre-set measures (Hardy et al., 2004; Mead & Mosely, 2001) ensuring meaningful statistical feedback to

experts, and to refine the definition of consensus (Boje & Murnighan, 1982; Dajani et al., 1979; Keeney et al., 2001; Rowe et al., 2005). A pre-test of the round one survey instructions and data collection instrument was undertaken with the phase one focus group informants.

The literature provides little guidance on exactly how to establish rigour in the Delphi because each study report describes different designs, sampling and consensus processes. Any process to establish rigour can be criticised, reflecting the debate on the flexibility of the methodology versus scientific robustness, and determining a position that the Delphi does "not offer indisputable facts and instead they offer a snapshot of expert opinion from that group at that particular time which can be used to inform thinking, practice or theory" (Hasson & Keeney, 2011, p. 1701).

The most well-planned Delphi may yield a comprehensive but not necessarily an all-inclusive set of ideas from participants. Comparison with relevant published literature, more inquiry or extra research to validate or refine the findings has, therefore, been proposed (Foth et al., 2016; Keeney et al., 2011; Kennedy, 2004). Findings have been verified with interviews undertaken before the Delphi process, focus groups, nominal group technique, narrative analysis, and surveys (Foth et al., 2016). Identifying interest groups and undertaking individual member interviews as a pilot or exploring the results with a different participant sample, particularly in various geographical locations, have also been utilised. However, the majority of Delphi rarely undertake additional research. In this study, the co-constructed WR framework from the Delphi research will be explored in relation to the BN MA programme (phase 3) with the nursing tutors who facilitate the teaching, learning, and assessment.

3.3 Methods and data analysis

3.3.1 Phase one

i. Literature review

A scoping review methodology (Arksey & O'Malley, 2005) was conducted to discern WR elements. I searched the literature widely, endeavouring to capture all that existed because, as previously stated, it would be the survey participants who decided what was important rather than me. The methodology and findings from the literature review were presented in Chapter 2.

ii. Focus group

Key informant perspectives were elicited through a focused group in-depth interview, also known as a focus group (Rea & Parker, 2014). The focus group was used as an information gathering technique (Polit & Hungler, 1999; Rea & Parker, 2014) and focussed on the topic of WR of NGNs. The informants were invited to articulate their perspective and perceptions of the concept of WR. I then acted as a moderator of the semi-structured round table discussion to maintain the focus to obtain a greater understanding of the topic (Rea & Parker, 2014). The focus group interview transcripts were analysed using the qualitative content analysis technique of 'in vivo coding', a technique deemed appropriate for assisting analysis. 'In vivo' essentially means "in that which is alive" (Saldana, 2014, p. 590) and signals the actual informant discourse.

The method and results can be found in Chapter 4. Phase one ethics approval can be found in Appendix A, the recruitment protocol in Appendix B, participant information sheet in Appendix C, the informant consent form in Appendix D and finally the research protocol in Appendix E.

3.3.2 Phase two - Round one survey

The multi-stage survey design follows a stipulated set of procedures (Powell, 2003). Phase one results were formed into a survey as structured closed-ended statements. Closed-ended statements were used to:

- Facilitate fixed answers of 'YES/NO,' to measure consensus; that is to say, measuring how much the participants agreed with each other. This scale limits irrelevant and large amounts of data (Rea & Parker, 2014) keeping the questionnaire manageable. The aim for the participants was to commit to agreeing whether the element was or was not an aspect of WR. The level of agreement was set at 80% ensure that one nursing sector alone could not determine consensus. The development of the survey is described in Chapter 4 and results are presented in Chapter 5.
- Judge the expected level of performance of the WR element using an adapted professional tool. The tool comprised five components for the participant: *Knowledge* (two levels), *Independence* (three levels), *Proficiency* (three levels), *Timeliness* (two levels) and *Confidence* (two levels). I measured the level of agreement, that is to say, to what level each participant agreed with each of the performance level components. No level of agreement was set. The development

of the round one survey, including the adapted professional tool and results, can be found in Chapter 4.

Survey results were analysed using descriptive statistics, specifically frequencies measured by percentages. Percentages have been rounded to the nearest 1%. The purpose of rounding is to remove the least significant digits, making it easier to interpret, yet keeping close to the original value (Moore et al., 2014). The methods and results can be found in Chapter 5. The phase two survey one AUTEC ethics approval can be found in Appendix F, the recruitment protocol in Appendix G, the participant information sheet in Appendix H and the first survey in Appendix I.

3.3.3 Phase two - Round two survey

Each participant received individual feedback on his/her own response and the group response for each of the close-ended statements that did not reach consensus in the first round. Participants were then invited to make a final judgement and, if they wished, to re-score considering group responses. It is at this stage that convergence towards consensus and agreement occurred (Powell, 2003). Survey results were analysed using descriptive statistics, specifically frequency measured by percentages. Iteration of the survey, analysis and results can be found in Chapter 5. The phase two, round two survey AUTEC approval letter can be found in Appendix J and the phase two, round two survey can be found in Appendix K. The WR consensus and agreement scores can be found in Appendix L and the WR framework in Appendix M.

3.3.4 Phase three

A focus group interview elicited key informant perspectives (Rea & Parker, 2014). The focus group was used as an information gathering technique (Polit & Hungler, 1999; Rea & Parker, 2014) and focussed on examining the WR framework. The informants comprised the WITT BN MA nursing tutors and they made judgements on whether each of the elements were 'taught', 'practised' by undergraduate nursing students, and 'assessed' within the programme. The informants were invited to articulate their perspective.

Survey results were analysed using descriptive statistics, specifically frequencies measured by percentages as well as the qualitative data analysis strategy of 'in vivo coding', developing categories (Graneheim & Lundman, 2004) and themes, all deemed appropriate for assisting analysis (Saldana, 2014). Further details of the analysis techniques and the focus group results can be found in Chapter 6. The phase three

AUTEC ethics approval can be found in Appendix N, the recruitment protocol in Appendix O, informant information sheet in Appendix P, consent form in Appendix Q and the research protocol in Appendix R.

4. Study phase summary

The research design comprised three phases; each phase informing the next as shown in Figure 2 (p. 63-65).

PHASE ONE

Purpose:

To generate and gather together all the pertinent information available

Objective:

To develop a framework of elements as a basis for the first round of the Delphi survey

Participants:

Key Informants identified as those nursing leaders who have contributed to the development of the WITT undergraduate programme development

Methods:

Data collection

✓ Literature review
✓ Key informant survey

Data analysis

✓ Descriptive statistics
✓ Qualitative content analysis

PHASE TWO

Purpose:

To co-construct a consensus framework of elements of WR of NGNs in NZ

Objective:

To use the survey questionnaire from the previous analysis and identify the construct elements of WR

Participants:

The group of nurses identified from practice, education, professional and regulatory bodies

Methods:

Data collection

✓ Online survey

Data analysis

✓ Descriptive statistics

PHASE THREE

Purpose:

To explore the WR framework in relation to the WITT BN 'MA' programme

Objective:

To determine whether the WR elements are 'taught', 'practised' by undergraduate nursing students, and 'assessed' in the WITT BN 'MA' programme

Participants:

Tutors teaching on the WITT BN 'MA' programme

Methods:

Data collection

✓ Focus group interview

Data analysis

✓ Descriptive statistics
✓ Thematic analysis

Figure 2. Study phases

The purpose of phase one was to generate and gather together all the pertinent information available (Keeney et al., 2011). This included a literature review and professional document examination, as well as results from a focus group interview of

key informant perspectives. Modifying the Delphi to pre-establish the questionnaire elements in this way meant that the participants in the second phase start with a common base (Keeney et al., 2011); a base whereby participants were not forced to agree just with the literature, thereby reducing bias (Keeney et al., 2006). The objective for phase one was to develop a framework of WR elements to inform the first questionnaire round of the Delphi study. The details are presented in Chapter 4.

The purpose of phase two was to co-construct an initial consensus framework of elements of WR of NGNs in NZ. The objectives included developing a survey questionnaire from the previous analysis and identifying the construct elements of WR. The questionnaire used an online survey in two rounds to attain consensus. The Delphi technique provides a framework for establishing the expert panel membership, the level of consensus, and analysis techniques (Keeney et al., 2011) and can be found in Chapter 5.

The resulting co-constructed consensus of the WR construct was then explored in relation to the WITT BN MA model in phase three. The objective of phase three was to determine whether the WR elements are 'taught', 'practised' by undergraduate nursing students, and 'assessed' in the WITT BN MA programme. A focus group was used as an information gathering technique (Polit & Hungler, 1999; Rea & Parker, 2014) whereby the tutors teaching on the programme examined and then made judgement on these elements. This is discussed in Chapter 6.

5. Ethical considerations

This study required, conformed to, and received approval from the AUT Ethics Committee (AUTEC) for each phase of the project. The AUTEC approval numbers are 16/116, 18/73 and 19/90. The approval letters are attached as Appendices A, E and L. As each phase of the study informed the next, all three phases required separate approval. Starting with phase one approval, phase two approval was obtained once the elements for the survey questionnaire were identified from phase one. Phase three approval was achieved for the final focus group exploring the co-constructed WR framework in relation to the BN MA programme.

As a RN, I am also bound by the NCNZ Code of Conduct in my role as a primary researcher. Specific ethical considerations for the Delphi technique have not been identified in the literature (Keeney et al., 2011). Therefore, the following general

principles, based on respect for human dignity, justice, beneficence, and non-maleficence (Keeney et al., 2011) were applied to carefully consider and meet my ethical obligations.

5.1 Indigenous relationships

Using the principles of a bicultural approach, as well as adequate heterogeneity, steps have been taken to ensure Māori participation. A kaupapa Māori framework creates conditions for self-determination in that the community should benefit from the research which in turn should represent their own voices (Smith, 2018). As a RN, I am currently deemed competent to practice as a nurse within my scope of practice. This includes practising as a researcher in a manner that is culturally safe and applying the principles of Te Tiriti o Waitangi (NCNZ, 2011b).

Participation in this research study has ensured Māori voices are heard. Participation is one way of establishing the Māori view, but data analysis must also be employed in such a way that these perspectives are not marginalised. There are implications for determining the level of consensus in a Delphi study. All elements not meeting the consensus level were examined for cultural or minority perspectives and elements not achieving consensus remained in the questionnaire for phase two, round two, whereby participants were given the opportunity to further consider and reflect on their responses (Green et al., 1999; Trevelyan & Robinson, 2015).

5.2 Informed consent

Respect for human dignity underpins the right for choice in participation (Denzin & Lincoln, 2011; Keeney et al., 2011). The nursing sector was informed of the study at a strategic level with a letter addressed to the National Nursing Organisation, raising awareness of the project. Participants were then identified by health care organisation nursing leaders across the sector and for new graduate participation by advertising in local professional journals. Participants have the right to be fully informed on the nature and potential consequences of the study. This was outlined in information sheets giving sufficient information and enabling an informed decision. Participation was entirely voluntary and not influenced by rewards or coercion (Denzin & Lincoln, 2011). Participants were asked to carefully consider all the information before completing the survey, as in completing the phase two survey, consent was assumed. Withdrawal at any time, without any redress or consequences, was assured and potential participants were informed of this. In phase two, participants were informed of the commitment to two

survey rounds. No deception was employed in this study. Phase one and three informants were asked to sign a consent form (see Appendices D and O).

5.3 Privacy and confidentiality

Safeguards must be put in place to protect participant identity (Denzin & Lincoln, 2011). Confidentiality means that the study results in the public domain cannot be linked back to a particular participant (Polit & Hungler, 1999). In phases one and three, participants were asked to keep the identity of fellow participants, the discussions, and information elicited in the focus group confidential to the group.

In phase two, although the participants were not known to one another, in such a small professional community and country such as NZ, where professionals know each other and meet on different occasions for varying reasons, confidentiality can be a minimal weakness. However, although phase two participants may be known to each other, their responses would not be. Panel members were assured that their responses and judgements would remain confidential. Confidentiality issues were outlined in the information sheets for each phase of the study (see Appendices C, G and N).

Phases one and three consent forms and digital recordings have been stored separately and in locked cabinets in the Faculty of Health and Environmental Science at AUT for a period of six years, following which the consent forms will be shredded and the digital recordings, stored on a password protected USB, will be deleted. Phase two survey data has been securely stored in the Faculty of Health and Environmental Science at AUT for a period of six years, following which the digital recording, stored on a password protected USB, will be deleted. Participants were informed of this in the information sheets.

5.4 Anonymity

Anonymity protects the participant in that the researcher is unable to link the participant to their responses (Polit & Beck, 2017). However, in this study, full anonymity could not be guaranteed because participants were known to me and may have been known to each other due to the nature of the small community as discussed above. This type of anonymity is known as quasi-anonymity (McKenna, 1994). Phase one and three informants were directly known to me, these are nurses who I have worked with. Online responses were employed in phase two and a response rate was set; thus, I knew who had responded. I needed to know who had and had not responded to the request to complete the survey so that follow-up reminders could be made to non-responders.

Participants also received individual feedback between survey rounds so that they could view their own responses in light of the rest of the participant group. However, participants were assured that their responses and judgements would remain anonymous to the extent that they would only be known to myself and my supervisor. Anonymity issues were also outlined in the information sheet.

5.5 Principles of beneficence and non-maleficence

Establishing beneficial outcomes to the researcher, the participants, and the professional and wider community required me to act with integrity at all times (Keeney et al., 2011) and, above all else, do no harm. It was not anticipated that participants would experience any discomfort because of agreeing to participate in the study. Further, no deception was used. Participants were informed of the benefits of the research, including that the results of the data collection and analysis form part of the required fulfilment of the Doctor of Health Science. Research article publication, conference presentation, professional projects, and ongoing research studies may also be achieved as outcomes of the research project.

6. Summary

This chapter presented an overview of the research methodology employed to answer the research question. The question sought to gain consensus on the elements of WR of NGNs in the NZ health care context. The lack of current consensus provided rationale for use of a consensus-gaining methodology; the Delphi. The purpose of the Delphi methodology is to achieve a level of agreement from a group of experts on a particular issue where none previously existed. The research design provides a framework that connects the research question first, with the underpinning paradigm, then the methodological approach, associated methods of the inquiry, as well as data analysis methods. Both the constructivism and positivist paradigms, as well as constructionism principles, contribute to the Delphi, a methodology that does not provide right or wrong answers but a valid expert opinion and one that is more informed than currently known. Discussion of rigour considered and used the different paradigm perspectives. The topic has benefitted from exploration, generation, and correlation of differing views; that is, there is benefit to having consensus on WR so that the profession can understand and support transition of NGNs to professional practice.

The next chapter will present the phase one focus group method and results. The data collection, decision-making, and analysis processes are explained. How the results were

melded with the literature, described in Chapter 2, to create the first-round survey is described.

Chapter 4 Phase One

1. Introduction

Chapter 3 described the research methodology of the study. Three phases were outlined. This chapter presents phase one of the research project. The purpose of phase one was to generate and gather all the pertinent information available regarding WR of NGNs (Keeney et al., 2011). An overview of phase one can be found in Figure 3.

PHASE ONE

Purpose:

To generate and gather all the pertinent information available

Objective:

To develop a framework of elements as a basis for the first round of the Delphi survey

Participants:

Key Informants identified as those nursing leaders who have contributed to the development of the WITT BN 'MA' programme development

Methods:

Data collection

✓ Literature review
✓ Key informant survey

Data analysis

✓ Descriptive statistics
✓ Qualitative content analysis

Figure 3. Outline of phase one

The objective for phase one was to develop a framework of WR elements as a basis for the first round of the Delphi survey. Constructing the framework was undertaken in three steps. First, the literature review, using a scoping methodology elicited:

1. A set of indicative questions for the selected informants in a focus group interview
2. A set of WR elements

Results of the literature scoping review can be found in Chapter 2. The second part in constructing the framework pertained to the focus group interview. Details of the data collection, decision-making and analysis process, and results can be found in the next section of this chapter. Finally, the first round Delphi survey was shaped from merging the WR elements identified from the literature and the codes analysed from the focus group interview. The details of establishing the WR elements for the construction of the survey can be found in the 'survey tool development' section below.

2.　Key Informant focus group

2.1 Data collection

To meet the objectives of the first phase, the key informants were defined as those regional nursing leaders who have contributed to the development of the WITT BN MA nursing programme. Although, this group of nurses are localised to one NZ region, they have had the opportunity to examine WR from a curriculum development perspective and their views will be presented to their national colleagues along with the literature findings in phase 2. The research project participants are known as informants in this phase of the study. Informants, is an anthropological term used to elicit information on the cultural norms of a particular group; in other words the researcher is being instructed on what is happening (Morse, 1991). This notion fits with the Delphi methodology because the researcher, although having a view, is not considered the expert (Jünger et al., 2017; Keeney et al., 2011).

The nursing degree was developed using a partnership approach between the polytechnic and the region's nursing leaders, where good faith prevailed. Nursing leaders continue to act as stakeholders and in an advisory capacity with the WITT School of Nursing, particularly in the ongoing evaluation of the programme. The informants have a vested interest because they employ the BN programme NGNs. These nursing leaders were purposively selected and invited to participate first by email along with an information sheet, then by telephone if a response was not received within 10 working days. The recruitment protocol can be found in Appendix B.

Ethical approval was received from AUTEC (see Appendix A). Eight eligible informants were identified. Nursing leaders representing tangata whenua, local iwi, included in the curriculum development, ongoing stakeholder and advisory roles, were invited to participate in the focus group. All informants expressed an interest in participating but only seven of the eight could attend.

2.2 Key informant consent, confidentiality and anonymity

Participation was voluntary, and informants received an information sheet (found in Appendix C) and signed a consent form (found in Appendix D). The informants' perspectives and discussion in the focus group were digitally recorded. The recording remained confidential (i.e., the information is not able to be publicly linked to the individual informants). Informants were asked to keep the identity of fellow colleagues, the discussions and information elicited in the focus group confidential to the group. This was stated in the information sheet and consent form. Furthermore, the content analysis did not identify informants and so their links with public information is confidential.

2.3 The focus group interview

Key informant perspectives were elicited through a focused group in-depth interview, also known as a focus group (Rea & Parker, 2014). The focus group was used as an information gathering technique (Polit & Hungler, 1999; Rea & Parker, 2014) and focussed on the topic of WR of NGNs. The informants were invited to articulate their perspective and perceptions of the concept of WR, structured around a set of indicative questions (see Appendix E for the Research Protocol). As the primary researcher, I acted as a moderator of the semi-structured round table discussion and maintained the focus to obtain a greater understanding of the topic (Rea & Parker, 2014). The set of indicative questions constructed from the literature search findings and used in the interview can be found in Table 13.

Table 13. Interview questions

Phase One - Focus group interview questions
• How do you perceive the term 'work readiness'? [Overall perception]
• Is this a view of your organisation/managers? [Whose perception?]
• What are the attitudes, attributes, and skills required? [Attributes]
• How would you define that attribute/attitude/skill? Can you give an example? [The standard]
• Who is responsible for judging that these attributes/attitudes/skills meet the standard? [Where does the responsibility lie?]
• How do you judge that a graduate nurse has successfully transitioned into the work environment? [What is 'success in the work environment'/]
• What are the graduates meant to be ready for?
• What else is work readiness known as?
• What criteria does your organisation use to recruit new graduates [Does the perspective match the practice]?
• Are there any other comments or statements you would like to make? [Ensure all perspectives are captured]

2.4 Data analysis

2.4.1 Data analysis challenges

Any qualitative content analysis technique can be used in the first phase of a Delphi study (Keeney et al., 2011). However, given that the literature review found a lack of consensus, possibly due to different understanding of the terminology used, keeping the analysis simple to ensure the informant's own words were not lost was imperative (Keeney et al., 2011). There certainly must not be any change in meaning because this will only add to the lack of agreement. There were opportunities for some collapsing of statements but, where unique statements emerged, these were retained. There is potential for researcher bias because judgements were made on similarities of statements but, even when they appeared similar, it was sometimes difficult to know whether they should be combined (Green et al., 1999). Whenever faced with these decisions, I opted for an inclusive approach and ensured the informants' statements remained in their raw state because it would be the participants in the second phase of the research study who determined the relevance of the statements.

2.4.2 Data analysis method

The focus group took 70 minutes and I transcribed the digital recording verbatim. Analysis was undertaken in two stages. In stage one, the text was carefully read and 'filler' words and expressions such as 'um' or 'you know' were greyed out to allow me to focus on the key informant perspectives. I also removed the names when the informants were addressing each other. This was an attempt to increase the focus on what was being said rather than being distracted by who said it.

In the second stage, the qualitative data analysis strategy of 'in vivo coding' was deemed appropriate for assisting analysis. Words or phrases standing out in the text, extracted directly from the transcript, become codes as they appear to me as significant. Most code phrases kept the same wording but were sometimes altered to ensure the informant's meaning was shown. The resulting 77 codes can be found in Table 14 (p. 74-75).

Table 14. Focus group codes

Focus group codes

1. Good undergraduate programme grades
2. Good undergraduate clinical references
3. Experience in the/similar setting as an undergraduate transition student
4. Very nice person
5. Passionate
6. Mature
7. Has personal attributes, values and guiding principles that fit the ward area
8. Understands the health care system, social determinants of health, inequities and inequalities
9. Able to work across primary and secondary settings
10. Understands and able to work in different health care models
11. Willingness to work in the setting
12. Mature and willing to work holistically and person-centred (not just the illness), including providing preventative and mental health in same setting
13. Knows where health care is heading in the future with changing models of care
14. Pick up full workload after orientation
15. Has basic knowledge and skills to work independently with lower acuity patients
16. Know the role and scope
17. Know the purpose of, care delivery model and be familiar with the setting
18. Know how you and your role fit into the bigger health care system
19. Has a concept and understanding of service; puts others before self
20. Confidence
21. Empowered
22. Think like, act like and be a nurse
23. Know about and how to work within professional boundaries
24. Know about and how to work to the code of conduct
25. Has a high ethical outlook
26. Understand social media risk
27. Able to use the competencies to demonstrate practice
28. Willingly and actively seek and ask about clinical practices
29. Knowledge of and able to use technology in health
30. Used to shift work
31. Punctual
32. Loyalty
33. Learns from RN role-modelling to understand how an RN thinks, behaves and acts
34. Knowing what is expected of them
35. Have fundamental clinical knowledge (recognise a fall is a sign of unwellness) from practising so they are capable of what they are doing
36. Running a shift
37. Medication management
38. Assessments
39. Always thinking about patient outcomes
40. Critical thinking - recognise early something is abnormal to what they expected and get it corrected
41. Focussed
42. Organised
43. Time management
44. Know when to call for help
45. Make safe decisions
46. Willing and able to use collegial support to critically think and make decisions, protecting self as a neophyte
47. Recognise early something is abnormal to what they expected and get it corrected
48. Understand that personal values will shape their decision-making
49. Knowledge of Māori health
50. Knowledge of tikanga
51. Te reo pronunciation
52. Local iwi knowledge

53. Willingness to learn more cultural knowledge
54. Willingness to participate and embrace indigenous models for better health outcomes
55. Willingness to take responsibility to change health outcomes
56. Understands that cultural care is part of clinical health care
57. Challenging your own personal values
58. Willing to make changes
59. Establishing and maintaining relationships (sometimes long-term)
60. Understanding generational differences
61. Willing to work in a team at different levels and different people (including patients, sometimes challenging patients)
62. Knowing where you fit / team-fit
63. Managing interpersonal relationships (preceptor/mentor/buddy/colleague)
64. Not take days off at the drop of a hat
65. Mental toughness
66. Staying power
67. Need to get along
68. Willingness to commit to the practice setting
69. Adaptable
70. Personal growth
71. Calm not panic
72. Manage unregulated workforce
73. Understand legislation and regulation
74. Go looking for how to do things
75. Continue to learn
76. Understand that the learning is progressive
77. Self-awareness and responsible to self-teach, self-learn, self-assess

2.4.3 Establishing trustworthiness

Text can always be interpreted in different ways and divergent meanings elicited (Leavy, 2014). These issues are central to establishing trustworthiness of the study. Trustworthiness is commonly used within the qualitative tradition to achieve as reliable findings as possible (Denzin & Lincoln, 2011). Credibility, dependability, and transferability are concepts that have been used to describe trustworthiness (Polit & Beck, 2017); although the boundaries of these aspects may be blurred and intermingled (Graneheim & Lundman, 2004).

i. Credibility

The credibility of the findings of the focus group interview and subsequent analysis can be found with the level of confidence in the decisions I made (Leavy, 2014; Polit & Beck, 2017). The decisions for this phase of the research project are now presented.

- The participants: selecting a variety of informants captured and provided an array of responses on the study question. In this study, the seven informants, although having a common background in their involvement in curriculum development, all came from different clinical backgrounds. This included DHB Nurse Leader, DHB

Nurse Leader in community services, Māori health, child health, occupational health, mental health and residential care. The nursing leader unable to attend represented primary health care.

- Data collection approach: determining and selecting the most appropriate approach adds credibility. In this study a focus group was deemed most appropriate as an information gathering technique (Polit & Hungler, 1999; Rea & Parker, 2014). Using this approach engaged the sector from the beginning, and acknowledged their perspective alongside the literature rather than forcing them to accept the literature, an approach that can reduce potential bias (Keeney et al., 2006).

- The amount of data generated: depending on the complexity of the topic and the quality of the data, findings are evaluated in terms of credibility. This first phase had a single focus; that of 'work readiness', and so the complexity was reduced. As primary researcher, I acted as a moderator of the semi-structured round table discussion and aimed to maintain the informants' focus (Rea & Parker, 2014).

- Analysis process and suitable codes: the aim was to achieve greater credibility through ensuring no relevant data was excluded nor irrelevant data included, and then carefully ascertaining appropriate codes (Saldana, 2014). Data were retained as close as possible to the informants' language, ensuring that the meaning of the text was not lost. In vivo coding ensured the data are presented to the phase two participants for judging.

ii.   Dependability

Dependability refers to the stability of data or how much data changes over time and any changes I made in decisions during the analysis process (Polit & Beck, 2017). In this study, there was only one interview comprising 10 semi-structured questions with resultant data collected in 70 minutes. This reduced the risk of any significant data change over time. Further, as primary researcher, I created a decision trail, closely monitored by my supervisor, who also oversaw the analysis process.

iii.   Transferability

Transferability alludes to the degree to which the findings can be transferred to another group (Denzin & Lincoln, 2011; Polit & Beck, 2017). If a different group of nurse leaders were asked the same questions, it is likely that there would be some different responses. However, the informants' responses largely reflected what was found in the literature with a few exceptions, such as Māori cultural knowledge.

3. Survey tool development

Merging the 201 WR elements identified from the literature (see Chapter 2) and the 77 WR elements from the focus group responses (see Table 14) established a base for the construction of the round one survey for phase two of the research project.

The majority of the focus group codes reflected the literature findings. The unique contributions included:

- Good undergraduate programme grades
- Good undergraduate clinical references
- Experience in the/similar setting as an undergraduate transition student
- Social determinants of health, inequities and inequalities
- Holistic and person-centred care (not just the illness), including providing preventative and mental health in same setting
- Concept and understanding of service; puts others before self
- Think like, act like and be a nurse
- Understand that personal values will shape their decision-making
- Challenging your own personal values
- Understanding generational differences
- Knowledge of Māori health
- Knowledge of tikanga
- Te reo pronunciation
- Local iwi knowledge
- Willingness to learn more cultural knowledge
- Willingness to participate and embrace indigenous models for better health outcomes
- Willingness to take responsibility to change health outcomes
- Understands that cultural care is part of clinical health care

The co-construction of the survey is now described.

3.1 The work readiness elements

The first part of the survey co-construction concerned the WR elements. The focus group results yielded 77 WR elements which were amalgamated with the 201 elements from the literature, totalling 278 raw elements. Long questionnaires may disincline interest

and engender participant reluctance to complete the survey, ergo risking response rates (Keeney et al., 2011; Rea & Parker, 2014). The questionnaire needed to be as concise as possible whilst still including all relevant components (Rea & Parker, 2014). Several steps were, therefore, undertaken to prepare the final list of work readiness elements ready for the phase two participants to judge:

1. All elements were brought together, and the number of similarities was established. Where actual duplication existed, only one version of the element was retained; the remainder eliminated.

2. Slang and colloquialisms identified were altered to reflect professional language (e.g., 'not take days off at the drop of a hat' became 'does not take days off ad hoc').

3. Codes were examined to ensure presence of a single element for participant judging, focusing their opinions on only one aspect rather than being unsure on the nature of their judgement. Where a code manifested more than one element, it was split into separate items. For example, 'Takes appropriate measures to prevent or minimise risk of injury to self and clients' became 'Takes appropriate measures to prevent or minimise risk of injury to self' AND 'Takes appropriate measures to prevent or minimise risk of injury to clients'.

4. Where similarity occurred between statements, I carefully decided on whether collapsing statements changed the meaning, through changing the wording. Some elements were collapsed; for example, 'Accesses electronic data' and 'Retrieves electronic data necessary for client care' was collapsed to 'Accesses and retrieves electronic data necessary for client care'; others remained separate.

5. All potential elements were reviewed for ambiguity and clarified. For example, 'Apart from that clinical practice that there is a cultural practice' became 'Provides cultural care as part of clinical health care'.

6. Where elements reflected items at a more conceptual level, careful scrutiny of underpinning elements of the concept was undertaken to discern if these were already captured in the list of elements. Where these existed, the conceptual level item was deleted.

7. Remaining items were compared with NCNZ competencies for the RN SoP (not indicators) and where wording was the same, items were eliminated. All RNs, by virtue of meeting NCNZ requirements, have met the competencies for RN SoP.

8. As the focus is on practice, knowledge-only elements were altered to ensure they read as practice, to reflect a practising RN (e.g., 'Understands client rights' became 'Practises using an understanding of client rights').

9. Elements were revised for consistent tense.

10. Elements reflecting categories in the adapted professional tool for participants to judge the expected level of performance were removed. For example, 'actually capable of doing what they are doing' was removed, as capability was one of the categories to be judged under 'proficiency' in the level of performance tool.

11. Negative statements were altered to achieve a positive stance (e.g., 'Does not experience difficulty starting tasks' was changed to 'Demonstrates ability to start tasks').

12. Where statements were judged as being hospital-oriented, they were altered or added to, to reflect all clinical settings because NGNs can begin professional practice in any setting (e.g., 'Copes with practising across the shifts across the week' became 'Copes with practising across the shifts/different work patterns across the week').

13. Where statements were judged to be potentially interpreted differently, a definition was supplied; for example, 'Able to co-operate' had '(assist/comply with requests)' added.

14. Finally, the elements were examined for professional language and minor alterations made (e.g., 'Handles personal problems in the team' became 'Manages personal problems in the team').

At the consummation of this process, 173 resulting elements remained for the phase two participants to make a judgement on whether or not they comprised WR. The next task addressed the development of a professional tool for judging the expected level of performance for each of the WR elements.

3.2 The expected level of performance

The second part of the survey questionnaire used an adapted professional tool for judging the 'level' of performance expected of the NGN. The literature review found debate on the standard of performance or level of achievement that should be demonstrated by NGNs (Brown & Crookes, 2016; Clark & Holmes, 2007; El Haddad, 2016; Greenwood, 2000; Walker & Bailey, 1999), including what their practice looks like when beginning professional practice and what needs post-employment support to develop. Three frameworks were identified—the Bondy (1983) scales measuring levels of competence, Benner's (1984) 'novice to expert' describing progressing proficiency of

RN nursing practice, and a Likert-scale measurement ascertaining the level of direction NGNs (Walker & Bailey, 1999) required when first entering professional practice. These measures attempted to explicate NGNs' expectations of professional practice.

Bandura (1982) posited that self-efficacy, also known as self-confidence, is connected to "judgments of how well one can execute courses of action required to deal with prospective situations" (p. 122). People are more willing to take on and undertake activities which they judge themselves as capable of accomplishing. They will also be inclined to avoid activities which they perceive to be beyond their coping capabilities. One's sense of self-efficacy can be a key factor in how one contemplates goals, tasks, and challenges. There is a clear debate on the impact of confidence (Clark & Holmes, 2007; Lofmark et al., 2006; Romyn et al., 2009) on NGN competence and, therefore, perception of WR.

3.2.1 The adapted professional tool

Along with the concept of confidence, the three frameworks—the Bondy (1983) scales, Benner's (1984) 'novice to expert', and the Likert-scale measurement (Walker & Bailey, 1999) were examined for key words and phrases. The results identified a measuring scale that included expectations of:

- Knowledge base
- Independent safe practice
- Level of appropriate confidence
- Proficiency (accomplished/well practised) in a timely manner
- Any further development requirement
- Level of direction and supporting cue requirement

These indicators were then collapsed into five categories; knowledge, independence, proficiency, timeliness, and confidence. 'Further development' and 'level of direction' became performance levels. 'Proficiency in a timely manner' was separated into two categories as these can be perceived as two different aspects of professional performance.

Final performance level indicators were constructed, producing ordinal data points. The number of indicators was kept to a minimum yet aimed to capture all possibilities. Like the consensus options YES/NO, the indicators were created to enable a fixed response

rather than a scale. Table 15 outlines the adapted professional tool level of performance framework used in the survey.

Table 15. Adapted professional tool

Category	Performance level indicators
Knowledge	2. Sufficient knowledge / knows to
	1. Will need to develop knowledge
Independence	3. Independent and safe
	2. Will need some direction
	1. Will need further development / supervision
Proficiency	3. Accomplished and well-practised
	2. Will need further practice
	1. Will need to learn to practice
Timeliness	2. Takes appropriate amount of time
	1. Will need extra time
Confidence	2. Feels assured of own capability
	1. Will not yet feel assured of own capability

Not all WR items had associated levels of performance attached as levels of performance were not appropriate for some of them; such, as 'is a very nice person' and 'achieved good undergraduate programme grades'. *Knowledge* and *Timeliness* levels of performance were measured in 142 WR items with *Independence* measured in 146 items and *Proficiency* in 144 items. *Confidence* was the most measured component, being judged in 157 items.

3.3 The survey questionnaire

The 173 elements, along with the adapted professional tool comprising five categories, identifying levels of performance, established the survey questionnaire. A pre-amble was constructed to introduce and focus the participants on the purpose of the survey, as well as provide clear and concise instructions (Rea & Parker, 2014). The next version of the co-constructed round one survey was divided into three. Part one comprised request for demographic data including area of nursing practice and:

- Academic level
- Initial nurse education undertaken in NZ
- Length of time registered with NCNZ
- Gender
- Age group

- Ethnicity

The literature has identified that perspectives have been shaped by individual education experiences, generational factors, and current working environment (Greenwood, 2000; Wolff, Pesut, et al., 2010; Wolff, Regan, et al., 2010b). The demographic data would assist in analysing the results of the survey questionnaire rounds.

Participants were further supported in their focus by identifying the underpinning assumptions about the NGNs as well as themselves as a participant (Hasson & Keeney, 2011). The assumptions were listed on the survey and included:

1. Items are recognised as WR across *any and all* practice settings where NGNs may be employed
2. Items apply when *first* employed as a RN
3. The NGN has *attained the level of knowledge and theory* as outlined in the NCNZ education standards. A copy of these standards was provided at the bottom of the survey
4. The NGN has *attained technical ability in a range of basic nursing skills* (including dressings), as well as a range of assessment skills (including history, physical examination, and vital signs) and medication management across a range of settings
5. The NGN *knows the RN role and practises* according to code of conduct and within scope of practice, professional boundaries, legal and ethical frameworks (including confidentiality and privacy)
6. The NGN has *provided evidence of meeting the NCNZ Competencies for the RN SoP* (as a Transition student), agreed by both the tertiary education and practice sector
7. Participant judgement is based on their knowledge and experience of NGNs entering the workforce, not on what they might think the researcher wants to see or what is in the literature
8. Participant judgement is relatively impartial and provides a valid opinion from their knowledge and experience

The second part of the survey comprised the 173 WR elements, expressed as close-ended statements (Rea & Parker, 2014), accompanied by the consensus indicators 'YES/NO'. Closed-ended statements have fixed responses available, facilitating comparisons of these specific responses and eliminating irrelevant data (Rea & Parker, 2014). Participants were asked to decisively judge whether each of the elements

comprise WR; there was no opportunity for ambivalence or 'don't know'. However, disadvantages of closed-ended statements include participant uncertainty on the options available and consequently making random choices without thoughtful consideration (Rea & Parker, 2014), despite the guidance provided in section one of the survey.

Finally, where a participant deemed an element does comprise WR, they were asked to judge the expected level of NGNs' performance using the adapted professional judgement tool. Examination of the survey for accuracy, legibility, and completeness encompassed the efforts of both myself as the researcher (Keeney et al., 2011; Rea & Parker, 2014) and a pilot group. Prior to sending the survey to participants, it was piloted with the phase one informant group. The Taranaki nursing leaders had a vested interest in the topic having contributed to the survey through their focus group interview and sharing of perspectives and views.

3.4 The survey pilot

The online survey was piloted to check for clarity of statements, ease of making judgements, the time commitment, (Burns & Grove, 2005; Keeney et al., 2011) and any other comments. The seven respondents who participated in the phase one focus group were asked to undertake the survey and respond to the following questions:

1. The survey is estimated to take approximately 60 minutes – is my estimation correct?
2. The survey has information and instructions for the participants – is the information helpful? Are the instructions clear?
3. There are three parts to the survey overall: Demographics, statements of YES/NO, and then judgement on level of expectation – are these clear for the reader? Is the 'level of judgement' tool easily understood?
4. Are there any ambiguous statements/wording?
5. How easy/difficult is it to complete the survey electronically?
6. Any other comments?

Four (57%) of the respondents chose to participate and their feedback included:

- It took approximately 60 minutes to complete the survey
- Information and instructions are clear
- Level of judgement tool easily understood
- Would be helpful to have more drop-down menus

- There were some specific elements that require changes:
1. 'Anticipates client risk' and 'Identifies actual or potential client safety risks' – it was unclear what the difference might be; therefore, 'Anticipates client risk' was removed
2. 'Initiates changes for clients' was removed as meaning was unclear
3. 'Takes calculated risks' was removed as this is an element that would be considered unsafe
4. 'Where appropriate, defers judgement and does not jump in too quickly to resolve a problem' was removed as this could be considered unsafe practice
5. 'Practises knowing there is never a fixed set of steps for solving problems' was removed as it was unclear how this could be judged

Other comments related to the pilot informant's own personal views of WR, such as commenting that elements were not part of WR. Although this feedback is valued, the nature of the research project was for the phase two participants to make this judgement. Similarly, some feedback related to challenges in determining performance levels, such as perspectives on the level required. Because the elements were developed from the phase one literature and the focus group interview, these elements remained in the survey.

Finally, because of the appreciable size of the survey, a recommendation was made to divide it into sections to help the participant visualise organisation of the elements, reduce the potential sense of being overwhelmed, and perhaps undertake sections one at a time, as and when they have time. The survey was re-developed with headings, the names of which were sought from the literature review, except for 'culture'. The aim of the selecting headings was to ensure a generic nature to the final heading names; designations that will neither distract nor influence the participant decisions (e.g., the group of elements named leadership may automatically initiate a negative response because of the section name rather than examining the elements as individual items). The closed-ended statements were re-arranged and re-ordered under the following headings.

1. Workload
2. Provision of care
3. Making decisions
4. Learning
5. Health education

6. Quality
7. Communication
8. Leadership
9. Time management
10. Team working
11. Organisation
12. Resilience
13. Healthcare
14. Culture
15. Career

As a result of the respondents' pilot feedback, the survey was reduced to 167 closed-ended statements under 15 headings. The final round one survey questionnaire can be found in Appendix I.

4. Summary

The objective for phase one was to develop a framework of elements as a basis for the first round of the Delphi survey. The development of the framework comprised merging findings from the literature with the results of a focus group interview. Key informant perspectives, elicited through a focus group, identified 77 work ready elements. A piloting process of examining the survey finalised the questionnaire into 167 closed-ended statements. The literature revealed discourse on levels of NGN performance. An adapted professional tool was constructed from the literature for the participants to judge the expected level of performance for those elements identified as constituting WR. The final construction of the survey questionnaire incorporated an introduction, a set of assumptions and instructions, all designed to support the participants' contribution. A set of demographic data for the purpose of assisting analysis of the results of the survey questionnaire rounds concluded the final framework. Chapter 5 presents the details of phase two. The two survey round iterations, including data collection, results and convergence to consensus, results in the co-construction of a WR NGNs framework.

Chapter 5 Phase Two

1. Introduction

Chapter 4 presented the phase 1 findings of the research project. This chapter presents phase two of the study. Phase two comprises three parts; round one survey, round two survey, and the creation of a WR framework. The purpose of phase two was to co-construct an initial consensus framework of elements of WR of NGNs in NZ. An outline of phase two can be found in Figure 4.

PHASE TWO

Purpose:

To co-construct a consensus framework of elements of WR of NGNs in NZ

Objective:

To use the survey questionnaire from the previous analysis and identify the construct elements of WR

Participants:

The group of nurses identified from practice, education, professional and regulatory bodies

Methods:

Data collection

✓ Online survey

Data analysis

✓ Descriptive statistics

Figure 4. Outline of phase two

The objectives included using the survey questionnaire from the previous analysis and identifying the construct elements of WR. The construction of the round one survey was described in Chapter 4. This chapter reports the results of the round one survey and the subsequent consensus-gaining process leading to the co-construction of a WR of NGNs framework.

2. Participants

The nursing sector in this phase of the study comprised eight groups of nurses. The groups were identified as the Nursing Schools (excluding the WITT, because this nursing programme is the focus of this research project), DHBs, primary health care organisations, community and private health services, aged care, NGNs, professional and regulatory nursing bodies. A total of 117 potential participants were identified. Those identified participants had to be willing to participate, able to commit to two rounds of questionnaires, have access to a computer, computer literacy to complete online surveys as well as having met one of the following criteria:

- Responsible for undergraduate curriculum design
- Responsible for undergraduate programme accreditation and monitoring
- Responsible for employing/supporting NGNs
- Responsible for examining/advising on professional/cultural nursing issues (both Māori and non-Māori where a bicultural structure is in situ)
- NZ NGN having just completed approximately one year of practice, from each of the following (both Māori and non-Māori):
    - Nurse Entry to Practice programme (NEtP),
    - Nurse Entry to Specialty Practice programme (NEtSP)
    - Aged Residential Care Nurse Entry to Practice programme (ARC NEtP)
- NZ NGN having just completed approximately one year of practice, without a NEtP, NEtSP, or ARC NEtP programme

3. Recruitment

Following AUTEC ethics approval (see Appendix F), a letter explaining the research project was sent to the National Nursing Organisation, a body representing the nursing sector. The purpose of the letter was to raise awareness of the research project. The phase two recruitment protocol can be found in Appendix G. Then, an introductory email was sent to the nursing leaders of the NZ nursing schools, DHBs, primary health care organisations, community and private health services, aged care, professional and regulatory nursing bodies to introduce the research project, provide information and ask them to identify staff member(s) who would meet the stated inclusion criteria and relay the information to them. The DHBs were asked to identify two participants; one from mental health and one from general services, ensuring both nursing services were

represented in the study. The professional organisations were asked to identify two participants; one Māori and one non-Māori where a bicultural structure is in situ, seeking opportunities for Māori participation.

Those identified individuals were provided an information sheet (see Appendix H), and asked to contact me, the primary researcher, directly. Where a response was not received from an organisation within 10 days, I made contact again to remind them of the request to participate. Eight organisations required an internal ethics approval process which was successfully attained. This unforeseen step contributed to the time between surveys extending to three months rather than the two weeks originally planned.

An advertisement was placed in two NZ nursing journals inviting NGNs to participate. The advertisement can be found in the recruitment protocol in Appendix G.

Eight nursing leaders invited to identify survey participants within their health care organisation disclosed they did not or rarely employed NGNs. These organisations were subsequently excluded. Also excluded was the Office of the Chief Nurse in the Ministry of Health whose position was that any perspective they held on WR of NGNs would be sought from the nursing sector. Total potential participants were then reduced to 109; 93% of the original identified cohort.

Table 16 (p. 89-90) shows the total participants and the nursing group the participants represented. Sixty-seven participants completed the survey, giving a response rate of 61%. Although the DHB group comprised the greatest number of participants overall (n=24), 13 (54%) participants were from general services and 11 (46%) from mental health services. The lowest participation rate came from primary health care organisations with 11 (42%) participants. Due to a mis-understanding in the recruitment process, five participants (125%), rather than four of the community and private group completed surveys. Although 75% (n=6) of potential NGNs participated, only one (17%) identified as Māori and five (83%) as non-Māori. Further, there were no participants having recently completed an ARC NEtP programme. The NCNZ did not participate. By completing the survey, participants were giving consent to participate.

The survey (found in Appendix I) was sent to the 67 participants with a request for a response within 10 working days. Thirty of the participants requested and received extra time to complete the survey due to their employment workloads. Where responses had not been received within 30 days, a follow up reminder email was sent.

Table 16. Total participants and the nursing sector group representation.

Nursing Sector Groups	Identified for invitation to participate	Potential participants	Participants
1. *Tertiary Education Schools of Nursing* 17 schools with 21 programmes Excluding WITT	20	20	14 (70%)
2. *District Health Boards* 20 DHBs - 2 from each DHB representing each of the following: • General services • Mental health	40 2 do not employ NGNs in mental health - excluded	38	24 (63%) • General services 13 (54%) • Mental health 11 (46%)
3. *Primary Health Care Organisations* 30 organisations	30 4 do not/rarely employ NGNs – excluded	26	11 (42%)
4. *Professional Bodies* 2 participants (Māori and non-Māori where bicultural structure in place) • NZNO • College • Māori Nursing Council • Ministry of Health	8 Ministry of Health consults and seeks advice - excluded	7	4 (57%) • 2 Māori (50%) • 2 Non-Māori (50%)
5. *Aged Care* 5 largest organisations	5 1 not employ NGNs – excluded	4	3 (75%)
6. *Community / Private Health Services* • Hospice • Plunket • Private • Occupational health	4	4	5 (125%)
7. *New Graduate Nurses* • Māori and non-Māori • Completed NeTP/NeSP/ARC • Completed no graduate programme	8	8	6 (75%) • Māori 1 (17%) • Non-Māori 5 (83%) • NeTP 4 (67%) • NeSP 1 (17%)

			• ARC 0 (0 %)
			• No graduate programme 1 (17%)
8. Regulatory Body	1	1	0 (0%)
• NCNZ			
TOTAL	**117**	**109**	**67 (61%)**

4. Phase Two - Round one survey

4.1 Demographics

Demographic data were collected in the first part of the survey. Analysis was undertaken using descriptive statistics, specifically frequency distributions, reported as percentages and rounded to the nearest 1%. Figure 5 (p. 91) shows the results of demographic analysis. The majority of participants identified as female (90%, n=60), in the over-50 years of age category (63% n=42) and as Pākeha (73%, n=49).

The qualification participants most indicated was a Masters (36%, n=24), with 19 participants (28%) having a Post Graduate Diploma. Eighty-one percent (n=54) of participants held a post-graduate qualification. A degree was the highest qualification for 13 (n=9) of the participants (including six NGNs). The majority of participants undertook their initial nursing programme leading to registration as a RN in NZ (n=48, 72%) and were registered with the NCNZ for more than 20 years (n=27, 40%). Eight participants (12%) were registered for less than five years (including the six NGNs). Figure 6 (p. 91) shows the demographic data for highest qualification achievement, country of origin of nursing qualification and length of time registered with the nursing regulatory body, the NCNZ.
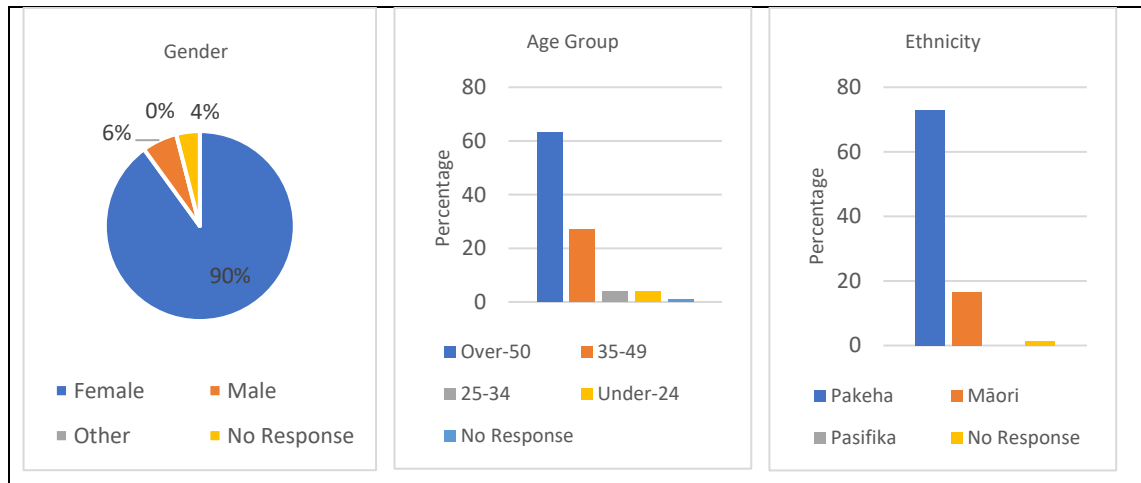
Figure 5. Gender, age group and ethnicity demographic data
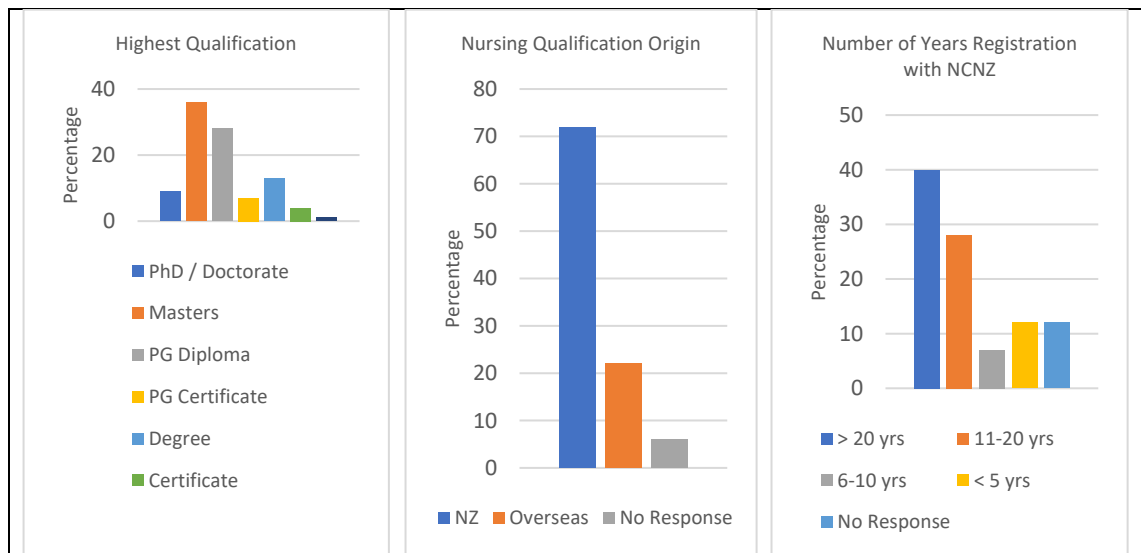
Figure 6. Highest qualification, origin of nurse qualification and years registered with NCNZ demographic data

4.2 Work readiness elements

The second part of the round one survey comprised 167 closed-ended statements, named 'items' in the survey, used to facilitate fixed answers of 'YES' or 'NO,' to seek consensus, measuring how many participants agreed with each other. The aim for the participants was to commit to agreeing if the item was or was not an element of WR. These results were also analysed using descriptive statistics specifically frequency measured by percentages and rounded to 1%. The level of agreement was set at 80% to ensure a majority consensus; yet, safeguard against one nursing group alone determining consensus. For each item, the level of agreement was calculated and those items that met the consensus threshold percentage of 80% were ascertained.

113 (68%) of the items met consensus in the first-round survey. 110 items were judged by the participants as comprising WR and three were determined as *not* comprising WR. Consensus levels ranged from 80-100%. All items meeting consensus, along with the level of agreement can be found in Appendix L.

The 167 items were grouped into 15 sections; Workload, Provision of Care, Making Decisions, Learning, Health Education, Quality, Communication, Leadership, Time Management, Team Working, Organisation, Resilience, Health Care, Culture, and Career. The largest level of agreement ascertained in this first survey round was in the *Learning* section with 15 of the 17 items (88%) meeting a YES consensus; closely followed by *Provision of Care* with 11 of the 13 (85%) items, and *Quality* with 12 from 15 items (80%). However, *Leadership* received a NO consensus in three from five (60%) items. There were no YES consensus items found in *Leadership* and this was the only section where a NO consensus was found in the first survey. Table 17 (p. 93) shows the highest-ranking sections of items meeting a YES consensus in the first survey.

The first draft of the WR framework was able to be co-constructed with 110 WR items. The next stage of the framework construction was to determine the expected levels of performance for each of these items.

Table 17. First survey highest ranking of section items

Ranking of highest percentage levels	Sections	YES consensus	
		Number of items	Percentage of items
1	Learning	15/17	88
2	Provision of Care	11/13	85
3	Quality	12/15	80
4	Making Decisions	20/27	74
5	Career	20/29	69
6	Workload	2/3	67
7	Time Management	2/3	67
8	Team Working	11/17	64
9	Culture	5/8	62
10	Communication	4/8	50
11	Health Care	2/4	50
12	Health Education	2/6	33
13	Organisation	2/6	33
14	Resilience	2/6	33
15	Leadership	0/6	0

4.3 Level of performance

The third part of the round one survey asked the participants to make a judgement about the expected level of performance of the NGN for each of the WR items they had scored a YES on. The participants used an adapted professional tool with five components; *Knowledge* (two levels), *Independence* (three levels), *Proficiency* (three levels), *Timeliness* (two levels), and *Confidence* (two levels). The construction of the adapted professional tool was described in Chapter 3. Table 18 (p. 94) shows the five components and the levels of performance participants could select and score from. Not all WR items had associated levels of performance, as levels of performance were not appropriate for some of them, such as 'is a very nice person' and 'achieved good undergraduate programme grades'. *Knowledge* and *Timeliness* levels of performance were measured in 142 WR items, with *Independence* measured in 146 items and *Proficiency* in 144 items. *Confidence* was the most measured component, being judged in 157 items.

Table 18. Levels of expected performance

	Levels of Performance		
Component	1	2	3
Knowledge (142 WR items)	Will need to develop knowledge	Sufficient knowledge/knows to	NA
Independence (146 WR items)	Will need further development/ supervision	Will need some direction	Independent and safe
Proficiency (144 WR items)	Will need to learn to practice	Will need further practice	Accomplished and well-practised
Timeliness (142 WR items)	Will need extra time	Takes appropriate amount of time	NA
Confidence (157 WR items)	Will not yet feel assured of own capability	Feels assured of own capability	NA

I measured the level of agreement, that is to say, at the highest level of performance the participant agreed with each of the performance level components of the 110 WR items that had already achieved YES consensus. For the 110 WR items that met a YES consensus, 92 items had levels of *knowledge* measured, 95 items had levels of *independence* measured, 93 items had levels of *proficiency* measured, 92 items had levels of *timeliness* measured and 105 items had levels of *confidence* measured. Levels of agreement were analysed using descriptive statistics, specifically frequency, measured by percentages, calculating how many participants scored each performance level. No specific threshold level of agreement for performance expectation had been set in the research design.

Analysis showed that in 99 WR items, the performance level for each component could be determined by the highest percentage of participant responses. However, in six WR items, the percentage of participants' scores was the same in each of *two* performance levels within one or two components. I decided that the lower score provided a greater level of agreement as all participants agreed with the level of performance at least to this minimal level. The lower level of performance was, therefore, entered into the first draft of the WR framework. These six items can be found in Table 19 (p. 95).

Levels of performance were then added into the WR framework. The framework can be found in Appendix M.

Table 19. Determining item performance levels

	WR Item	Participant Performance Scores	Final Decision on Performance Level
1	Willing and able to use collegial support to critically think and make decisions, protecting self as a beginning practitioner	*Independence* - 41% of participants scored at each Level 2 and 3 *Proficiency* – 43% of participants scored at each Level 2 and 3	Level 2 entered into the WR framework Level 2 entered into the WR framework
2	Evaluates client learning	*Knowledge* - 50% of participants scored in each Level 1 and 2	Level 1 entered into the WR framework
3	Thrives on completing tasks and achieving results	*Proficiency* - 48% of participants scored in each of Levels 2 and 3	Level 2 entered into the WR framework
4	Communicates changes in client condition	*Independence* - 44% of participants scored in each of the levels 2 and 3.	Level 2 entered into the WR framework
5	Practises with a knowledge of the routine of the clinical setting (e.g., handover procedure, ward round, clinical setting ways of doing things, the purpose and care delivery model)	*Timeliness* - 50% of participants scored in each of levels 1 and 2	Level 1 entered into the WR framework
6	Is willing to learn more cultural knowledge	*Independence* - 44% of participants scored in each of level 2 and 3	Level 2 entered into the WR framework

5. Phase Two - Round two survey

The second-round survey (see Appendix K) was created with the 54 remaining WR items that did not achieve consensus in the first survey. The three items that met a NO consensus, along with the 110 items that met a YES consensus, in the first-round survey were excluded from the second survey. Where a fixed consensus response of YES/NO is used, there is no requisite or advantage in re-submitting the items (Keeney et al., 2011) and the shorter survey can promote participant retention (Hasson et al., 2000). Ethical approval for the second survey was received from AUTEC (see Appendix J).

Each participant received individual feedback on their own scoring and the group response for each of the 54 close-ended statements where there was insufficient agreement to achieve the threshold consensus in the first survey. Participants were invited to make a final judgement on WR and, if they wished, re-score considering their colleagues' perspectives. It is at this stage that convergence to consensus and agreement occurred. The opportunity to amend previous scores in light of group responses is important in progressing towards a consensus in a Delphi study (Powell, 2003).

Survey results were analysed and measured by percentages. Fifty-one participants (76%) returned the second survey. A response rate of 70% across rounds has been suggested as a minimum to maintain rigour (Hasson et al., 2000). Seven participants (14%) reviewed their responses and concluded no changes were required. The remaining 44 participants (86%) all re-scored their responses. Four participants only re-scored on WR item level of performance and the remaining participants made changes to both their choices on whether or not items comprised WR as well as levels of performance.

The level of agreement was calculated for each of the 54 items and, of these, 24 items (44%) met the consensus threshold percentage of 80%. Twenty-three of the twenty-four items (96%) meeting consensus were ascertained as a YES consensus and one item (4%) was ascertained as a NO consensus. Consensus levels were achieved at between 80-89%. The levels of consensus for each WR item can be found in Appendix L.

A YES consensus threshold was achieved in the second survey round for 23 work WR items, giving a total of 133 items in the co-constructed WR framework. A further 10 items received a level of agreement between 70-79%. These items were examined further to identify the nursing group that had the greatest influence on the scores. Results can be found in Table 20 (p. 97-98).

Overall, participant response rate to the 10 ten items was high. Eight items had a response rate of 96-100% and two items had a response rate of 90-91%. Although the DHB group were consistently the biggest group in the nursing sector scoring a YES for each of the 10 items (26-41%), they were the highest scoring YES group in only two items (manages conflict with colleagues, manages conflict with clients), and equal scoring with the NGN group in one item (keeps track of multiple responsibilities). Therefore, no single group was responsible for the overall YES scoring for each item.

Table 20. Nursing group responses to WR elements

Item	Overall Participant Response rate	Consensus Percentage % YES/ NO		Group	Group YES % Response rate	Group YES % of the Nursing Sector
Manages a full workload of mixed acuity clients after completing orientation	100%	73	27	SoN	71	21
				DHB	75	**37**
				PHC	91	20
				PB	75	6
				AC	67	4
				Com	75	6
				NGN	50	6
Uses previous experience to figure out what is going on when a current situation takes an unexpected turn	96%	78	22	SoN	79	21
				DHB	78	**35**
				PHC	90	18
				PB	33	2
				AC	33	2
				Com	80	6
				NGN	100	12
Manages conflict with colleagues	97%	74	26	SoN	79	23
				DHB	87	**41**
				PHC	64	13
				PB	75	6
				AC	33	2
				Com	50	4
				NGN	67	8
Manages conflict with clients	96%	78	22	SoN	79	21
				DHB	91	**39**
				PHC	73	15
				PB	75	6
				AC	67	4
				Com	40	4
				NGN	67	7
Keeps track of multiple responsibilities	99%	73	27	SoN	71	21
				DHB	83	**40**
				PHC	73	16
				PB	50	4
				AC	33	2
				Com	50	4
				NGN	83	10
	97%	71	29	SoN	79	23

Item	Agreement	Bar	Group	Value 1	Value 2
Presents information at case reviews and ward rounds			DHB	75	**39**
			PHC	73	17
			PB	50	4
			AC	33	2
			Com	50	4
			NGN	67	8
Is willing to take responsibility to change health outcomes for Māori	97%	78 / 22	SoN	86	22
			DHB	74	**32**
			PHC	100	21
			PB	50	4
			AC	33	2
			Com	75	6
			NGN	83	10
Demonstrates a concept and understanding of service; puts others before self	99%	74 / 26	SoN	71	20
			DHB	75	**36**
			PHC	91	20
			PB	75	6
			AC	67	4
			Com	75	6
			NGN	50	6
Is a very nice person	90%	75 / 25	SoN	75	19
			DHB	76	**34**
			PHC	80	16
			PB	50	3
			AC	67	3
			Com	75	5
			NGN	83	10
Is humble	91%	72 / 28	SoN	77	23
			DHB	60	**26**
			PHC	90	19
			PB	50	3
			AC	67	3
			Com	75	6
			NGN	100	11

The level of agreement was originally set at 80% to ensure that one nursing group alone could not determine consensus. Analysis of the 10 items scoring 70-79% YES found that no single group determined this level. Therefore, the consensus was lowered to 70%, which is still an acceptable level (Hardy et al., 2004; McKenna, 1994). The 10 items

scoring 70-79% YES was, therefore, added to the WR framework giving a total of 143 items (86%).

The ranking of sections of items meeting a YES consensus changed order from round one survey to round two survey. *Learning* remained the highest ranked section of items with 100% of items meeting consensus but shared the lead with *Provision of Care* (was second in round one survey), *Workload* (was sixth in round one survey but note only three items in this section) and *Time Management* (was seventh in round one survey but note only three items in this section). The *Leadership* section did not attain any YES consensus in the second-round survey and languished at the bottom of the final rankings with 0% YES consensus. Table 21 (p. 100) shows the item sections meeting consensus in round one and then round two as well as the final section rankings.

Table 21. Item sections meeting round one and two consensus; and the final section rankings

Item Section	Total number of items in the section	SURVEY ONE		SURVEY TWO		OVERALL			
		Number of items meeting a **YES**/ **NO** consensus	% of items meeting consensus	Number of items meeting a **YES**/ **NO** consensus	% of items meeting consensus	Number of items meeting NO consensus	% of items meeting NO consensus	Number of items meeting YES consensus	% of items meeting YES consensus
1.Learning	17	**15**	88	**2**	12	0	0	**17**	100
1.Provision of care	13	**11**	85	**2**	15	0	0	**13**	100
1.Workload	3	**2**	67	**1**	33	0	0	**3**	100
1.Time management	3	**2**	67	**1**	33	0	0	**3**	100
2.Career	29	**20**	69	**6**	21	0	0	**26**	90
3.Communication	8	**4**	50	**3**	38	0	0	**7**	88
3.Team working	17	**11**	65	**4**/**1**	29	**1**	6	**15**	88
3.Culture	8	**5**	63	**2**	25	0	0	**7**	88
4.Quality	15	**12**	80	**1**	7	0	0	**13**	87
5.Making decisions	27	**20**	74	**3**	11	0	0	**23**	85
6.Health education	6	**2**	33	**3**	50	0	0	**5**	83
7.Healthcare	4	**2**	50	**1**	25	0	0	**3**	75
8.Organisation	6	**2**	33	**2**	33	0	0	**4**	67
8.Resilience	6	**2**	33	**2**	33	0	0	**4**	67
9.Leadership	5	**3**	60	0	0	**3**	60	0	0
Totals	**167**	**113**	**68**	**34**	**20**	**4**	**2**	**143**	**86**

6.1 Amount of change between survey rounds

Because participants opinions change between rounds, in light of their colleagues' responses, I sought to measure the amount of change to calculate the levels of change required to meet consensus (Trevelyan & Robinson, 2015). In this study, neither IQR nor median measurement was considered appropriate because of the minimal variation of scores with a two-option (YES/NO) response. The response change was ascertained by percentage measures to calculate the amount of change between the two survey rounds. To calculate the percentage increase, the difference between the survey one figure and survey two figure was measured, and the resultant number (positive or negative) was divided by the survey one figure and then multiplied by 100. A positive figure meant a percentage increase and a negative result a percentage decrease.

The amount of participant change from the first survey to the second survey, leading to a YES consensus was overall 7-20%. The amount of participant change in the WR items that still did not reach YES consensus in the second survey was 1-20%. One item reached a NO consensus with a 4% response change. Seven items did not reach consensus despite a negative-2% - negative-20% change. There was no specific percentage level of participant change ascertained that achieved consensus. Table 22 (p. 102-104) shows the levels of change for each of the 54 items in the second survey.

The next stage of the framework construction was to determine the expected levels of performance of those items having now achieved consensus in the second-round survey.

Table 22. Levels of change for each of the 54 items in the second survey

Section	Item	Reach agreement by second round	Participant 'YES' responses %		Response change %
			First	Second	
Workload	Manages a full workload of mixed acuity clients after completing orientation.	YES	67	73	+9.
Provision of Care	Provides end-of-life care	YES	72	85	+18.
	Demonstrates a mind-set whereby can transfer skills to another clinical setting.	YES	73	87	+19.
	Judges urgency of changing situations	YES	75	80	+7
	Tries to solve problems themselves	YES	79	87	+10
	Uses previous experience to figure out what is going on when a current situation takes an unexpected turn	YES	67	78	+16
Making Decisions	Identifies from a mass of detail the core issues in any situation	NO	64	67	+5
	Sees how apparently unconnected activities are linked and make up an overall picture	NO	56	58	+4
	Traces out and assesses the consequences of alternative courses of action and, from this, pick the one most suitable	NO	59	67	+14
	Recognises patterns in a complex situation	NO	40	35	-13
Learning	Helps others to learn	YES	77	84	+9
	Demonstrates ability to learn advanced skills	YES	68	80	+18
	Makes effective presentations to clients	YES	67	80	+19
	Teaches prevention, health promotion activities and effects of lifestyle on health	YES	78	85	+9
Health Education	Utilises community resources to enhance client care	YES	77	84	+9
	Advocates for policy changes that promote health of individuals, families or communities	NO	38	36	-5
	Demonstrates an eye for detail	YES	78	84	+8
	Questions and challenges the wider system	NO	48	45	-6
Quality	Practises with an understanding of quality improvement methodologies	NO	58	66	+14
Communication	Motivates others	YES	68	80	+18
	Manages conflict with colleagues	YES	68	74	+9
	Manages conflict with clients	YES	73	78	+7
	Makes appropriate impromptu speeches	NO	41	40	-2

Section	Item	Reach agreement by second round	Participant 'YES' responses %		Response change %
Leadership	Is approached for original ideas	NO	43	44	+2
	Acts as a resource	NO	34	33	-3
Time Management	Keeps track of multiple responsibilities	YES	66	73	+11
	Works with senior staff without being intimidated	YES	79	89	+13
	Practises with an understanding of population generational differences.	YES	76	85	+12
	Practises with an understanding and sharing of feelings / emotions of others	YES	78	86	+10
	Presents information at case reviews and ward rounds	YES	68	71	+4
	Chairs and participates constructively in meetings	YES			-19
Team Working		(reached NO consensus)	21	17	(Increased NO response by 4%)
	Gives constructive feedback to work colleagues and others without engaging in personal blame.	NO	65	69	+6
	Practises with an understanding of the rules, hierarchy and place in the organisation.	YES	74	80	+8
Organisation	Practises with an understanding of organisational processes and protocols.	YES	78	86	+10
	Practises with an understanding of how the organisation operates	NO	68	69	+1
	Practises with an understanding of how the different groups that make up the organisation operate and how much influence they have in different situations	NO	46	42	-9
	Likes the idea of change	YES	70	82	+17
	Remains calm under pressure or when things go wrong; does not panic	YES	76	83	+9
Resilience	Copes with multiple and competing demands	NO	62	65	+5
	Does not become overwhelmed by challenging circumstances	NO	65	68	+5
	Practises with an understanding of and ability to work in different health care models	YES	73	82	+12
Health Care	Practises with an understanding of where health care is heading in the future with changing models of care	NO	58	64	+10

Section	Item	Reach agreement by second round	Participant 'YES' responses %		Response change %
Culture	Correctly pronounces te reo (particularly client names)	YES	76	86	+13
	Is willing to take responsibility to change health outcomes for Māori	YES	65	78	+20
	Practises with knowledge of local iwi	NO	54	65	+20
	Is focussed on career	YES	70	82	+17
	Eagar to throw self into work	YES	79	89	+13
	Demonstrates a sense of humour	YES	78	85	+9
	Demonstrates a concept and understanding of service; puts others before self	YES	69	74	+7
Career	Is humble	YES	66	72	+9
	Is a very nice person	YES	64	75	+17
	Undergraduate transition experience is the same / similar setting as new graduate RN position clinical setting	NO	41	33	-20
	Considers that nothing is too much for the client	NO	58	66	+14
	Achieved good undergraduate programme grades	NO	57	62	+9

6.2 Levels of performance

Participants were invited to make a final judgement on the expected levels of performance across the five components for each of the items and, if they wished, re-score considering their colleagues' perspectives. For the 33 WR items that met a YES consensus, two items did not have an associated level of performance, 29 items had levels of *knowledge* measured, 30 items each had levels of *independence* and *proficiency* measured, 29 items had levels of *timeliness* measured and 31 items had levels of *confidence* measured. Survey results were analysed using frequency, measured by percentages, calculating how many participants scored each performance level. No specific threshold level of agreement for performance expectation had been set in the research design. Analysis showed that in the 31 WR items, the performance level for each component could be determined by the highest percentage of participant responses. The levels of performance ascertained by the highest percentage of responses were annexed to the WR framework. Appendix L shows the percentage measures for each item and performance level component.

6. Work readiness framework

6.1 WR items

Consensus was achieved for a total of 147 of the WR items (88%), with 143 of items (86%) achieving a YES consensus and 4 items (3%) achieving a NO consensus. The WR framework was constructed with these 143 YES items with associated expected levels of performance.

6.2 Levels of Performance

Across the performance level components, the highest percentage of responses were measured at Level 2 in four of the five components. *Knowledge,* where participants judged the expected level of NGN performance in 81% of the items (n=98) as 'sufficient knowledge/knows to'. *Proficiency* was scored at Level 2 (will need further practice) in 77% (n=95) of items. For the *Independence* component, participants judged the expected level of NGN performance in 70% of the items (n=87) as 'will need some direction' and *Timeliness* in 83 items (69%) as 'takes appropriate amount of time'.

Proficiency had three levels of performance for participants to choose and no participant scored Level 1 'will need to learn to practice'. Similarly, with the *Independence*

component, also with three performance levels to choose from, Level 1 (will need further development/supervision) was scored by only one participant (1%).

Confidence performance levels had closer scores with 43% of items scoring Level 1 (will not yet feel assured of own capability) and 57% of items scoring Level 2 (feels assured of own capability). Table 23 shows the participants responses to the component expected levels of NGN performance.

Table 23. Component levels of performance

Component	Levels of Performance					
	1		**2**		**3**	
Knowledge	Will need to develop knowledge	n=23 19%	Sufficient knowledge/knows to	n=98 81%	NA	
Independence	Will need further development / supervision	n=1 1%	Will need some direction	n=87 70%	Independent and safe	n=37 30%
Proficiency	Will need to learn to practice	n=0 0%	Will need further practice	n=95 77%	Accomplished and well-practised	n=28 23%
Timeliness	Will need extra time	n=38 31%	Takes appropriate amount of time	n=83 69%	NA	
Confidence	Will not yet feel assured of own capability	n=59 43%	Feels assured of own capability	n=77 57%	NA	

Thirty-seven (26%) WR items achieved the highest level of performance in every component measured. Twelve are related to learning and asking for help. NGNs are expected to have sufficient knowledge/know (knowledge), to be independent and safe (independence), accomplished and well-practised (proficiency), taking the appropriate amount of time (timeliness) and feeling assured of own capability (confidence) in:

- Is experienced in and knows how to learn
- Demonstrates ability to look things up
- Demonstrates ability to learn quickly
- Is pro-active and keen to learn
- Demonstrates personal growth through learning
- Practises using an understanding that learning is progressive; they don't know everything
- Learns a lot from colleagues
- Approaches senior people to learn from

- Willingly and actively seeks and asks about clinical practices
- Learns from other RN role-modelling to understand how a RN thinks and acts like a nurse
- Is comfortable (not embarrassed) to ask questions when unsure/doesn't know about something
- Recognises when to ask for assistance

Ten items relate to providing nursing care in a professional manner. NGNs are expected to have sufficient knowledge/know (knowledge), to be independent and safe (independence), accomplished and well-practised (proficiency), taking the appropriate amount of time (timeliness) and feeling assured of own capability (confidence) in:

- Performs personal care/activities of daily living (ADLs) for clients
- Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse
- Gives handover
- Practises using an understanding of client rights
- Demonstrates concern for clients
- Willing to pitch in and undertake menial tasks when needed
- Recognises the need to get along with others
- Able to co-operate (assist/comply with requests)
- Acts in familiar situations
- Declines to undertake unfamiliar activities

Twelve items relate to professional attitude. NGNs are expected to have sufficient knowledge/know to (knowledge), be independent and safe (independence), accomplished and well-practised (proficiency), taking the appropriate amount of time (timeliness) and feeling assured of own capability (confidence) in:

- Demonstrates a concept and understanding of service; puts others before self
- General behaviour and conduct is appropriate (including use of language, mobile phone and social media, appearance and attire)

And independent and safe (independence), accomplished and well-practised (proficiency), taking the appropriate amount of time (timeliness) and feeling assured of own capability (confidence) in:

- Eager to throw self into work

Half of the professional attitude items only had confidence levels measured and NGNs are expected to feel assured of their own capability in:

- Respects authority figures
- Respects colleagues
- Is punctual
- Demonstrates a sense of humour
- Demonstrates a mature view on life
- Demonstrates an open and friendly approach
- Is willing to commit to the practice setting
- Is satisfied with choosing nursing as a career
- Feels ready for the professional nursing role

Three further items had two components measured; confidence and either proficiency or level of independence. NGNs are expected to feel assured of their own capability (confidence) and be independent and safe (independence) in:

- Wants to produce as good a job as possible
- Looks forward to the opportunity to learn and grow

NGNS are expected to feel assured of their own capability (confidence) and accomplished and well-practised (proficiency) in:

- Is reliable

Twenty-two items scored low/lowest performance levels across *all* the five components. No *Proficiency* components received a Level 1 score 'will need to learn to practice'. Analysis of the lowest score of *Proficiency* was therefore undertaken at Level 2 'will need further practice'. *Independence* received only one score at Level 1 (will need further development/supervision). Analysis of the lowest score of *Independence* includes this item along with the Level 2 indicator 'will need some direction'. The NGN will need to develop knowledge (knowledge), will need further development/supervision or will need some direction (independence), further practice (proficiency), extra time (timeliness) and will not yet feel assured of own capability (confidence) with the following items:

- Manages a full workload of mixed acuity clients after completing orientation
- Provides mental health care
- Provides end-of-life care

- Demonstrates a mind-set whereby can transfer skills to another clinical setting
- Interprets subjective and objective assessment data
- Manages the balance between patient want and need
- Is prepared for the unexpected to occur
- Uses previous experience to figure out what is going on when a current situation takes an unexpected turn
- Judges urgency of changing situations
- Changes focus when a crisis situation that needs attention arises
- Readjusts a plan of action in the light of what happens as it is implemented
- Tries to solve problems themselves
- Demonstrates ability to learn advanced skills
- Teaches clients and families
- Evaluates client learning
- Utilises community resources to enhance client care
- Judges when not to undertake planned or prescribed interventions
- Questions and challenges another nurse's practice
- Manages conflict with colleagues
- Manages conflict with clients
- Practises with an understanding of organisational processes and protocols
- Remains calm under pressure or when things go wrong; does not panic

Across the performance level components, the highest percentage of responses were measured at Level 2 'sufficient knowledge/knows to' for *Knowledge*. Eighteen items achieved the *Knowledge* Level 2 'sufficient knowledge/knows to' but received the lowest in *Timeliness* and *Confidence*. *Proficiency* and *Independence* components lowest levels were analysed at Level 2 'will need further practice' and 'will need some direction' respectively. The NGN will have sufficient knowledge/know to (knowledge), but will need some direction (independence), further practice (proficiency), extra time (timeliness) and will not yet feel assured of own capability (confidence) with the following items:

- Manages a full workload of low acuity clients after completing orientation
- Practises with knowledge of and ability to use technology in health
- Interprets the multi-disciplinary team orders/plans
- Bases practice on evidence rather than routine
- Sets and justifies priorities
- Re-sets priorities

- Recognises when something is abnormal to what they expected and get it corrected
- Judges the need to escalate care through additional forms of focussed observation from observing and noticing to the use of a particular assessment tool
- Re-assesses client's responses/situation and nursing interventions; conducts appropriate follow-up
- Teaches prevention, health promotion activities and effects of lifestyle on health
- Demonstrates an eye for detail
- Keeps track of multiple responsibilities
- Uses tools to self-organise and plan daily routines
- Practises with an understanding of pressures of the practice setting
- Presents information at case reviews and ward rounds
- Practises with a knowledge of the routine of the clinical setting e.g.: handover procedure, ward round, clinical setting ways of doing things, the purpose and care delivery model
- Willing to persevere when things are not working out as anticipated
- Able to keep working life in perspective

The WR framework can be found in Appendix M.

6.3 NO consensus items

Four (2%) WR items were ascertained as having met a NO consensus. Three items reached consensus in the first-round survey with 83-89% level of agreement. The fourth item met consensus in the second-round survey by increasing the NO response by 4-83%. These four items, along with consensus levels are:

1. Can run a shift/work period – 89%
2. Assigns clients to staff – 89%
3. Manages personal problems in the team – 83%
4. Chairs and participates constructively in meetings – 83%

All these WR items were classed as leadership items and participants strongly rejected them as elements of WR.

6.4 Items not reaching consensus

There may not be consensus on some things; this in its own right is equally important information for the topic being studied (Keeney et al., 2011). Twenty items (12%) did not reach consensus. Table 24 shows the percentage scores for each of these items.

Table 24. WR items not reaching consensus

LEVEL of AGREEMENT %		ITEM
YES	NO	
67	33	Identifies from a mass of detail the core issues in any situation
58	42	Sees how apparently unconnected activities are linked and make up an overall picture
67	33	Traces out and assesses the consequences of alternative courses of action and, from this, pick the one most suitable
35	65	Recognises patterns in a complex situation
36	64	Advocates for policy changes that promote health of individuals, families or communities
45	55	Questions and challenges the wider system
66	34	Practises with an understanding of quality improvement methodologies
40	60	Makes appropriate impromptu speeches
44	56	Is approached for original ideas
33	67	Acts as a resource
69	31	Gives constructive feedback to work colleagues and others without engaging in personal blame
69	31	Practises with an understanding of how the organisation operates
42	58	Practises with an understanding of how the different groups that make up the organisation operate and how much influence they have in different situations
68	32	Does not become overwhelmed by challenging circumstances
65	35	Copes with multiple and competing demands
64	36	Practises with an understanding of where health care is heading in the future with changing models of care
65	35	Practises with knowledge of local iwi
33	67	Undergraduate transition experience is the same/similar setting as new graduate RN position clinical setting
66	34	Considers that nothing is too much for the client
62	38	Achieved good undergraduate programme grades

More than half of the participants judged 12 items as YES and eight items as a NO.

7. Summary

The objectives for phase two of the study included using the survey questionnaire from the previous analysis and identifying the construct elements of WR. This chapter reported the results of the two survey rounds and the subsequent consensus-gaining process leading to the co-construction of a WR of NGNs framework. Sixty-seven participants (61%) meeting the entry criteria were recruited and completed the survey. Consensus was achieved for a total of 147 of the WR items (88%), with 143 of items

(86%) achieving a YES consensus and four items (3%) achieving a NO consensus. The *Learning* section of the WR items had largest level of agreement ascertained in the first survey round, retained as one of the leading sections at the completion of the second round. No *Leadership* items achieved a YES consensus, but four items achieved a NO consensus. Across the performance level components, the highest percentage of responses were measured at Level 2 in four of the five components; knowledge, independence, proficiency and timeliness. Confidence was more closely scored across the two performance levels. Chapter 6 presents the results of phase three of the study where the co-constructed WR framework is explored in relation to the WITT BN MA nursing programme.

Chapter 6 Phase Three

1. Introduction

This chapter presents phase three of the research project. Phases one and two have been completed and a WR framework co-constructed by NZ nurses working across the sector. The purpose of phase three was to explore the co-constructed WR of NGNs framework (constructed in phase two) in relation to WITT's BN MA programme. An overview of phase three can be found in Figure 7.

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PHASE THREE

Purpose:

To explore the WR framework in relation to the WITT BN 'MA' programme

Objective:

To determine whether the WR elements are 'taught', 'practised' by undergraduate nursing students, and 'assessed' in the WITT BN 'MA' programme

Participants:

Tutors teaching on the WITT BN 'MA' programme

Methods:

Data collection

- ✓ Focus group interview

Data analysis

- ✓ Descriptive statistics
- ✓ Thematic analysis

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Figure 7. Outline of phase three

The objective for phase three is to determine whether the WR elements are 'taught', 'practised' by undergraduate nursing students, and 'assessed' in the WITT BN MA programme, as a means for exploring the co-constructed WR framework in relation to WITT's BN programme.

NGNs demonstrating the elements of WR have learned these behaviours. Learning can be defined as "an enduring change in behaviour, or in the capacity to behave in a given

fashion, which results from practice or other forms of experience" (Schunk, 2012, p. 3). 'Taught' refers to any teaching method or strategy the student experiences in the undergraduate nursing degree that supports their learning of the WR element. 'Practised' refers to the opportunity for the student to practise the learned WR element. 'Assessed' refers to the observation of the student's ability to successfully demonstrate the WR element, either formally or informally. Details of the data collection, methods, and analysis are now presented.

2. Data collection

To meet the objective of this final phase, a focus group interview was conducted. The key informants were defined as those tutors teaching on the WITT BN MA programme. Only one programme was used in this phase because the MA programme was developed specifically to increase WR. The inclusion of other programmes is outside of the scope of this study. The research project participants are known as informants in this phase of the study. Most of the potential informants were employed by the tertiary institution when the new BN MA was commenced. The tutors were purposively selected and invited to participate, first by email along with an information sheet, then by telephone if a response was not received within 10 working days. The recruitment protocol can be found in Appendix O.

Eight eligible informants were identified, including those identifying as Māori and whakapapa to Taranaki. All informants expressed an interest in participating but only seven could attend. Ethical approval was received from AUTEC (see Appendix N).

2.1 The focus group interview

Key informant perspectives were elicited through a focused group in-depth interview, also known as a focus group (Rea & Parker, 2014). The focus group was used as an information gathering technique (Polit & Hungler, 1999; Rea & Parker, 2014) and focussed on examining the WR framework and making a judgement on whether each of the elements are 'taught', 'practised' by undergraduate nursing students, and 'assessed' within the programme. The informants were invited to articulate their perspective. Indicative questions can be found in the Research protocol in Appendix R.

2.1.1 Key informant consent, confidentiality and anonymity

Participation was voluntary, and informants received an information sheet (see Appendix P) and then signed a consent form (see Appendix Q). The informants' perspectives and discussion in the focus group was digitally recorded. The recording remained confidential (i.e., the information is not able to be publicly linked to the individual informants). Informants were asked to keep the identity of fellow colleagues, the discussions and information elicited in the focus group confidential to the group. This was stated in the information sheet and consent form. Furthermore, the content analysis did not identify informants and so their links with public information is confidential. Although confidentiality was maintained, anonymity could not be guaranteed because I knew all the informants, conducted the interview, and undertook the analysis (McKenna, 1994).

3. Data analysis

3.1 Results

Both qualitative and quantitative data were collected and analysed. The interview took 90 minutes. The quantitative data were analysed using descriptive statistics, specifically frequencies measured by percentages. Each of the WR elements had either a 'YES', indicated as √ or 'NO', indicated as X allocated to it under the following headings:

- 'Taught'
- 'Practised'
- 'Assessed'

The WR framework with these results can be found in Appendix M.

3.1.1 Judging 'taught, practised and assessed'

Ninety-two percent (n=132) of items were judged by the informants to meet each of the criteria of 'taught, practised, and assessed'. Eleven items (8%) were identified as not having achieved at least one criterion, including two items (1%) not achieving any criteria, five items (3%) only meeting the 'taught' criteria and four items (3%) were 'taught' and 'practised' but not 'assessed'. Table 25 (p. 116) shows these items.

Five items were judged as having language that would not reflect a professional stance; that should professional language be used, then the full 'taught, practised, and assessed'

criteria would be met. 'A very nice person' transposed to a 'compassionate' nurse, 'demonstrates a sense of humour' to 'uses appropriate humour", 'friendly' to 'engaged', curious' to inquisitive' or 'creative' and 'humble' captured (as it is within the MA programme) within a cultural safety paradigm would all meet the criteria. 'Humble' could also be considered within a learning framework whereby the student readily accepts feedback on performance with a view to improvement.

Table 25. Work readiness elements not taught, practised or assessed

Items	Taught	Practis ed	Assess ed	Informant Comment
Achieved good undergraduate clinical references	X	X	X	Clinical Practice Tutors have known the student for three years and have a contribution to make in providing a reference, yet this was not an option.
Is a very nice person	X	X	X	Perhaps 'compassionate' a more professional term in which case would meet 'taught, practised and assessed'
Questions and challenges another nurses practice	✓	X	X	Not always safe to do so in clinical practice
Is satisfied with choosing nursing as career	✓	X	X	Implicit with programme retention and successful completion of the programme
Demonstrates a sense of humour	✓	X	X	Used as a teaching method. Appropriate use of humour in the clinical context explored
Demonstrates an open and friendly approach	✓	X	X	Openness a communication technique but 'friendly' meaning unclear. Perhaps 'engaged' a more professional term in which case would meet 'taught, practised and assessed'
Is curious	✓	X	X	Perhaps 'inquisitive' and 'creative' are more professional terms in which case would meet 'taught, practised and assessed'
Works with senior staff without being intimidated	✓	✓	X	Students do not always feel safe to do this in clinical practice
Feels ready for the professional nursing role	✓	✓	X	Implicit with programme progression and retention
Is passionate	✓	✓	X	
Is humble	✓	✓	X	Perhaps reframed within cultural safety may be more professionally appropriate in which case would meet 'taught, practised and assessed'

The WR element 'Feels ready for the professional nursing role': The BN tutors indicated that this WR element, although not assessed, it was implied because the student

remained in the programme and progressed through to graduation. Given the nature of the MA programme whereby clinical practice is central to the programme, this response suggests that the BN tutors would expect to see the student withdrawing from the programme if they did not feel ready for the professional nursing role. Because the student nurse begins clinical practice at the beginning of the programme, the reality of clinical practice nursing is embedded early. For the majority of student nurses, clinical practice is both motivating and central to their learning, but some realise that nursing is not for them.

'Questions and challenges another nurse's practice' and 'works with senior staff without feeling intimidated' were considered to be elements exhibited as WR items only if the environment facilitates this. Some clinical units encourage students to question practice, yet others don't tolerate it. Therefore, should the nursing student question practice or in a manner deemed inappropriate by the practising RN, the tutor will be informed of this as a 'problem' that the student is exhibiting.

The student who demonstrates working with 'senior staff without feeling intimidated' may be viewed as working in a safe manner because the student who does feel intimidated may not report changes in a patient's condition. However, the student needs to feel safe and confident in an environment free from bullying or intimidation. Regardless of the environment, should the student not be reporting client findings, the practising RN reports this to the tutor as a safety issue. Hence, in reality, both WR items are 'assessed' by virtue of non-performance rather than performance.

3.1.2 Informant discussion

The discussion digitally recorded during the focus group interview was transcribed verbatim by the researcher. The text was carefully read and 'filler' words and expressions such as 'um' or 'you know' were greyed out to allow me to focus on the key informant perspectives. Identifying names used in the conversation were deleted.

The qualitative data analysis strategy of 'in vivo coding' was deemed appropriate for assisting analysis. Words or phrases standing out in the text, extracted directly from the transcript, became codes as they appeared to me as significant and stood out. The data expressed as codes related to those WR items not meeting the three 'taught, practised and assessed' criteria can be found in Table 25 above (p.115).

The second part of the qualitative data, 'other comments', were collated and analysed. I attempted to categorise the 'other comments' data by clustering together alike codes. This is an interpretive process (Graneheim, Lindgren, & Lundman, 2017; Saldana, 2014) where the researcher attempts to appropriately group the most seemingly comparable codes to construct patterns for further analysis (Saldana, 2014). Rearranging the data in this manner, means that particular features of each category, as well as any relationship between categories, can be further analysed. Category names summarise the overall characteristics of the group of codes (Saldana, 2014). The construction of themes comprises the final stages of analysis. Themes are constructed into extended phrases or sentences and summarise the actual (manifest) and underlying (latent) meanings of the data (Graneheim et al., 2017; Saldana, 2014). Thematic statements, therefore, represent the informants' experiences in judging the WR elements. The themes are as follows.

1. RN role-modelling is a powerful influence on how the NGN perceives the way an RN thinks like, acts like, and is a nurse.

Examples of WR items demonstrating this theme include:

*   Bases practice on evidence rather than routine
*   Manages conflict with colleagues
*   Works with senior staff without being intimidated

These three items are 'taught, practised, and assessed' within the programme, because tutors are facilitating all learning using a 'clinical-practice-like' (Benner et al., 2010) framework. However, RNs in clinical practice have a greater influence on nursing students regarding the practice of nursing, particularly in year three. Where these items are not observed in practising RNs, student nurses may experience conflict on what is the true meaning of 'thinking like, acting like, and being a nurse'.

2. There is a low expectation of WR element levels of NGN performance in this framework

Examples of WR items demonstrating this theme include:

*   Provides mental health care
*   Interprets subjective and objective assessment data
*   Tries to solve problems themselves

- Evaluates client learning

All these items were most highly scored by participants in phase two of the study at Level 1 knowledge (will need to develop knowledge), timeliness (will need extra time) and confidence (will not yet feel assured of own capability); and Level 2 in independence (will need some direction) and proficiency (will need further practice). The phase three informants all agreed that the MA model enables NGNs to perform at higher levels in all components for all these items.

3. The use of lay person language is not helpful in judging professional practice

Examples of WR items demonstrating this theme include:

- Is a very nice person
- Demonstrates a sense of humour
- Respects authority figures

Compassion is a nursing concept integrated into the MA model and informants considered that it would be a more appropriate professional term than 'nice', and it is also 'taught, practised, and assessed' in the programme. Although not well defined in the literature (McCaffrey & McConnell, 2015), compassion comprises the nurse having an awareness of a person's distress and then demonstrating the motivation to relieve it. These components are reflected in the WR framework with elements such as 'practices with an understanding and sharing of feelings / emotions of others', 'advocates for the client', 'always thinks about patient outcomes', 'demonstrates concern for clients', all 'taught, practised and assessed' in the MA programme.

Informants considered that possessing a sense of humour is not an appropriately termed professional WR item. Yet, humour is used as a teaching method, exemplifying how it can be aptly manifested in clinical practice.

Respect can be demonstrated in many forms and, for some practising RNs, respect may take the form of a 'power' semblance. Informants considered this WR item inappropriate and suggest a term such as 'colleagues' or 'health care team members' rather than authority figures, in which case respect is 'taught, practised, and assessed' in the WITT BN MA.

3.2 Establishing trustworthiness

Text can always be interpreted in different ways and therefore elicit different meanings (Saldana, 2014). These issues are central to establishing trustworthiness of the study. Trustworthiness is commonly used within the qualitative tradition to achieve as reliable findings as possible (Denzin & Lincoln, 2011) and can be described using the concepts of credibility, dependability, and transferability (Polit & Beck, 2017).

i. Credibility

The level of confidence in the decisions made by the researcher affects the credibility of the findings of the focus group interview and subsequent analysis (Leavy, 2014; Polit & Beck, 2017). The decisions for this phase of the research project are now presented.

- The participants: selecting all the tutors who teach on the WITT MA nursing programme captured and provided an array of all possible responses on the study question. In this study, the seven informants facilitate learning across the whole nursing programme, from year one through to year three, in clinical practice as well as in the classroom, in simulation and in the on-line learning environment. This way of working means that the tutors have a comprehensive understanding of how the programme is taught, the students' experience of practicing their learned behaviours, and the assessment processes, both formally and informally.

- Data collection approach: determining and selecting the most appropriate approach adds credibility. The tutors have significant experience with the programme and have a teaching role across the whole programme rather than only in one aspect or subject. This arrangement necessitates a team approach to facilitate learning and hence a focus group was deemed most appropriate as an information gathering technique (Polit & Hungler, 1999; Rea & Parker, 2014).

- The amount of data generated: depending on the complexity of the topic and the quality of the data, findings are evaluated in terms of credibility. Phase three had a single focus; that of judging whether the WR items were 'taught', 'practised' by the students, and 'assessed'; hence, the complexity was reduced. As the primary researcher, I acted as a moderator of the semi-structured round table discussion and aimed to maintain the informants' focus (Rea & Parker, 2014).

- Analysis process, suitable codes, and robust themes: the aim was to achieve greater credibility through ensuring no relevant data were excluded nor irrelevant data included, and then carefully ascertaining appropriate codes and themes.

Data were retained as close to the informants' language as possible, ensuring that the meaning of the text was not lost. 'In vivo' coding reveals the actual informant discourse (Saldana, 2014), an approach that ensures the data are presented accurately in relation to the individual WR items. The thematic analysis of the 'other comments' summarise the actual (manifest) and underlying (latent) meanings of the data (Graneheim et al., 2017; Saldana, 2014). Thematic statements, along with specific WR examples, represent the informants' experiences in judging the WR elements.

ii. Dependability

Dependability refers to the stability of data or how much data changes over time and any changes I made in decisions during the analysis process (Polit & Beck, 2017). In this study, there was only one interview focussed on the WR framework with resultant data collected in 90 minutes. This reduced the risk of any significant data changes over time. Further, as primary researcher, I created a decision trail, closely monitored by my supervisor who also oversaw the analysis process.

iv. Transferability

Transferability alludes to the degree to which the findings can be transferred to another group (Denzin & Lincoln, 2011; Polit & Beck, 2017). If a different group of nurse tutors were asked the same questions, it is likely that there would be some different responses.

4. Summary

The objective for phase three was to determine whether the WR elements are 'taught', 'practised' by undergraduate nursing students, and 'assessed' in the WITT BN MA programme, as a means for exploring the co-constructed WR framework in relation to WITT's BN programme. The informants of this focus group interview participated as tutors teaching on the programme. Ninety-two percent (n=132) of items were judged by the informants to meet each of the criteria of 'taught, practised, and assessed'. Five items were judged as having language that would not reflect a professional stance. Two items, although taught within the programme were not always safe to be practised in all clinical settings. Three themes were constructed; RN role-modelling is a powerful influence on how the NGN perceives the way a RN thinks like, acts like, and is a nurse; there is a low expectation of WR element levels of NGN performance in this framework; and, the use

of lay person language is not helpful in judging professional practice. Chapter 7 begins the discussion of the findings of the WR framework, including the WITT BN MA programme, the NCNZ Education Programme Standards for the RN SoP and divergent expected levels of performance.

Chapter 7 Discussion: Setting the scene and polarised expected levels of NGN performance

1. Introduction

This chapter presents part one of the discussion on the results of the research project. The context of the WR framework is presented with a discussion of the MA framework and the NCNZ Education Programme Standards for the RN SoP along with the NCNZ Competencies for the RN SoP. The two most significant phase one Taranaki nursing leaders' contribution to the development of the WR survey (culture and holistic care) are explored. The highest expected levels of performance were achieved in the NGN as the expert learner, having professional attitudes and providing general nursing care. In contrast, health education and promotion WR elements scored low expected levels of performance along with providing end of life care which scored the lowest in the survey. These WR elements are discussed in relation to the literature as well as the different phases of the study. The aims of the research project were:

1.   To gain consensus about the components of WR of NGNs from nurses working in education, practice, professional and regulatory bodies.
2.   To explore the co-constructed consensus of the WR framework in relation to the WITT BN MA model.

Three phases of research activity were undertaken and completed to meet the aims. However, the first aim did not achieve participation from NCNZ, the regulatory body, nor the MoH. The MoH view was that in articulating an opinion, they would consult with and reflect the sector's perspective. The NCNZ did not give a reason for not participating. The absence of the regulatory body perspective may be a limitation of the research project. Although the NCNZ's primary function is public safety, they also direct national standards for nursing education thus, inclusion of their views may have influenced the findings.

Phase one developed a survey tool of WR elements from the literature, melded with elements identified from a Taranaki nursing leader focus group interview. Phase two co-constructed a consensus framework of 143 elements of WR of NGNs in NZ after two rounds of surveys, along with expected levels of performance in knowledge, proficiency, independence, timeliness and confidence. Phase three explored the WR framework in

relation to the WITT BN MA model, and found 92% of the WR items are taught, practised, and assessed in the programme.

WR has been defined "as the extent to which graduates are perceived to possess the attitudes and attributes that make them prepared or ready for success in the work environment" (Walker et al., 2013, p. 116). The 'perception' as well as 'attitudes' (*expert settled way of thinking)* and 'attributes' (*expert qualities)*' of work readiness has been collaboratively determined by nurses across the sector in NZ and the 'extent' identified as the level of performance for each WR item.

The 143-item WR framework co-constructed by nurses from across the sector who were responsible for employing or supporting NGNs; undergraduate curriculum design; examining/advising on professional/cultural nursing issues or were NGNs themselves, presents a comprehensive and significant view of the NGN. Presented as a multi-dimensional construct (Caballero et al., 2011), WR extends beyond discipline–specific competence (Caballero et al., 2011; Walker et al., 2015). The WITT BN MA philosophy is now presented.

2. The WITT BN Modern Apprenticeship

Having experienced a traditional tertiary degree model of education for 20 years, the Taranaki nursing leaders and WITT Head of Nursing collaborated to create a new way of educating nurses. Taking into account the needs of both the education and health sector, the new WITT BN programme was re-designed using the MA model described by Benner et al. (2010). The previous traditional model of undergraduate nursing education structured learning via siloed, content-laden topics artificially divided into courses that demanded the theoretical examination of parts of the patient or client. The lay person was enrolled as a polytechnic student 'to do' a degree programme and exited as a nurse. In WITT's BN MA model, the lay person enrols on the programme to learn how to be a nurse and exits the programme with a degree qualification. The subtle distinction of 'doing' nursing or 'being' a nurse is played out in structuring the learning. For example, the WITT BN MA year one learning is divided into nursing concepts such as nutrition and hygiene, whereby all the underpinning knowledge from a range of fields, the skilled know-how and ethical comportment is equally taught, practised, and assessed in relation to the nursing concept in the 'classroom' as well as clinical practice each week. In the previous WITT traditional model, units of learning were divided up and taught in blocks that did not reflect the holistic stance of nursing practice. For example, the student

124

was expected to 'apply' the knowledge from theory courses of bioscience, cultural safety, pharmacology, and communication etc., to their clinical practice when they eventually got there. Furthermore, some of these blocks of teaching were not even taught by nurses. The WITT nursing students were asking the question 'When are we going to start learning nursing?'

The assumption that the student learns abstract theory or information and then applies that information to practice is ambivalent at best (Benner et al., 2010). It is problematic to assume the student can easily translate PowerPoint presentation information, textbook and literature concepts into skilled know-how and the ability to practice clinical reasoning and a sense of salience; what is best for a particular client at a particular time. In other words, a traditional structure can support the concept of the 'theory-practice' gap. Acquisition of knowledge must be accompanied by learning how to use that knowledge (Eraut, 1994); that is, to use knowledge needs productive thinking, and for nursing, that means developing a sense of salience—both the how and why, and also the when. For clinical knowledge to develop, the nursing student must be able to learn for and from practice, undertaking an "ongoing dialogue between information and practice, between the particular and general, so that students build an evidence-base for care and thus learn to make decisions" (Benner et al., 2010, p. 14).

The answer to the nursing student question 'When are we going to start learning nursing?' was from day one in the MA programme. Nursing students began to learn nursing practice both in the classroom and clinical practice from the first week, from concept-based learning in year one, unfolding case study learning in year two and action learning in year three. Clinical experience was introduced early because evidence shows that front loading theory does not work (Benner et al., 2010). The previous WITT traditional content-presentation lecture whereby the tutor spends significant time constructing the knowledge and delivering that knowledge by PowerPoint, meant that the tutors developed their knowledge and in turn became the 'textbook'; the knower, the content expert who imparts the knowledge (King, 1993). This pedagogy does not support the student engaging with the knowledge and understanding the relevance of it; and, furthermore, may not reflect the complexities of the clients they nurse.

The MA model aims to develop the student to think like, act like, and be a nurse—right from the beginning of the programme—establishing early professional nursing values and attitudes as a foundation to learning to be a nurse, core WR elements identified by the NZ nursing sector. The WITT programme more than socialises the nursing student

to nursing; rather, it deliberately focuses on 'forming' (Benner et al., 2010) the student to develop and commit to these professional values. The learning to think like, act like, and be a nurse philosophy drives all learning to be facilitated using a 'clinical-practice-like' framework; therefore, nursing students learn to be a nurse in both the clinical and non-clinical environments.

Apprenticeship is a metaphor for early and increasing experiential learning (Lave & Wenger, 1991) and is central to the programme. Students increasingly undertake and develop professional practice, take on more responsibility and work towards participation as a health care team member. Their professional practice is formed through an integrated and equal focus on the three professional apprenticeships described by Benner et al. (2010)—learning knowledge for practice, learning skilled know-how and clinical reasoning for salience, and learning ethical comportment using active learning with an emphasis on formation of the professional nurse. Figure 8 below outlines the three apprenticeships developed as a framework for the WITT BN programme. Further MA curriculum detail can be found in Appendix T.

The Modern Apprenticeship
1. An apprenticeship to learn nursing knowledge and science
Nurses need to draw on knowledge from a wide range of fields to provide safe and effective care. Knowledge from physiology, physics, microbiology, chemistry, genetics, pathophysiology, medical interventions, disease, pharmacology, algebra, calculus, statistics, nursing theory, nursing frameworks and models, psychology, education, law, communication, sociology, leadership, heritage, culture, language, religion, spirituality, ethics and morals.
2. A practical apprenticeship to learn skilled know-how and clinical reasoning
This apprenticeship is more than mastering technical skills. For the thinking nurse, these skills are used in conjunction with a well-developed communication and interpersonal skills base. The student learns to judge a situation, read a client's condition over time, manage time and resources, provide advocacy and coordinate client and family information. The student can gain an understanding of the client's illness and wellness, write and speak well and make a case for reporting client's changes or concerns.
3. An apprenticeship of ethical comportment and formation
Learned through situated coaching and clinical practice experience, the student is formed into a good practitioner, always seeking to improve practice and client outcomes through a commitment to professional values. The student nurse learns appropriate use of knowledge and skills to provide culturally safe, ethical and safe care, responding appropriately to care that does not meet these standards and to solve problems.

Figure 8 .The three apprenticeships

The co-constructed WR framework comprises 143 practice-performance items that can be perceived as a model of 'thinking like, acting like, and being a nurse'. This perceived model mirrors and aligns with the MA theoretical framework underpinning the WITT undergraduate nursing programme, accredited and approved by NCNZ and NZQA, and

where 92% of the WR elements were determined as being 'taught, practised, and assessed' in the programme.

3. NCNZ Competencies for RN Scope of Practice

An undergraduate nursing programme in NZ must be approved and accredited to meet the NCNZ Education Programme Standards for the RN SoP (NCNZ, 2015). Having successfully completed an approved NCNZ programme, the NGN has therefore demonstrated these standards. However, the required programme content contained within the standards is conceptual in nature such as "national health priorities and contemporary health care and practice trends" (NCNZ, 2015, p. 7), and open to interpretation on how these are integrated into the programme. The other NCNZ Education Programme Standard for the RN SoP content component is framed around the NCNZ Competencies for the RN SoP. However, there is no expected level of performance articulated. The NCNZ, as the body that regulates the practice of nursing, is required by the Health Practitioners Competence Assurance Act (2003) to ensure competence of senior nursing students to protect the health and safety of the public. The RN competencies are used as safety standards, whereby components are either MET or NOT MET.

Further, there is no reference to WR for beginning professional practice. Having the same competency standards for the senior student/NGN as the experienced RN implies practice performance is expected at the same minimum level. Although the NCNZ RN competencies indicate a minimum safety standard to protect the health and safety of the public, having the same competency standards for the senior student/NGN as the experienced RN implies practice performance is expected at the same minimum level. Moreover, it suggests that the role of the RN can be competently achieved as a student nurse. This is further discussed later in the chapter.

The NCNZ Education Programme Standard for the RN SoP and related content requirements have been mapped against the NCNZ Competencies for the RN SoP and the NGN WR elements and can be found in Appendix S. The purpose for undertaking this mapping is two-fold. First the BN programme needs to meet the NCNZ education standards and therefore programme content and student outcomes will reflect this. Secondly, the NCNZ competencies are the only measurement of student practice performance undertaken at the point of registration and therefore reflect readiness to enter professional practice.

The requirement for all undergraduate nursing programmes is

> an extended clinical experience of 360 hours minimum is included in the final semester of the programme to enable the student to meet the Nursing Council's Competencies for the registered nurse scope of practice and as preparation for transition to practice. (NCNZ, 2014, p. 7)

The first NCNZ Education Programme Standard for the RN SoP content requirement 'Development of critical thinking and nursing inquiry throughout the programme' does not have a NCNZ Competency for the RN SoP mapped against it; yet, there are 16 WR elements aligned. The second NCNZ Education Programme Standard for the RN SoP content requirement 'Professional responsibility' has five aligned NCNZ Competencies for the RN SoP but there are 20 WR elements mapped. The third NCNZ Education Programme Standard for the RN SoP content requirement 'Management and delivery of nursing care' has 10 NCNZ Competencies for the RN SoP mapped but 43 WR elements aligned. The fourth NCNZ Education Programme Standard for the RN SoP content requirement 'Interpersonal relationships' has four NCNZ Competencies for the RN SoP mapped but 25 WR elements. Finally, the fifth NCNZ Education Programme Standard for the RN SoP content requirement 'Interprofessional health care and quality improvement' aligns with three NCNZ Competencies for the RN SoP and also mapped against three WR elements. Thirty-four WR elements have not been mapped to the NCNZ education standards programme content requirements nor the NCNZ Competencies for the RN SoP. These were mainly comprised of professional attitudes and values as well as knowledge of the employing organisation. There is debate regarding the link between pre-knowledge of the working environment and WR (El Haddad, 2016; Haddad et al., 2017; Wolff, Regan, et al., 2010b), suffice to say that it may contribute to the NGN practising more confidently (Walker et al., 2015). This is discussed further in Chapter 8. Although a NGN may have met all NCNZ requirements to attain registration with NCNZ, doing so cannot assume WR. A NGN employment into an organisation without knowledge of that organisation will need cognisance by the employing body with regard to induction, orientation and time to achieve these WR elements.

BN regulatory standards need to reflect the reality of clinical nursing practice to support readiness to enter professional practice. The NCNZ (2015) Education Programme Standards for the RN SoP was last amended in 2015, having previously been reviewed in 2010. The NCNZ (2007) Competencies for the RN SoP are now 12 years old. Although currently under review, the current timeframes between updates may not reflect the rapid changes in the current health care system.

Additionally, the NCNZ (2015) require nursing students to demonstrate five key descriptors at a 'graduate' level. What a 'graduate' level looks like is not defined nor is the components for each of these descriptors, thus exposing the risk of disparate interpretation and differing NGN outcomes. Presumably these descriptors have been identified separately because of client safety and quality of care; yet, 'pharmacology management and medicine management' as well as 'the use of information technology and health information management' do not have NCNZ Competencies for the RN SoP mapped to them. The five graduate level descriptors are:

1. pharmacology knowledge and medicine management
2. comprehensive health consumer assessment skills and clinical decision-making skills supported by knowledge of pathophysiology
3. therapeutic communication with health consumers
4. working within a health care team; providing direction and delegation in practice
5. the use of information technology and health information management

Assessment skills, clinical decision-making, and direction and delegation as WR elements will be discussed further below.

4. New graduate nurses and cultural capability

The phase one Taranaki nursing leaders' contribution to the development of the WR survey had some unique perspectives that complemented or extended the literature findings, especially those elements relating to culture. Although the literature espoused the need for cultural competence and understanding of diversity and cultural factors impacting health care (Berkow et al., 2009; Brown & Crookes, 2016; Freer & Penman, 2016; Holland et al., 2010; Otoo, 2016; Utley-Smith, 2004; Walker, 1998; Walker & Bailey, 1999), as well as cultural safety (NCNZ, 2011b), this element was extended by the nursing leaders. The informants recognised Māori models of health are used in diverse ways with individual iwi. Furthermore, that local tangata whenua express their tikanga and language (dialect) differently.

The Cultural Safety, Te Tiriti o Waitangi and Māori health guidelines (NCNZ, 2011b) recognise the significance of Māori identity, beliefs, values and practices but do not distinguish between Māori as a single ethnicity or Māori as iwi, hapū, and whānau. Furthermore, the language is framed as responding *to* Māori identity rather than working

with Māori, an approach that may be questionable in achieving culturally safe (kawa whakaruruhau) care and meeting Treaty of Waitangi/Te Tiriti o Waitangi obligations.

Little guidance is found in the accreditation and approval body (NZQA, 2018; NCNZ, 2015) standards for programme development and maintenance. The NCNZ (2015) stated that "the curriculum is written and reviewed in consultation with stakeholders ….. tangata whenua" (p. 8). What 'consultation' or 'tangata whenua' mean is not defined. Likewise, NZQA (2018) and Universities NZ (2018) 'programme acceptability' and 'consultation' criteria state that whānau, hapū, iwi, or hapori Māori must be consulted on how the programme is acceptable to them. Furthermore, that Māori views are taken into account with evaluation and monitoring of the programme. Similar to NCNZ, there are no clear guidelines about what 'Māori', 'acceptability' and 'consultation' mean, in terms of influencing the programme development. In undertaking these tasks, each programme developer will determine their own meanings, suggesting national variance with consequent variable nursing programme outcomes.

The WITT BN MA programme worked with local iwi as partners, not just stakeholders. Their perspectives determining 'programme acceptability' were embodied—not just elicited. Hence, all the cultural WR items are integrated across the BN programme, and are 'taught, practised, and assessed' in partnership with local iwi. The term stakeholders is defined as "a person, company, etc., with a concern or (esp. financial) interest in ensuring the success of an organization, business, system, etc" ("Oxford English Dictionary," 2000). As Treaty of Waitangi/Te Tiriti o Waitangi partners, meeting the obligations of the Crown, on behalf of NCNZ, we, as nursing education providers were responsible for *engaging* Māori as *partners* (NCNZ, 2011b) rather than *stakeholders with an interest*.

The WR item 'Knowledge of local iwi' did not achieve consensus in either survey round in this study; yet, 'willingness to take responsibility to change health outcomes' and 'willingness to participate and embrace indigenous models' did. It is unclear how this could be achieved without 'knowledge of local iwi'. The culture codes from the focus group informants are now presented.

- Knowledge of Māori health
- Knowledge of tikanga
- Te reo pronunciation
- Local iwi knowledge
- Willingness to learn more cultural knowledge

- Willingness to participate and embrace indigenous models for better health outcomes
- Willingness to take responsibility to change health outcomes
- Understands that cultural care is part of clinical health care
- Social determinants of health, inequities and inequalities

The phase two participants agreed the remaining culture and related codes all met the threshold for consensus. All achieved an expected level of performance of sufficient knowledge/knows to (knowledge), takes appropriate amount of time (timeliness) and feels assured of own capability (confidence). The WR item 'correctly pronounces te reo (particularly client names)' achieved independent and safe (independence), whilst the remaining WR items achieved 'will need some direction' for expected level of independence. All achieved the lowest expected performance proficiency level of 'will need further practice'.

Health organisations may employ tangata whenua to keep iwi/hapū members culturally safe. However, because nurses are also responsible for cultural safety, this must be a shared role, eliminating the temptation for the nurse to hand over cultural care and potentially stifling the opportunity to improve health outcomes and address health inequities. This is the opportunity for nurses to work alongside tangata whenua to develop their practice and achieve the highest levels of performance in cultural proficiency and independence.

Phase two participants agreed that the element 'Is willing to take responsibility to change health outcomes for Māori' is part of WR of the NGN. This element extends the role of the NGN in that it demands more than just having an understanding of health outcomes but is willing to take responsibility to change health outcomes. Responsibility can be defined as "the state or fact of having a duty to deal with something or of having control over someone" ("Oxford English Dictionary," 2000). There is, therefore, an expectation that the NGN will have sufficient knowledge/knows to (knowledge), takes appropriate amount of time (timeliness), feels assured of own capability (confidence) but will need further practice (proficiency) and will need some direction (independence) in carrying out their duty to deal with the higher rates of Māori non-communicable diseases and lower rates of Māori life expectancy (Ministry of Health, 2015). These health outcomes are being compounded by inequitable access to health care and health professionals that are inconsistent with culturally appropriate services.

Māori are over-represented in NZ's mental health statistics and the NZ government (2018) has reported that underpinning these statistics are the impact of colonisation, loss of identity, and the "importance of cultural as well as clinical approaches, emphasising ties to whānau, hapū and Iwi" (p. 9). There is increasing urgency for nurses to have greater kawa whakaruruhau embedded in their practice and this includes knowledge of local iwi.

All the WR culture items, including that which did not meet consensus (practises with knowledge of local iwi), were identified by the phase three nursing tutor informants as being 'taught, practised, and assessed' using the three apprenticeships. Notably in the first year of the programme, these elements are blended with cultural safety and communication within the nursing concepts and then integrated across the remaining two years.

The NCNZ (2015) Education Programme Standards for the RN SoP state specific aspects of nursing practice that need to be demonstrated at the graduate level at the completion of the nursing degree, as discussed above, but these do not include cultural WR elements. The education standards further explicate content, including Professional responsibility related to:

- the application of the Treaty of Waitangi/Te Tiriti o Waitangi in clinical practice
- culturally safe care and understanding of cultural safety

and these map to two NCNZ Competencies for the RN SoP (NCNZ, 2007).

- Competency 1.2: Demonstrates the ability to apply the principles of the Treaty of Waitangi Te Tiriti o Waitangi to nursing practice.
- Competency 1.5: Practises nursing in a manner that the health consumer determines as being culturally safe.

The results of the phase two participant consensus have evinced that this NCNZ Education Programme Standard for the RN SoP and NCNZ Competencies for the RN SoP need further explication to represent WR of NGNs. The NCNZ Competencies for the RN SoP indicators for the competencies above reveal knowledge of the Treaty of Waitangi/Te Tiriti o Waitangi and application to nursing practice, recognising impact of culture, respecting individual's identity, providing advocacy, and reflecting on own practice. The cultural WR items may be the vehicle for this 'application', 'recognition', 'respect', and focus for 'reflection' to be demonstrated in clinical practice.

5. New graduate nurses as expert learners

The learning component WR elements were the fastest and most comprehensive group of items that achieved a YES consensus. All 17 items (100%) reached consensus with 15 in the first round and two in the second round. Moreover, 10 (59%) elements achieved the highest expected level of performance across all components. NGNs are expected to have sufficient knowledge/know to (knowledge), be independent and safe (independence), accomplished and well-practised (proficiency), taking the appropriate amount of time (timeliness) and feeling assured of own capability (confidence) as:

- Is experienced in and knows how to learn
- Demonstrates ability to look things up
- Demonstrates ability to learn quickly
- Is pro-active and keen to learn
- Demonstrates personal growth through learning
- Practises using an understanding that learning is progressive; they don't know everything
- Learns a lot from colleagues
- Approaches senior people to learn from
- Willingly and actively seeks and asks about clinical practices
- Learns from other RN role-modelling to understand how an RN thinks and acts like a nurse

Five further items had performance expectations of sufficient knowledge/knows to (knowledge), takes appropriate amount of time (timeliness) and feels assured of own capability (confidence) but will need some direction (independence) and further practice (proficiency).

- Develops practical knowledge from reflecting on/self-assessing own knowledge, practice and competence
- Faces and learns from mistakes
- Keeps up to date with current realities and changes
- Listens openly, accepts and applies constructive feedback
- Recognises and maximises opportunities for learning

Nurses across the sector have high expectations of the NGN performance in learning; becoming the expert learner. The concepts of self-directed and lifelong learning have

been one of the cornerstones of nursing education moving to the tertiary sector in NZ (Greenwood, 2000; Walker, 1998). Self-directed learning is concerned with taking self-responsibility to identify learning needs, devising individual learning plans and seeking relevant and appropriate resources in order to engage in self-learning activities, continuously self-evaluating learning and continually improving nursing practice. Readiness to engage with self-directed learning will depend on the learner's attitude, ability, and personality characteristics (Chakkaravarthy, Norzihan, Mardiah, & Munikumar, 2018; Fisher & King, 2010) such as curiosity, enjoying learning, self-motivation, reflection, courage, challenging tradition and values, and actively inquiring through both scholarly and practice-based activities (Davis, Taylor, & Reyes, 2014).

However, the stakes are high in the current health environment and, with rapid changes in knowledge and technology, the expert-learner skill is essential. The challenge for educators, in a content-laden curriculum, such as the previous traditional BN model, is to understand that gaining knowledge and knowing are different yet dynamic processes (Davis et al., 2014). Moreover, it is the attitude for lifelong learning, not just the knowledge and skills of it, that is important to overtly and explicitly embed in a nursing programme.

The NCNZ Education Programme Standards for the RN SoP content 3: Management and delivery of nursing care comprises 'lifelong learning, professional development and ongoing competence responsibilities' and maps to the NCNZ Competencies for the RN SoP Competency 2.9 Maintains professional development. The link between this competency and the associated content of self-directed, lifelong learning is unclear. Moreover, it does not emphasise the high expected levels of performance of the NGN as an expert learner. Given this expectation by the NZ nursing sector, more detailed guidance and specificity may give rise to the demonstration of this WR element by the NGN, thereby exposing the importance of professional development more overtly. Expert learning skills can be demonstrated in both the classroom and clinical practice using authentic assessment practices rather than assumed by just gaining a 'pass' grade.

NGNs from the WITT MA programme have successfully completed a programme using the 'formation of the nurse' (Benner et al., 2010) pedagogy that structures learning for the student nurse to engage in self-directed learning at a highly developed level, by integrating knowledge, skilled know-how and ethical comportment. Becoming an expert learner is not an add-on to the programme of study; it is integrated as a foundation across the whole programme, through deliberate pedagogical choices. Pedagogies of inquiry (Benner et al., 2010) support the nursing student to develop habits of thinking and working through clinical issues, skills needed for lifelong learning and aiding the transition of a student to an NGN more successfully (Walker et al., 2015). All WR learning elements

were explicit within the MA programme and determined as being 'taught, practised and assessed' by the phase three nursing tutor informants.

6. New graduate nurses and professional attitudes

The second group of elements gaining a YES consensus and scoring the highest levels on expected performance levels relate to professional attitudes. NGNs are expected to have sufficient knowledge/know to (knowledge), be independent and safe (independence), accomplished and well-practised (proficiency), taking the appropriate amount of time (timeliness) and feeling assured of own capability (confidence), were measured in:

- Demonstrates a concept and understanding of service; puts others before self
- General behaviour and conduct is appropriate (including use of language, mobile phone and social media, appearance and attire)
- Eager to throw self into work
- Respects authority figures
- Respects colleagues
- Is punctual
- Demonstrates a sense of humour
- Demonstrates a mature view on life
- Demonstrates an open and friendly approach
- Is willing to commit to the practice setting
- Is satisfied with choosing nursing as a career
- Feels ready for the professional nursing role
- Wants to produce as good a job as possible
- Looks forward to the opportunity to learn and grow
- Is reliable
- Sees it as very important to be the best nurse
- Does not take days off ad hoc
- Is passionate
- Is humble
- Is curious
- Demonstrates personal attributes, values and guiding principles that fit with the practice area

One WR item meeting consensus, but not achieving the highest expected levels of performance, was 'Is focussed on career'. The NGN will need some direction (independence) and further practice (proficiency) with this item. Nurses across the sector have determined that professional attitudes are highly regarded and expected of the NGN. However, professional attitudes comprise the largest component of WR elements not mapped to the NCNZ Education Programme Standards for the RN SoP content. Furthermore, they are not mapped to the NCNZ Competencies for the RN SoP and the term 'attitude' is not found in the competency document. However, the NCNZ guidance (NCNZ, 2019) states that competence is "the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse" (p. 4) and that nursing practice may be assessed on any of these aspects, including attitude. If nursing students' attitudes are to be assessed, clarity on professional attitude requirements is necessary. When an individual becomes a nurse, there is an expectation that individual attitudes will be replaced by professional attitudes, but the question is who is deciding how those professional attitudes manifest. The NZ nursing sector have begun to identify these.

If the undergraduate nursing programme aims to prepare nurses for beginning professional practice, then that undergraduate programme necessitates a curriculum to 'form' (Benner et al., 2010) nurses' professional values by 'thinking like, acting like, and being a nurse'. These WR attitude elements are integrated into and across the WITT MA nursing programme. The clinical-practice-like 'classroom' time demands a professional environment for students to learn ethical comportment and practice a positive work ethic and attitude. The same values are applied in the 'classroom' that would be expected in clinical practice. The 'classroom' refers not only to the traditional space at the educational institution, but also the simulation centre, online learning environment, tutorial and action learning forums, journal clubs, marae learning and community health promotion activities.

The phase three nursing tutors reported that most of the WR attitude elements are 'taught, practised, and assessed' in the WITT BN programme. Attitudes are located within the ethical comportment apprenticeship and drive the acquisition of professional values, a pedagogical cornerstone of the MA in 'forming' (Benner et al., 2010) the professional nurse. Assessing attitudes is difficult (Taylor, 2014); often it is the absence of professional attitudes that is noticed rather than purposively evaluating nursing student attitudes because internal behaviours such as attitudes emerge as emotions and feelings (Bloom, 1956).

Traditionally, nursing education has encompassed Bloom's (1956) domains of cognitive, psychomotor, and affective learning (Shultz, 2009). The affective domain has been associated with ethical and moral development subsequently linked with the development of professional values which in turn drives professional practice. An example is the development of values underpinning a therapeutic relationship critical to quality patient care and improved health outcomes (Shultz, 2009). Thus, it is fundamentally important for values, morals and ethics (i.e., the apprenticeship of ethical comportment) to underpin nursing education.

The teaching, learning and assessment of attitudes and professional values must be viewed as a process (Rodriguez, Plax, & Kearney, 1996), because the student's emotions and feelings are processed and internalised over time, resulting in the development of his/her own professional beliefs, values, and attitudes and which ultimately emanates in actions. Effective teaching strategies include the work of Bingham and O'Brien (2018) who described the teaching strategy of bringing mental health consumers into the classroom to work with student nurses. The results of this education intervention showed, over time, a decrease in student stigma and discrimination toward those with mental health and addiction issues.

The outcome of teaching and learning within the ethical comportment apprenticeship is influenced by its relationship with the cognitive and skilled know-how apprenticeships and subsequently evidenced as professional practice. Hence, professional attitudes and values are difficult to measure as they are usually only observed (or not observed) in nursing practice. Moreover, time is required for the development of ethical comportment and topics such as ethics, morals and values cannot be taught as a one-off block of study. In the WITT BN programme, the third-year students in their final semester of study undertake an assessment identifying, describing and critiquing their own beliefs, values and assumptions of nursing. This work reflects the three-year journey of ethical comportment learning and prepares them for successful recruitment to an RN position to begin professional practice.

In a highly relational profession such as nursing, attitudes underpin how nursing is practised (Price, 2015). Given the pre-eminence of professional attitudes, greater specificity such as those indicated by the NZ nursing sector begins to make explicit what is expected of the NGN to develop over time and then demonstrate in terms of being ready for work.

7. New graduate nurses practising general nursing care

The third group of WR elements gaining a YES consensus and scoring highly on expected performance levels relate to providing nursing care in a professional manner. NGNs are expected to have sufficient knowledge/know to (knowledge), be independent and safe (independence), accomplished and well-practised (proficiency), taking the appropriate amount of time (timeliness), and feeling assured of own capability (confident) in:

- Performs personal care/activities of daily living (ADLs) for clients
- Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse
- Gives handover
- Practises using an understanding of client rights
- Demonstrates concern for clients
- Willing to pitch in and undertake menial tasks when needed
- Recognises the need to get along with others
- Able to co-operate (assist/comply with requests)
- Acts in familiar situations
- Declines to undertake unfamiliar activities

This surprising result means that in all other nursing care activities, the NZ nursing sector are proposing that the NGN will need to develop their nursing care performance in any or all of the knowledge, proficiency, level of independence, timeliness and confidence level components; that these levels of performance will need to be developed once employed as a NGN, having entered professional practice and working within a legal framework where the NGN can be held legally accountable for their practice. Patient safety may be at risk should a NGN be practising without this level of competence, because safe standards of care may not be provided. It can therefore be argued that an extended clinical practice period is required by the NGN to demonstrate safe delivery of nursing care. The WR element performance levels can be a vehicle for this demonstration.

In contrast, the following two assessment skills, although achieving a YES consensus, were judged by the phase two participants for the NGN expected level of performance very low in knowledge (will need to develop knowledge), independence (will need some

direction), proficiency (will need further practice), timeliness (will need extra time), and confidence (will not yet feel assured of own capability).

- Demonstrates a mind-set whereby can transfer skills to another clinical setting
- Interprets subjective and objective assessment data

The phase three nursing tutor informants disagreed with this judgement. Subjective and objective assessment data were strongly present within the teaching to think like, act like, and be a nurse across the whole programme; client assessment skills are not siloed into one course. The phase two participants judged the NGN to highly perform hands-on assessment skills in conjunction with technology yet perform at a low level when interpreting assessment data. If the NGN needs to develop more knowledge, need direction and further practice, more time, and will not yet feel assured of own capability, it suggests the NGN practice does not align with the RN SoP It aligns more with the enrolled nurse because the enrolled nurse can contribute to patient assessment, usually in the form of performing the assessment, but their SoP means they are not accountable for the clinical reasoning and decision-making when interpreting the assessment data. This is the SoP of the RN and the NGN will need to develop this aspect of their RN SoP post-employment, supporting the view that a NGN is practising differently at the point of registration compared with a RN with some experience.

The NCNZ Education Programme Standards for the RN SoP (NCNZ, 2015) 3: Management and delivery of nursing care, includes content of comprehensive health consumer assessment and decision making, mapped to the NCNZ Competency for the RN SoP 2.2: Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings. This NCNZ Competency for the RN SoP will have been met as a senior nursing student and does not align with the NZ nursing sector view, that is to say that the NGN needs to develop more knowledge, need direction and further practice, more time, and will not yet feel assured of own capability when interpreting and making decisions regarding assessment data. Decision-making is further discussed in Chapter 8.

Interpreting subjective data or noticing, interpreting, responding, and reflecting on the patient informing the nurse about their symptoms, feelings, concerns and perceptions is fundamental to RN practice (Wilkinson, 2016). Likewise, confirming or adding to subjective data with objective data. However, the acuity of patients on acute wards has significantly increased to the extent where, in the past, many of these patients would have been cared for in the intensive care unit (Missen et al., 2016). Alongside high acuity,

is increasing numbers of patients with co-morbidities, leading to increased risk of patient deterioration. Despite the introduction of early warning systems (EWS), patient deterioration is often detected and reported late (Martins et al., 2015). A scoping review of the literature (Wood, Chaboyer, & Carr, 2019) found that a lack of confidence is one factor in not activating the rapid response team, along with previous experience of calling the team. The findings also suggest that nurses paid more attention to the EWS scores than clinical signs of deterioration. With the use of EWS in NZ hospitals, it could be that the expectation for the NGN is to highly perform assessment skills but that the EWS is used for decision-making, rather than clinical judgement. Decision-making is further discussed in Chapter 8.

The WITT BN MA NGNs have all experienced clinical practice time across a range of settings including mental health, medical, surgical, aged care, community/primary health care, and paediatrics. The nursing students have had the opportunity to transfer their skills learned in one area to another; for example, using their mental health assessment skills in the emergency department as well as the mental health setting. All provision of care WR elements have been 'taught, practised, and assessed' in the WITT BN MA programme.

8. New graduate nurses and holistic care

Another notable phase one focus group informants' contribution related to holistic care. Clients who require both mental and physical health care must receive care in the most appropriate environment, whether that means a mental health, acute, or primary health care setting. Requesting the assistance of a 'mental health' nurse to 'watch over' a client with mental ill-health receiving care for an acute physical condition in an acute ward was no longer considered sufficient. Likewise, transferring a medical nurse to the mental health unit to manage a patient's physical care issue, such as diabetes meant the patient receives a siloed nursing service. The general health and mental health dichotomy must be removed (National Nursing Organisation, 2017). Additionally, holistic care means not only delivering care for the immediate health issue but also using opportunities to provide preventative or health promotion support. The nurse can function as the generalist health practitioner and work opportunistically in providing health care (National Nursing Organisation, 2017).

The WITT BN MA programme uses a framework wherein the student nurse learns nursing practice via structured learning such as nursing concepts and unfolding case

studies, rather than siloed theoretical topics. An example is the year two unfolding case study of Mr Manu who has diabetes and depression. The students learn to care for Mr Manu through the unfolding of his health story, as well as health promotion opportunities via the three apprenticeships of knowledge for practice, skilled know-how, and ethical comportment.

The WR item related to holistic care met consensus with the highest expected performance levels in knowledge 'sufficient knowledge/knows to', timeliness 'takes appropriate amount of time' and confidence 'feels assured of own capability' but 'will need some direction' for level of independence and 'will need further practice' for proficiency for the WR element 'providing holistic and person-centred care (not just the illness), including providing preventative and mental health in same setting'. This WR element is mapped to the NCNZ Education Programme Standards for the RN SoP 3: Management and delivery of nursing care and linked with the NCNZ Competency for RN SoP 2.2: Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings. However, it is a weak correlation and makes the assumption that 'management and delivery' and 'comprehensive' means holistic. Perhaps holistic is not a term all nurses associate with person-centred care. In the US, the holistic nurse practises within a nursing specialty (Dossey, Keegan, & Barrere, 2016; Shamian, 2018). Whereas, the National Nursing Organisation, a group of NZ nursing organisation leaders describe nursing practice and health models as having an holistic view; that all nurses use this framework in their role (National Nursing Organisation, 2017). Conceivably, it could be that holistic and person-centred care are similar in the NZ context.

The UK Health Foundation use of the phrase 'person-centred care' emphasises a holistic approach wherein the client's health issue along with their wellbeing and socio-cultural backgrounds play a part in health service delivery. As an emerging and evolving area, there is no definition of 'person-centred care' but providing health care in this manner will depend on what it is the client needs and prefers (The Health Foundation, 2016), a model that can be seen in NZ. Careerforce, a health and wellbeing industry training organisation, uses the Health Foundation stance with person-centred care. Their philosophy is based on working in partnership with clients to provide social, emotional, physical, spiritual, cultural and mental care (Careerforce, 2017).

Another model unique to NZ, is the Whānau Ora model, which also could be described as holistic, but rather than person-centred is whānau-centred. The model aims to use

the whānau strength to improve the wellbeing of the person and the whānau, through the provision of appropriate services (Te Puni Kokiri, n.d.).

The term holistic has disparate meanings for different groups of nurses and has similarities and differences within different health models. For this NGN WR item, it may be that 'patient-centred care' is inferred; that is, it refers to patient preferences about the clinical decision-making in their health care (Health Navigator NZ, n.d.). Further, that integrating physical and mental health care comprises this patient-centred care with an inference for students to learn patient-centred care in the same manner as they will be expected to practise it. The implications for the WR framework are that further clarity will need to be agreed on 'holistic care', ensuring a more robust consensual view.

9. New graduate nurses and mental health care

The NZ nursing sector agreed that the NGN provides mental health care but that the NGN will need to develop knowledge (knowledge), will need some direction (independence), further practice (proficiency), extra time (timeliness) and will not yet feel assured of own capability (confidence). This was highly contested by the phase three nursing tutor focus group informants. Previously, in the WITT BN programme, physical health was taught separately from mental health; yet, nurses would be expected to provide holistic care. Nursing education should reflect learning to be a nurse rather than progressing through siloed topics artificially divided into courses that demand the theoretical examination of parts of the patient or client. In the WITT BN programme mental and physical health and wellbeing is taught, practised, and assessed together in a holistic and integrated manner across the three years, as briefly discussed above.

Although there is debate about the undergraduate programme curriculum commitment to mental health and addiction content, and concern that the topic is diluted in today's programmes (Bingham, 2015), there is increasing need for NGNs who can meet the complex needs of a modern population. Fifty to eighty per cent of New Zealanders will have a mental health or addiction issue in their lifetime (New Zealand Government, 2018) and at any one time, nurses will be caring for clients, 20% of whom are likely to be experiencing these health issues (Bingham, 2015). Nursing students who are lay people on a journey to being a nurse and, therefore, like the general public, need to have a facilitated journey whereby their beliefs, attitudes, stigmas, assumptions and discriminations are challenged (Bingham & O'Brien, 2018). Effective mental health promotion and wellbeing, and appropriate response to NZ citizens with mental health

issues should be a role of all health professionals, including nurses (New Zealand Government, 2018).

The expected levels of performance by the NGN for mental health are low. In contrast, the expected levels of performance for physical health such as the WR element 'Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse' achieved the highest expected levels of performance across all components, which may reflect a view that mental health is not mainstream nursing.

The phase two *DHB mental health* participant group agreed with each other on the levels of performance but these differed to the whole phase two nursing sector, particularly in two components. Sixty-seven percent of mental health nurses agreed the expected level of knowledge at Level 1 'will need to develop knowledge' compared to 71% of the nursing sector. Fifty-six percent of mental health nurses agreed the expected level of independence to be at Level 1 'will need further development/supervision', whereas 55% of the nursing sector agreed at the higher Level 2 'will need some direction'. Fifty-six percent of mental health nurses agreed the expected level of proficiency to be at Level 2 'will need further practice' compared to 75% of the nursing sector agreeing at Level 2. Timeliness and confidence expected levels of performance agreement at Level 1 (will need more time and will need further practice) were slightly lower by the mental health nurses (78%) compared to the nursing sector (84%). The DHB mental health nurse cohort, therefore, agreed the expected levels of performance to be lower in every component compared to the whole nursing sector. These results may reflect the acuteness of mental ill-health in the DHB mental health setting. However, the World Health Organization (2013) stated that good mental health is "related to mental and psychological wellbeing", that a spectrum of mental health promotion and prevention, including reducing stigma and discrimination to mental illness treatment, rehabilitation, care and recovery. The NZ nursing sector were asked to identify if mental health care was a NGN WR element. The findings may be influenced by the participant's own knowledge, experience and expertise of mental health/illness. However, given the current mental health crisis and significant government resources being released into this health field, it may be that the NZ nursing sector needs to re-visit the mental health/illness care spectrum and determine more specific mental health care elements as well as the extent of the expected levels of performance of the NGN.

10. New graduate nurses practising health education and promotion

Another group of WR elements reaching a YES consensus but with low expected levels of performance, include health education and promotion activities. The WR elements of 'teaching clients and families' and 'evaluating client learning' was judged by the phase two participants for the NGN expected levels of performance to—will need to develop knowledge (knowledge), will need some direction (independence), will need further practice (proficiency), will need extra time (timeliness) and will not yet feel assured of own capability (confidence).

These expected levels of performance were challenged by the phase three nursing tutor informants. Health education, promotion and prevention activities are taught, practised, and assessed across the three years in the WITT BN MA programme, as part of the holistic approach to learning to think like, act like, and be a nurse, in both clinical and non-clinical experience throughout the programme. Health education takes place in any and potentially every setting where the nurse interacts with clients and whānau/family (Smith & Zsohar, 2013), acknowledged by the phase two participants agreeing a YES consensus of the WR element 'Willing to work holistically and person-centred (not just the illness), including providing preventative and mental health care in same setting', which scored expected levels of performance higher in knowledge (sufficient knowledge/knows to), timeliness (takes appropriate amount of time) and confidence (feels assured of own capability).

The NCNZ RN SoP stated that RNs "advise and support people to manage their health" (NCNZ, 2007, p. 3). The NCNZ Education Programme Standards for the RN SoP (NCNZ, 2015) 3: Management and delivery of nursing care comprises content on health promotion and health education, as well as chronic disease state management and maps to NCNZ Competency for the RN SoP 2.7: Provides health education appropriate to the needs of the health consumer within a nursing framework. This NCNZ Competency for the RN SoP and the achievement of it as a senior nursing student does not align with the NZ nursing sector low levels of expectations of the NGN's levels of performance.

The NZ Ministry of Health 'Advanced Choice of Employment' (ACE) recruitment process is the most common pathway for senior nursing students or NGNs to apply for a NGN position. Thirty-nine percent of senior nursing students applying for RN positions via the ACE process in 2018 were interested in primary health care, a health service with a focus

on health education (Ministry of Health, 2001, 2011, 2016b). Health education is more than just handing out pre-printed literature. Skills such as motivational interviewing, choosing/creating the right environment, and using strategies such as 'teach-back' can be successful in health education (Smith & Zsohar, 2013).

The nuances of health education and health promotion for the undergraduate nursing curriculum are unclear and, therefore, open to interpretation by the nursing education and practice sectors in NZ. Given the NZ nursing sector's low expected levels of performance, there is a need for the profession to explore this aspect of nursing further. It will be important to establish whether or not the myth that a nurse needs to work in acute hospital care for two years before being employed in the primary health care sector has been debunked.

11. New graduate nurses and end of life care

The WR element 'provides end-of-life care' met consensus in the phase two second round survey. However, this element achieved the only expected level of independence performance at the lowest score possible in the whole survey: 'will need further development/supervision'. No other WR element in the framework attained this performance level. The element also achieved low levels of performance in knowledge (will need to develop knowledge), proficiency (will need further practice), timeliness (will need extra time), and confidence (will not yet feel assured of own capability).

In 2015, over 25,000 deaths were recorded for people 65 years and over in NZ (Ministry of Health, 2018c). Approximately a third of these deaths occurred in hospital, one third at home and one third in residential aged care. Although death rates are decreasing for non-communicable diseases, as the baby boomer generation (born 1946-1965) ages, the overall number of deaths is increasing (Ministry of Health, 2016a). However, end-of-life palliative care is not just reserved for the over 65-year population. There is a need for increased palliative care services which becomes everyone's business—not just specialist services—because everyone should have a respectful end of life (Ministry of Health, 2016a). Dr Sinéad Donnelly, a public-hospital based palliative care specialist, stated "It is really up to every healthcare professional – the generalist nurse, hospital doctor and GP to have some experience and skill in caring for people who are dying" (https://healthcentral.nz/live-well-stay-well-get-well-die-well/).

Although there is not yet national agreement on what quality end-of-life care constitutes, key issues include being close to loved ones, control of pain and symptoms, cultural and spiritual needs met, being well informed and receiving personal care as needed (Ministry of Health, 2016a). Each of these aspects is integrated and taught, practised and assessed within the WITT BN MA programme but it may be the lack of a national agreement which led to the low expected levels of performance for this WR element.

12. Summary

The 143-item WR framework co-constructed by nurses from across the sector presents a comprehensive and significant view of the NGN and signals the 'perception' as well as 'attitudes' (*expert settled way of thinking)* and 'attributes' (*expert qualities)*' of WR and the 'extent' that makes them prepared for professional practice, identified as the level of performance for each work readiness element. The WR framework can be perceived as a model of 'thinking like, acting like, and being a nurse'. This perceived model mirrors and aligns with the MA theoretical framework underpinning the WITT undergraduate nursing programme.

Mapping of the NCNZ Education Programme Standards for the RN SoP content requirements, the NCNZ Competencies for the RN SoP and the NGN WR elements show poor alignment, that is to say that not all content requirements are linked to competencies. Cultural competency, strengthening of the Treaty of Waitangi/Te Tiriti o Waitangi relationship with Māori as partners, rather than stakeholders, strongly emerged in order for the NGN to take responsibility to change health outcomes for Māori. NZ nurses across the sector have high expectations of the NGN performance in learning—becoming the expert learner and taking responsibility for ongoing professional development. They also have high expectations of the NGN demonstrating professional attitudes; yet professional attitudes comprise the largest component of WR elements not mapped to the NCNZ Education Programme Standards for the RN SoP content. Furthermore, they are not mapped to the NCNZ Competencies for the RN SoP and the term 'attitude' is not found in the competency document, despite the ability for attitude to be assessed.

The term holistic has disparate meanings for different groups of nurses and has similarities and differences within different health models. Despite the current mental health crisis, the expected levels of performance by the NGN for mental health are low. In contrast, the expected levels of performance for physical health such as the WR

element 'Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse' achieved the highest expected levels of performance across all components which may reflect a view that mental health is not mainstream nursing. The nursing care activities judged to have the highest levels of performance are personal care and undertaking observations, meaning that all other nursing practice will require the NGN to develop competence post employment as an RN. Health education and promotion, and end-of-life care, both key roles for the RN, met consensus but with low levels of expected performance.

Chapter 8 further discusses the findings of the WR framework; the NGN performing in the health care system including the remaining WR sections, those elements meeting a NO consensus along with scrutiny of the expected levels of performance of all the WR elements.

Chapter 8 Discussion: Performing as a NGN in the health care system

1. Introduction

Chapter 7 has commenced the NGN WR discussion by setting the context of the WR framework and describing those WR elements achieving the highest and lowest expected levels of performance. This chapter presents part two of the discussion on the results of the research project. The cornerstone of the RN role that of clinical decision-making is explored within the context of workload along with time management and working as a team member. Leadership, managing conflict, quality, organisational elements and health care system WR elements are examined and pertain particularly to the future with changing health care models. Finally, a review of the overall expected levels of performance is articulated with narrative focussed on the role of the undergraduate degree.

2. New graduate nurses, their workload and decision-making

All three workload WR elements met the threshold for a YES consensus but 'Manages a full workload of *mixed acuity* clients after completing orientation' only achieved the YES consensus when 73% of participants agreed with each other on the second round and after analysis to ensure that one participant group did not influence the consensus level. Furthermore, this item's expected levels of performance were scored low with—will need to develop knowledge (knowledge), will need some direction (independence), will need further practice (proficiency), will need extra time (timeliness), and will not yet feel assured of own capability (confidence). The WR element 'Manages a full workload of *low acuity* clients after completing orientation' easily met the threshold for consensus with 93% of phase two participants agreeing with this item. The only difference in performance levels with this element and the former is that although NGNs have sufficient knowledge/knows to (knowledge) in managing a full workload of *low acuity* clients; they will still require time to develop the remaining expected levels of performance to the highest levels after induction and orientation.

Today's acute care clients in the medical and surgical hospital facilities are the intensive care patients of the previous decades (Missen, Porter, Raymond, de Vent, & Larkins, 2018). With increasing longevity and people living with chronic illnesses (e.g., dementia

and diabetes) (Ministry of Health, 2016b), the workplace and health care needs are increasingly complex (El Haddad et al., 2017). The question, therefore, needs to be asked if a low acuity workload exists. Moreover, if it does, stable clients may often be cared for by second level nurses under the delegation and direction of the RN. More likely, a mixed acuity workload will be the expectation and NGNs need to function safely and independently and, as far as is reasonably possible, "hit the ground running" (Greenwood, 2000, p. 21).

Clinical decision-making is a complex process and the cornerstone of the RN role (Johansen & O'Brien, 2016). It differentiates the RN from the enrolled nurse and health care assistant roles. The NCNZ RN SoP states "They [RNs] provide comprehensive assessments to develop, implement and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making" (NCNZ, 2007, p. 3). The development of critical thinking and nursing inquiry throughout the programme is one of the NCNZ Education Programme Standards for the RN SoP content requirement (NCNZ, 2015). It is assumed that critical thinking and nursing inquiry are the antecedents of decision-making. Sixteen WR items are mapped to this education standard statement but no NCNZ Competencies for the RN SoP are.

The decision-making section of the WR framework was the largest and 23 items met the threshold for a YES consensus by the phase two participants. Four elements did not reach consensus. Only two decision-making WR items (9%) achieved the highest expected levels of performance—sufficient knowledge/knows to (knowledge), independent and safe (independence), accomplished and well-practised (proficiency), takes appropriate amount of time (timeliness), and feels assured of own capability (confidence) and can be found in Table 26 (p. 152-153). The remaining 91% of the decision-making WR items will need further development to meet the highest levels of expected performance after the NGN commences professional practice. RN decision-making affects client care, health outcomes as well as client safety (Benner et al., 2010; Tanner, 2006); therefore, it is imperative decision-making performance levels are effective. The NZ nursing sector clearly indicated that decision-making was a significant role of the NGN that needed development once employed as an RN.

Clinical decision-making is a complex process and involves a series of steps. Gathering subjective and objective data (a NGN WR element that met a YES consensus) and interpreting this data (a NGN WR element that did *not* meet a YES consensus) is one of

these steps alongside consulting protocols and utilising best evidence (Johansen & O'Brien, 2016), reflecting an analytical, information processing model. The other decision-making model identified in nursing is the intuitive-humanist model, a model that differentiates the experienced RN from the NGN. Commonly known as intuition, it is based on experience and the recognition of patterns in client situations. The RN sees the situation as a whole, rather than discrete parts and works to synthesize "empirical, ethical, aesthetic, and personal knowledge" (Johansen & O'Brien, 2016), acknowledging Carper's (1978) ways of knowing in nursing. The NGN needs to develop an analytical decision-making capability whilst gaining clinical experience over a period of time, eventually developing intuition. The decision-making WR elements that did not reach the threshold for consensus could be classified as belonging to the intuitive-humanist model. The NZ nursing sector recognises these will take experience and time to develop.

Many of the decision-making WR elements that did reach the threshold for a YES consensus focused on recognising client health status changes and seeking assistance. Situational awareness is the key antecedent to decision-making (Johansen & O'Brien, 2016). Critical thinking and clinical reasoning terms have been used interchangeably with decision-making; however, are different in that they work as thinking processes in pursuance of making a decision (Johansen & O'Brien, 2016). Along with other types of thinking, such as analytical and creative, problem-solving techniques such as the nursing process model of practice (the WR element of writing plans of care met a YES consensus) and the hypothetico-deductive model can be useful frameworks for developing beginning analytical decision-making skills.

Likewise, clinical judgement has been used interchangeably with clinical decision-making. An analytic model, it has been defined as "an interpretation or conclusion about a patient's needs, concerns, or health problems, and/or the decision to take action (or not), use or modify standard approaches, or improvise new ones as deemed appropriate by the patient's response" (Tanner, 2006, p. 204). It could be argued that the decision-making WR elements that met the threshold for a YES consensus meet the 'interpretation or conclusion' in this definition, just not the 'decision to take action', except to ask for assistance.

Decision-making is a cornerstone role for the RN, one that impacts on all health outcomes. Even though the RN SoP states that RNs undertake clinical decision-making, the NCNZ have not articulated decision-making competencies. The NZ nursing sector indicates that the preliminary skills of situational awareness along with thinking skills are required by the work ready NGN. The WR framework could therefore be used to

150

construct assessment of these elements for the senior nursing student. The first year of practice would then focus on hypothetico-deductive decision-making skills before the NGN eventually gains sufficient experience to develop the intuitive skills evident within the WR framework performance levels as well as those WR elements not meeting consensus. These could form part of the learning framework for the first year of professional practice.

Table 26. Decision-making WR elements and expected levels of performance

WR item	Knowledge Sufficient knowledge / knows to	Timeliness Takes appropriate amount of time	Confidence Feels assured of own capability	Independence Independent and safe	Proficiency Accomplished and well-practised
Is comfortable (not embarrassed) to ask questions when unsure/doesn't know about something	✓	✓	✓	✓	✓
Recognises when to ask for assistance	✓	✓	✓	✓	✓
Demonstrates ability to start tasks	✓	✓	✓	✓	
Writes nursing care plans or plans of care	✓	✓	✓		
Develops and uses networks of colleagues to assist in solving problems	✓	✓	✓		
Listens to different points of view before coming to a decision	✓	✓	✓		
Willing and able to use collegial support to critically think and make decisions, protecting self as a beginning practitioner	✓	✓	✓		
Bases decision-making on nursing process or plan of care	✓	✓			
Always thinks about patient outcomes	✓	✓			
Interprets the multidisciplinary team orders/plans	✓				
Bases practice on evidence rather than routine	✓				
Sets and justifies priorities	✓				
Re-sets priorities	✓				
Recognises when something is abnormal to what they expected and get it corrected	✓				
Judges the need to escalate care through additional forms of focussed observation from observing and noticing to the use of a particular assessment tool	✓				

WR item	Knowledge Sufficient knowledge / knows to	Timeliness Takes appropriate amount of time	Confidence Feels assured of own capability	Independence Independent and safe	Proficiency Accomplished and well-practised
Re-assesses client responses/situation and nursing interventions; conducts appropriate follow-up	✓				
Manages the balance between want and need		✓			
Tries to solve problems themselves					
Readjusts a plan of action in the light of what happens as it is implemented					
Changes focus when a crisis situation that needs attention arises					
Judges urgency of changing situations					
Uses previous experience to figure out what is going on when a current situation takes an unexpected turn					
Is prepared for the unexpected to occur					

WR decision-making elements NOT meeting a YES consensus:

- Identifies from a mass of detail the core issues in any situation

- Sees how apparently unconnected activities are linked and make up an overall picture

- Traces out and assesses the consequences of alternative courses of action and, from this, pick the one most suitable

- Recognises patterns in a complex situation

3. New graduate nurses and their time management

All three time management WR items achieved the threshold for a YES consensus but also had low levels of expected performance judged. The NGN is expected to have sufficient knowledge/know to (knowledge) in 'uses tools to self-organise and plan daily routines' and 'practises with an understanding of pressures of the practice setting', otherwise all other levels of performance scored at—will need some direction (independence), will need further practice (proficiency), will need extra time (timeliness), and will not yet feel assured of own capability (confidence). The third time management WR element 'keeps track of multiple responsibilities' achieved low expected performance levels in all components.

NGNs have mostly completed their undergraduate programme as a full-time student, often with job and family commitments. They have successfully completed their learning, clinical placement shift work and assessment priorities, and managed their time to do so—some more competently than others. Furthermore, time management learning is undertaken within simulation in the WITT BN MA programme. Students are facilitated to practice as the 'RN', use planning tools and keep track of responsibilities in complex patient scenarios. Hence, the phase three nursing tutor informants disagreed with the judged expected levels of performance identified by the phase two participants. All time management WR items are 'taught, practised and assessed' in the WITT BN MA programme.

The time management WR elements have been mapped to the NCNZ Education Programme Standards for the RN SoP 3: Management and delivery of nursing care and the associated NCNZ Competency for the RN SoP 2.1: Provides planned nursing care to achieve identified outcomes. Meeting this NCNZ Competency for the RN SoP does not align with the expected levels of performance judged by the phase two nursing sector participants in this study. A requirement for all undergraduate nursing programmes is "an extended clinical experience of 360 hours minimum is included in the final semester of the programme to enable the student to meet the Nursing Council's Competencies for the RN SoP and as preparation for transition to practice" (NCNZ, 2014, p. 7). The NZ nursing sector are suggesting that this period of clinical practice time is insufficient to meet the highest expected levels of performance in these WR elements. Time management WR elements have significant importance (Nayak, 2018) given the complex and often challenging health care environment where decisions on care

priorities need to be made, often when insufficient time is available (Kalánková, Žiaková, & Kurucová, 2019).

4. New graduate nurses as team workers

Of the 17 team working WR elements, 16 met consensus; including one item meeting a NO consensus (chairs and participates constructively in meetings). For those items meeting a YES consensus, all NGNs were expected to have a knowledge performance level of 'sufficient knowledge/know to'. There appears to be a hierarchy of the remaining expected levels of performance as determined by the phase two participants (independence, proficiency, timeliness and confidence). Table 27 (p. 159) shows this hierarchy of expected levels of performance.

At the first level, the NGN is expected to perform at the highest levels across the five components in only four WR elements. Next, the nursing sector has expectations that in 14 of the 15 WR elements, the NGN also performs at the highest level in timeliness; takes appropriate amount of time. Ten WR elements have an expected confidence performance level of 'feels assured of own capability'. Six WR elements have an expected independence performance level of 'independent and safe', whilst the highest level of proficiency (accomplished and well-practised) was found in only four WR items. This hierarchy of performance components suggests that the NZ nursing sector considers the undergraduate nursing programme is primarily concerned with gaining knowledge, followed by performing in an appropriate amount of time, then confidence, followed by being independent and safe, and lastly, being accomplished and well-practised. It is difficult to comprehend how confidence, timeliness, independence and safety can be found in a WR element when the NGN is not expected to be accomplished and well-practised.

The NCNZ Education Programme Standards for the RN SoP 4: Interpersonal relationships (NCNZ, 2007) comprises content relating to effective communication within the health care team and documentation; information management and is mapped to the NCNZ Competency for the RN SoP 3.3: Communicates effectively with health consumers and members of the health care team. The NCNZ Education Programme Standards for the RN SoP 5: Interprofessional health care and quality improvement (NCNZ, 2007) specifies co-ordination of health consumer care within the health care team including discharge planning, interprofessional collaboration and communication, and respect for all members of the health care team. This content is mapped to NCNZ

Competency for the RN SoP 4.1: Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care and NCNZ Competency for the RN SoP 4.2: Recognises and values the roles and skills of all members of the health care team in the delivery of care.

The NZ nursing sector agreed that the WR element 'practises as an effective multi-disciplinary team member' although meeting consensus as a WR element was only determined as having expected performance levels of sufficient knowledge/knows to (knowledge), takes appropriate amount of time (timeliness) but not yet feel assured of own capability (confidence), will need direction (independence) and will need more practice (proficiency). Likewise, the WR element 'presents information at case reviews and ward rounds' highest expected level of performance was only with knowledge (sufficient knowledge/knows to). The NZ nursing sector's judgement on team working does not align with the related NCNZ Competencies for the RN SoP. With these expected levels of performance, competence, as evidenced by successful sign-off by practice or education or both, may not actually have been met as a senior nursing student.

The WR item 'gives constructive feedback to work colleagues and others without engaging in personal blame' found 69% of phase two participants agreed but it did not reach the threshold for consensus. This WR element is likely a required skill to undertake the role of direction and delegation; a team work role and is further discussed below.

Several interchangeable iterations of the term team working are used within health care; multidisciplinary, interdisciplinary and transdisciplinary, depending on the degree of collaboration and decision-making (Dyer, 2003). A NGN will potentially work in many different teams; a team of nurses (RNs, enrolled nurses, health care assistants and care givers) or a team with different professional health members. A multidisciplinary team can be described as many branches of knowledge working together in a manner whereby one team member determines the team to be involved and makes overall decisions. These other team members undertake their own specific discipline roles and this information is then submitted back to the team leader and either directly or indirectly to the whole team (Dyer, 2003). This may be described as a model commonly experienced within an acute tertiary or secondary health care setting and reflects the WR team work elements in the WR framework.

An interdisciplinary (interprofessional) team works between more than one branch of knowledge and expands the multidisciplinary team process whereby the team members

have collaborative communication and decision-making (Weller, Thwaites, Bhoopatkar, & Hazell, 2010). Team members share problem-solving beyond their normal discipline-specific remits (Dyer, 2003). A transdisciplinary team functions with overlapping disciplinary knowledge, skills, and responsibilities, and a high level of team values and trust. The team is dependent on effective communication skills and has a focus on the delivery of the health service (Dyer, 2003; Weller et al., 2010). These two models, with a higher level of collaboration and decision-making, may be more commonly seen in the primary care sector.

RNs are expected to work both autonomously and collaboratively (Lapkin, Levett-Jones, & Gilligan, 2013) and, regardless of the team model, will need to have effective team work skills. Based on the aforementioned definition, multidisciplinary team work skills would include discipline-specific clinical knowledge and good communication skills, written and spoken. Interdisciplinary skills build on these to include an understanding of the roles of the other health professions; it is not enough to just have contact with members of the team (Sargeant, Loney, & Murphy, 2008). Working knowledge of the health service delivery model, team meeting skills, ability to show respect, developing ways of interacting and moving away from traditional hierarchical communities of practice are further characteristics of interdisciplinary working (Sargeant et al., 2008).

The term interprofessional learning can be found within the education sector and is often associated with health care professions learning with, from and about each other to improve collaboration, decision-making and the quality of patient-centred care provided (The Centre for the Advancement of Interprofessional Education, 2002). However, the constraints of the education sector structures, as well as the siloed professional education programmes, mean that interprofessional education may be difficult to implement (Pardue, Cohen Konrad, & Dunbar, 2018). Furthermore, there is little strong evidence that interprofessional education achieves its aims; that learning outcomes are met and attitude changes are sustained (Lapkin et al., 2013). This may be explained by the nature of the educational pedagogy because interprofessional team practice utilises more developed collaborative and decision-making skills than multidisciplinary team working. Using an interprofessional learning approach assumes the health care professionals already have discipline-specific clinical knowledge and good communication skills, written and spoken. The NZ nursing sector does not have high expected levels of performance of team working skills and therefore implementing interprofessional learning pedagogies may not be successful in undergraduate education

and may be more successful when engaging in professional development post-employment.

All the team working WR elements are 'taught, practised, and assessed' in the WITT BN MA programme. Because there are no other professional health care programmes at WITT, 'clinical-practice-like' classroom team work capability is developed through formalised learning and assessment activities as well as simulation learning. Learning to work in a team uses the Belbin (2019) model to learn team forming, storming, norming, and performing; and simulation activities include multidisciplinary team patient scenarios integrated within unfolding case studies.

Phase 2 participants may view team working differently because there are different iterations of the term. The NZ nursing sector indicates that the NGN has a high level of knowledge of team working but a low level of proficiency (accomplished and well-practiced) suggesting that team working is accomplished once employed as an RN. The role of undergraduate interprofessional learning for the purpose of developing collaborative decision-making capability is therefore questionable and may be better suited to ongoing professional development within the first year of practice. Guidance for this development could be accessed from the WR framework.

Table 27. Team work WR elements with expected levels of performance

WR element	Knowledge – sufficient knowledge / knows to	Timeliness – takes appropriate amount of time	Confidence – feels assured of own capability	Independence – independent and safe	Proficiency – accomplished and well-practised
1 Gives handover	✓	✓	✓	✓	✓
Able to co-operate (assist / comply with requests)	✓	✓	✓	✓	✓
Recognises the need to get along with others	✓	✓	✓	✓	✓
Willing to pitch in and undertake menial tasks when required	✓	✓	✓	✓	✓
2 Practises with an understanding of population generational differences	✓	✓	✓	✓	
Practises knowing where he/she fits within the team	✓	✓	✓	✓	
3 Practises with an understanding and sharing of feelings / emotions of others	✓	✓	✓		
Practises with knowledge and understanding of self, including knowing own strengths and weaknesses	✓	✓	✓		
Practises with an understanding of the different roles of RNs in different treatment or care settings	✓	✓	✓		
Practises as an effective nursing team member	✓	✓	✓		
4 Practises as an effective multi-disciplinary team member	✓	✓			
Contributes to team discussion	✓	✓			
Works with senior staff without being intimidated	✓	✓			
Manages interpersonal relationships with colleagues, including understanding and managing own emotions	✓	✓			
5 Presents information at case reviews and ward rounds	✓				

5. New graduate nurses as leaders

None of the five leadership WR items met a YES consensus and four met a NO consensus. These four items were the only items in the survey that met a NO consensus.

- Can run a shift/work period
- Assigns clients to staff
- Manages personal problems in the team
- Chairs and participates constructively in meetings

The WR element 'acts as a resource' did not meet consensus and 67% of phase two participants scored a NO. Another related WR element 'gives constructive feedback to work colleagues and others without engaging in personal blame' found 69% of phase two participants agreed but it also did not reach the threshold for consensus. Nurses across the sector indicated strongly that all the leadership elements specified do not fit the WR profile of the NGN. Yet, the NGN is accountable for directing, monitoring and evaluating nursing care that is provided by enrolled nurses and others. It could be that the phase one literature and focus group interview findings did not identify the skills required for this leadership role.

The decision-making process described by the NCNZ (2011a) Guidelines for Direction and Delegation does not assist with illuminating the required skills. Nevertheless, NCNZ does purport that NGNs will require experience (will need further practice), time (will need extra time), support (will need some direction) to develop confidence (will not yet feel assured of own capability). However, the NCNZ (2011) guideline suggested that NGNs have sufficient knowledge/knows to (knowledge). The NCNZ Education Programme Standards for the RN SoP state under 'Professional responsibility' that accountability and the direction and supervision of second-level nurses is embedded into the BN programme enabling NCNZ Competency for the RN SoP 1.3: Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by enrolled nurses and others to be met as a senior student nurse. The misalignment between the NCNZ expectations in the Guidelines for Direction and Delegation, NCNZ Education Programme Standards for the RN SoP programme content and meeting the associated NCNZ Competency for the RN SoP may explain the absence of leadership WR elements by the NZ nursing sector.

However, there are changes in the skill mix of nursing services in NZ (New Zealand Nurses Organisation, 2017). In their employment survey, the NZNO reported a 23% change in skill mix where RN roles were reduced with an increase in the number of enrolled nurses or where RN/enrolled nurses' roles were reduced with an increase in health care assistants or care givers. With these changes in skill mixes, the expectations of NGNs' role in adequately performing direction and delegation can only increase. Hughes, Kirk, and Dixon (2018) found that leadership skills were required in the direction and delegation role so that the team members work together. Furthermore, different types of leadership were needed for successful delegation relationships and possessing, as well as being seen to possess, workplace clinical knowledge was essential.

Additionally, the NCNZ Education Programme Standards for the RN SoP 5: Interprofessional health care and quality improvement includes leadership; and the NCNZ Competency for the RN SoP 4.1: Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care, has been mapped to this educational content. This assumes that 'facilitating' and 'co-ordinating' are leadership skills. Pursuant to the nursing sector failure to agree and meet the threshold for consensus on leadership WR items, the NCNZ low expected level of direction and delegation performance, meeting competence on facilitating and co-ordinating care, and the literature findings for leadership skills, reveal confusion relating to the NGN undertaking any leadership role.

In 2018, 56 NGNs registered interest in undertaking a NEtP programme in the aged care sector (Technical Advisory Services, 2019) along with an unknown number of NGNs who were employed into the aged care sector without a NEtP programme. Given the acute shortage of staff within this sector (New Zealand Nurses Organisation & Etu, 2019), it is difficult to understand how NGNs are practising with the—will need some direction (independence), will need extra time (timeliness), will need further practice (proficiency), and will not yet feel assured of own practice (confidence) profile for delegation and direction of second level nurses and care givers. Furthermore, it is prudent to consider that in some circumstances the NGN role will likely include the WR items listed above that met a NO consensus in the survey (discussed later in the chapter). Moreover, within this sector, 'acting as a resource' would also be an important role, particularly if the NGN was in the work place as the sole RN. Notably, further analysis of the phase two data showed that the *aged care* participant group also did not agree and achieve consensus on the leadership WR items.

The NZ undergraduate nursing degree comprises 3600 hours of learning. Considering that a minimum of 1100 of these hours must be in clinical practice (many programmes including the WITT BN MA have more hours), and that the remaining 2500 hours includes simulation and self-directed learning time as well as learning knowledge for practice, it is easy to gauge that the three-year programme can become over loaded.

Leadership skills take time to develop, and given the requirement for clinical knowledge (Hughes et al., 2018) it is conceivable that direction and delegation, as well as 'facilitating and co-ordinating care' may not be roles for the NGN within the current education structure; that the NGN is unable to meet these NCNZ Competencies for the RN SoP as per the current NCNZ requirements.

6. New graduate nurses and conflict in the work place

The two WR elements relating to managing conflict, 'manages conflict with colleagues' and 'manages conflict with clients' both met consensus but were two of the group of elements achieving the lowest scoring expected performance levels across all five components; will need to develop knowledge (knowledge), will need some direction (independence), will need further practice (proficiency), will need extra time (timeliness), and will not yet feel assured of own capability (confidence). However, all were 'taught, practised, and assessed' in the WITT MA nursing programme.

The NZ nursing sector does not have high expectations of the NGN being able to manage conflict. This is despite bullying in health care practice remaining a significant concern (Blackwood, Bentley, Catley, & Edwards, 2017; Cleary, Hunt, & Horsfall, 2010; Gamble Blakey et al., 2019). Students are also affected by bullying (Gamble Blakey et al., 2019) impacting on their ability to learn to think like, act like, and be a nurse, as well as potentially affecting their own mental health and wellbeing. Brunworth (2015) asked "Eating our young in nursing… Are we full yet?" (p. 1) and described how bullying behaviour causes significant stress that may lead to psychological and physical ill-health.

NGNs are especially at risk for workforce bullying (Vogelpohl, Rice, Edwards, & Bork, 2013), at a time when they are making the transition to beginning professional practice. The experience of bullying has an impact on attrition from the profession. NGN attrition rates are high (Milton-Wildey, Kenny, Parmenter, & Hall, 2014). Of the NZ NGNs who registered with the NCNZ in 2005/2006, only 52% were still practising in NZ 10 years

later (NCNZ, 2016). In a previous study, NGNs comprised a significant nursing turnover of 44% attrition in acute care (North et al., 2013).

Given the high stakes of work place bullying for NGNs, the literature does not support the low expected levels of performance for the conflict WR elements judged by the NZ nursing sector. Nursing tutors have a role in preparing NGNs who can manage and contribute to helping break the work place bullying cycle (Bellack, 2018). The WITT BN MA programme supports students to develop skills in identifying and appropriately responding to signs of bullying to themselves or others (Birks, Budden, Biedermann, Park, & Chapman, 2018). A question of morality arises when employing a NGN into a professional bullying culture without pre-requisite skills for managing this situation. It would therefore be reasonable to expect NGNs to have strongly developed conflict management skills as they enter professional nursing practice where the environment is further compromised by violence from the public. Violence from members of the public is on the increase (Richardson, 2017), further exacerbating the overall conflict within the workplace and raising the stakes of complexity and volatility. This is the environment in which nursing students are learning to be a nurse and NGNs are making the transition to a RN.

From the beginning of the WITT BN MA programme, students learn the skills of communication, cultural safety and social-emotional intelligence. They participate in resilience and wellbeing activities, both for their personal use and also for their early and ongoing clinical practice experiences (Bingham, 2015). Emotional intelligence has been discussed as an important entry criterion for nursing programmes because such skills are necessary for nursing practice, a profession underpinned by excellent relational skills. Equally, in preparing NGNs for WR and given the existence of work place bullying, to what extent do our graduate profiles reflect emotional intelligence qualities, particularly of "being nice" and "being aware?" (Bellack, 2018, p. 456). The WR element 'Is a very nice person' met consensus in phase two of this research project. Although this term was criticised by the phase three nursing tutor informants as unhelpful and unprofessional use of language, it is one of the four attributes being considered as entry criteria in a business school in the UK (Bellack, 2018). Informal discussion with recruitment of NGNs may include statements such as 'he/she is a nice person'. Perhaps the phase two participants were cognisant of emotional intelligence descriptors when agreeing that this element is a part of WR of NGNs. The question remains, however, as to whether or not social-emotional intelligence skills help to break the work place bullying cycle.

The NCNZ Competencies for the RN SoP includes a competency statement related to conflict with clients but not with colleagues. The NCNZ Competency for the RN 2.5: Acts appropriately to protect oneself and others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations. However, the NCNZ Education Programme Standards for the RN SoP required content does not give nuance to the requirements to meet this NCNZ Competency for the RN SoP. Considering the NZ nursing sector's low expectation of performance levels, it is unclear how a NGN could meet this NCNZ Competency for the RN SoP as a senior nursing student.

The WR framework could be used to structure pre-registration education for nursing students to learn and demonstrate conflict management skills. However, the literature challenges the NZ nursing sector views on conflict WR elements, and the consensus results point to a need for further discussion to agree on skills for the NGN staying safe in the work environment from colleagues, patients and members of the public.

7. New graduate nurses and quality

Thirteen of the fifteen (87%) quality WR items converged to a YES consensus. The four WR elements 'acts in familiar situations', 'declines to undertake unfamiliar activities', 'demonstrates concern for clients' and 'takes appropriate measures to prevent or minimise risk of injury to self' all met a YES consensus and achieved the highest levels of expected performance in all components; sufficient knowledge/knows to (knowledge), independent and safe (independence), accomplished and well-practised (proficiency), takes appropriate amount of time (timeliness), and feels assured of own capability (confidence). These measures indicate that quality in nursing practice was most highly rated as a *safety* issue by the NZ nursing sector.

'Recognises unsafe practice in others' met a YES consensus but expected level of performance was determined as—will need some direction (independence), will need further practice (proficiency) and will not yet feel assured of own capability (confidence). However, the NGN is expected to have sufficient knowledge/knows to (knowledge) and takes appropriate amount of time (timeliness). This suggests, fortunately, that practices that may put patients or clients at risk will at least be identified early, even though the NGN needs further development in performing this WR element.

With low judged expected levels of performance, the NGN will need to develop knowledge (knowledge), need some direction (independence), further practice (proficiency), extra time (timeliness) and will not yet feel assured of own capability

(confidence) with the WR element 'judges when not to undertake planned or prescribed interventions'. This implies that the NGN will need ongoing supervision of practice until the performance levels of this element are developed.

The WR element 'practises with an understanding of quality improvement methodologies' did not converge to consensus, with only 66% of participants agreeing a YES. Yet, one of the four domains of the NCNZ Competencies for the RN SoP (NCNZ, 2007) is Domain four: Interprofessional healthcare and quality improvement with related content including quality improvement and research activities. This content is mapped to the NCNZ Competency for the RN SoP 4.3: Participates in quality improvement activities to monitor and improve standards of nursing. The ambiguity of the NGN meeting this NCNZ Competency for the RN SoP as a senior nursing student yet not being expected to perform this as part of their role as an NGN is perplexing.

All quality WR elements are 'taught, practised and assessed' in the WITT BN MA programme with the exception of 'questions and challenges another nurse's practice'. Although the element is taught, in so far as the student nurse learns how to approach colleagues, this WR element necessitates a supportive and safe work environment for the NGN to practise it. Moreover, the culture of the environment must welcome nurses challenging and questioning each other; thereby illustrating and role-modelling professional practice.

The Health Quality and Safety Commission New Zealand, a standalone Crown Agency leads, and coordinates work to improve safety and quality in NZ; monitors and reports on safety and quality as well as developing sector capability for safety and quality improvement. Hand hygiene and prevention of falls are two examples of work for the commission. The organisation uses the NZ Triple Aim for Quality Improvement model (Health Quality and Safety Commission New Zealand). See Figure 9 (p. 162).

Figure 9. NZ Triple aim for quality improvement (Health, Safety and Quality Commission, 2019)

Approximately 13% of admissions to NZ hospitals are associated with an adverse event and 1.9% of those are associated with serious disability or death (Merry & Seddon, 2006). Iatrogenic harm can be caused by error or violation and responding to both in the same manner will not rectify the problem. However, "all involved with healthcare, from the minister through senior consultants and chief executive officers, to the newest trainee nurse, need to understand fully their responsibility for deliberate choices that have the potential to impact on safety" (Merry & Seddon, 2006, p. 3).

The NCNZ guidelines on quality and safety in the undergraduate programme are open to interpretation across the nursing programmes in NZ generating differences in the programme content and, therefore, potential variable outcomes. Quality and safety competencies, particularly within a knowledge, skills and attitude framework (Cronenwett et al., 2007) (apprenticeships to knowledge for practice, skilled know-how and ethical comportment) are recommended for all of education to embrace. Moreover, they cannot be taught within a didactic, siloed pedagogy. Instead these competencies must be integrated with learning to think like, act like, and be a nurse. It is imperative that NGNs have levels of performance that keep clients and their family/whānau safe and receiving high quality care. Without requisite skills, patients are at risk (Otoo, 2016) and errors causing morbidity and mortality can occur (Diatta, 2015). Within the NZ context, it would be reasonable for the nursing profession to consider collaborating with the Health Quality and Safety Commission New Zealand to further develop NGN WR levels of performance.

8. New graduate nurses and the organisation

Four of the six (67%) organisation WR items met a YES consensus. The results of this section of WR items showed a confusing picture. See Table 28.

Table 28. Organisation WR elements

Did not meet consensus	Met consensus
Organisation Level	
Practises with an understanding of how the organisation operates	Practises with an understanding of organisational processes and protocols
Practises with an understanding of how the different groups that make up the organisation operate and how much influence they have in different situations	Practises with an understanding of the rules, hierarchy and place in the organisation
Clinical Unit Level	
	Practises with a knowledge of the routine of the clinical setting e.g.: handover procedure, ward round, clinical setting ways of doing things, the purpose and care delivery model
	Practises with an understanding of how and where to access clinical resources and information

These WR elements are explored at two levels; firstly, at organisational level and, secondly, at the clinical unit level.

a. Organisational level

The WR element 'Practises with an understanding of how the organisation operates' just missed reaching the threshold for achieving consensus level with 69% participant agreement. The WITT BN MA programme assesses students on their knowledge of the organisation and their practice areas prior to clinical placements. Moreover, the students are coached as part of the preparation and practice interviews for job applications because it is anticipated they may be asked a question about the employing organisation and/or the clinical unit to which they have made an application for employment. Furthermore, it is thought that knowledge of the organisation would assist with accessing resources and information.

The WR element, 'Practises with an understanding of organisational processes and protocols' did meet the threshold for a YES consensus but with low levels of expectation across the five components; will need to develop knowledge (knowledge), will need some direction (independence), will need practice (proficiency), will need extra time (timeliness) and will not yet feel assured of own capability (confidence). It is not clear how a NGN needs to understand organisational processes but not how the organisation

works, unless the NGN had undertaken some clinical practice experience in the health care organisation as part of the nursing degree. NGNs often seek to practice as a beginning practitioner in the region where they completed their degree and often in an organisation where they undertook clinical practice within their undergraduate degree programme (Rydon, Rolleston, & Mackie, 2008). This familiarity can assist with confidence levels when commencing professional practice.

Fifty-eight percent of the NZ nursing sector participants in phase two indicated they did not agree with the WR item: 'Practises with an understanding of how the different groups that make up the organisation operate and how much influence they have in different situations'. Yet 80% of participants did agree with the WR item: 'Practises with an understanding of the rules, hierarchy and place in the organisation'. This suggests that the NZ nursing sector considers that for the NGN commencing professional practice, knowing the rules in the organisation was more important than understanding how the organisation was made up.

b. Clinical unit level

The two clinical unit level WR items both met the threshold for a YES consensus. 'Practises with a knowledge of the routine of the clinical setting e.g.: handover procedure, ward round, clinical setting ways of doing things, the purpose and care delivery model' strongly met consensus at 94%. Likewise, 'Practises with an understanding of how and where to access clinical resources and information' had a strong consensus at 90% of participant agreement. Both achieved the same level of expected performance at sufficient knowledge/knows to (knowledge), will need some direction (independence) and will need further practice (proficiency). However, how and where to access clinical resources met expected levels of performance at—takes appropriate amount of time (timeliness) and feels assured of own capability (confidence), whilst knowledge of the clinical setting routine level of expected performance achieved—will need extra time (timeliness) and will not yet feel assured of own capability (confidence).

Presumably, the Phase 2 participants viewed these WR elements as very important and achievable within the orientation period, albeit with differing expected levels of performance. However, they were asked to rate the WR items as an NGN beginning professional practice unless otherwise stated. From these results, it can be deduced that the NGN will need more than the orientation period to develop these WR elements to the highest expected levels of performance.

The related WR element 'Undergraduate transition experience is the same/similar setting as new graduate RN position clinical setting' strongly did not meet consensus with 67% of participants agreeing NO to this item. In a recent small study (Fergusson, 2019b), most of the WITT NGNs were working in an area of nursing the same as, similar to or related to their year three student nursing experience in the BN Transition to Practice placement. NGNs have applied for these positions because of their interest in the field and familiarity gained. They have developed clinical confidence in their significant programme experiential learning (commences in acute care in the first week of the three-year programme) including their final semester Transition to Practice placement experience. Knowledge of the clinical unit, the staff, roles and routine as well as determining own learning needs was described as advantageous to commencing professional practice in the same clinical area. The WITT BN MA nursing students identify closely with health organisations in Taranaki where they have undertaken all their practice learning.

Elsewhere, NGNs have reported that unfamiliar organisation routines, increased workloads and responsibility render a sense of ill-preparedness for RN practice (Cho, Laschinger, & Wong, 2006; Duchscher, 2008; Kramer, 1975; Laschinger & Leiter, 2006). Although pre-knowledge of the working environment linked to work readiness is debated (El Haddad, 2016; El Haddad et al., 2017; Wolff, Regan, et al., 2010b), it may contribute to a quicker transition to practising more confidently as an NGN (Walker et al., 2015).

The organisation WR elements, having met consensus, could provide a structure of components deemed important enough to include in induction and orientation programmes, whether for student placements or for RN employment. Such a structure would be transparent for the health care organisation as well as the student or NGN.

9. New graduate nurses and the health care system

Three of the four health care system WR elements met the threshold for a YES consensus but one did not: 'practises with an understanding of where health care is heading in the future with changing models of care'. The NGN of today will face changing health priorities in NZ within fiscal constraints as the current model is unsustainable (Ministry of Health, 2016b). New and fast developing technology means the health sector will need to be adaptable. Changing RN roles may include such things as the impact of food supply and therefore healthy diets (Sinclair, 2019) in this time of climate change.

Furthermore, the changing NZ demographic means the NGN is likely to be practising with those NZ citizens aged 65 and over.

The NGN may soon have colleagues whose undergraduate education has a different focus. The New Zealand Nursing Organisation (2017) recently made the case for the RN to become the "generic health worker" (p. 3) with an ability to supervise and direct an enormous unregulated workforce and be the key to leading and managing change. The focus for the nurse will be on "supporting decision-making and self-management; responding to information available from a wide range of sources and curating and translating evidence-based information to enable healthy choices. Empathetic, respectful, contextually appropriate care and communication and a family systems approach remain the hallmark of nursing service delivery. Family/Whānau Ora informed holistic nursing is highly sought after" (National Nursing Organisation, 2017, p. 4). It has been argued that to create this generic health care worker a significant curriculum change is necessary. Such changes would emphasise "health literacy; greater emphasis on children; social prescribing; networked care, navigation, exercise, nutrition, brief interventions for smoking cessation, mental health and addictions" (National Nursing Organisation, 2017, p. 5), with removal of the mental and general health dichotomy. Further non-clinical educational requirements are described in the report including; "business skills, technology, leadership, change management, innovation and transformation" (National Nursing Organisation, 2017, p. 8). The fundamental clinical components were listed as: "comprehensive assessment, diagnostic and clinical formulation skills, community and public/population health assessment, emphasis on family/whānau, equity, social determinants, cultural safety, health literacy, a unitary appreciation of mental and physical health, self-determination and a deliberate focus on compassion" (National Nursing Organisation, 2017, p. 8).

This thinking about future health care and changing models of care relates to the two health care WR elements that did reach the threshold of a YES consensus: 'practices with an understanding of the health care system, social determinants of health, inequities and inequalities' and 'practises with an understanding of and ability to work in different health care models'. Furthermore, these elements had expected levels of performance judged as sufficient knowledge/knows to (knowledge), takes appropriate amount of time (timeliness), feels assured of own capability for the former and will not yet feel assured of own capability for the latter (confidence), but both will need some direction (independence) and will need further practice (proficiency). The phase two participants across the NZ nursing sector have recognised that social justice is a key component of

contemporary nursing practice. Social justice is identified as a core value in public health to achieve desirable population health outcomes; it affects the way people live, their consequence chance of illness, and their risk of premature death (Smith, 2016). Social justice has been described as the motivation for forming the World Health Organization's Commission on Social Determinants of Health (2008). The term has been interchangeably used with health equity. The WR framework could be used to identify how social justice is visible within the undergraduate programme. Moreover, where these WR elements are highly performed by a senior nursing student/NGN, it may attest to their preferred area of nursing aligned with these skills such as primary health care.

These NGN WR elements have been mapped to the NCNZ Education Programme Standards for the RN SoP 2: Professional responsibility with corresponding content: nursing practice and professional, ethical and legal responsibilities; understanding of health policy and health regulation. Notwithstanding a weak link and assumption that social justice and future health care models align with health policy and regulation, the WR elements do not map to the NCNZ Competencies for the RN SoP.

10.   The NO consensus work readiness elements

The phase two participants made judgement on four WR items that met the threshold for a NO consensus. The NZ nursing sector strongly agreed (83-89% consensus) these elements do not comprise WR of NGNs. These four items all relate to leadership roles.

1. Can run a shift/work period
2. Assigns clients to staff
3. Manages personal problems in the team
4. Chairs and participates constructively in meetings

However, 1.9% of RNs working in the aged care sector are NGNs and 21.6% are RNs having worked in the sector 1-4 years (New Zealand Work Research Institute, 2016); suggesting that nearly a quarter of RNs are relatively inexperienced. In an industry with increasing levels of client acuity, whereby the number of clients requiring hospital, dementia and psychogeriatric levels of care now outnumber rest home care and the average number of RNs per aged care facility is 4.9 (New Zealand Aged Care Association, 2018), the RN (including the NGN) role may include those WR elements that achieved the threshold for a NO consensus. In addition to running a shift and assigning clients, the RN will need to demonstrate high performance levels of knowledge

(sufficient knowledge/knows to), independence (independent and safe), proficiency (accomplished and well-practised), timeliness (takes appropriate amount of time), and confidence (feels assured of own capability) in direction and delegation because 71% of the care staff comprise the unregulated workforce of caregivers (New Zealand Aged Care Association, 2018). Given the aging population and expected increase in health care requirements for the 65 and over age group, there is a strong argument that NGNs are not work ready for beginning professional practice in the aged care sector.

11.   New graduate nurses expected levels of performance

The 143-item WR framework co-constructed by nurses across the sector contends that the highest expectations of WR element performance lays in the knowledge component (knowledge/knows to), suggesting that NZ nurses view the main purpose of the undergraduate nursing degree preparing NGNs for beginning professional practice is knowledge for practice acquisition. The highest level of performance in timeliness (takes appropriate amount of time) was scored in over two-thirds of the WR elements, followed by confidence (feels assured of own capability) in just over 50% of elements. NGNs working at an independent level of performance (independent and safe) was scored in only 30% of elements. The lowest scoring component was found in proficiency (accomplished and well-practised) with less than a quarter of WR elements achieving this highest level of performance (see Table 29, p. 173). In other words, the NGN in over three-quarters of the WR elements are not expected to be accomplished and well-practised. The implications for this picture are that the first or new graduate year of professional practice will need to comprise a structure for NGNs to develop knowledge in one-fifth of WR elements, timeliness in one-third of WR elements, confidence in nearly half of WR elements, independence in two-thirds of the WR elements and, most of all, develop proficiency in three-quarters of all the elements agreed to comprise WR.

A significant level of support and supervision from experienced RNs would be required for this professional development. NGNs cannot be left to cope, struggle and feel out of their depth and potentially impacting on patient safety. With significant workloads in contemporary nursing practice, the required supervision and mentoring may be challenging to deliver.

Table 29. Percentage of WR elements with the highest expected levels of performance

Component	Highest level of performance	Frequency of WR elements (%)
Knowledge	Sufficient knowledge/knows to	81
Timeliness	Takes appropriate amount of time	69
Confidence	Feels assured of own capability	57
Independence	Independent and safe	30
Proficiency	Accomplished and well-practised	23

Aiding the NGN performance development is their learning skills; being the expert learner, along with professional attitudes because these are WR sections of elements that NGNs are expected to perform highly in all components. However, whilst developing their WR skills, the NGN will only be able to perform nursing care to the highest levels of expectations in:

- Performs personal care/activities of daily living (ADLs) for clients
- Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse
- Gives handover
- Practises using an understanding of client rights
- Demonstrates concern for clients
- Willing to pitch in and undertake menial tasks when needed
- Recognises the need to get along with others
- Able to co-operate (assist/comply with requests)
- Acts in familiar situations
- Declines to undertake unfamiliar activities

The scenario constructed here, along with the poor alignment between NCNZ Education Programme Standards for the RN SoP, the NCNZ Competencies for the RN SoP and the WR elements, indicates how essential the first year of RN practice professional development is to achieve WR competence. This aligns with the NGN level of practice described in regional DHB Professional Development and Recognition Programmes (PDRP) (Taranaki DHB, 2016), recognising that it takes time to develop competence. However, the phase one informants described how the patient does not know nor is concerned whether 'their nurse' is in their first year or tenth year of professional practice. They are all nurses and expected standards of nursing care practice are the same.

Although not measured in this study, it is reasonable to consider the first year of professional practice may also include the WR items not meeting consensus (except 'achieved good undergraduate programme grades' and 'undergraduate transition experience is the same/similar setting as new graduate RN position clinical setting'), as well as those reaching the threshold to meet a NO consensus.

Having identified that proficiency (well-practised and accomplished) is the expected level of performance requiring the greatest development post-employment as a NGN, the Taranaki nursing leaders correctly anticipated that clinical practice learning (proficiency) was central to the development of WR. Notwithstanding El Haddad's (2016) findings regarding concerns of too much theory and insufficient clinical practice learning, effective clinical practice learning environments are not plentiful and suffer from variable student learning support, an inconsistent focus on proficiency and expected outcomes along with varying clinical attendance patterns (length of placement, shifts work) (Patterson et al., 2017; Stayt & Merriman, 2012).

The opportunities for proficiency development are therefore limited, particularly when student nurses are unable to truly experience, and are protected from, the full RN responsibility and accountability for patient care (Missen et al., 2015). A crucial and problematic gap exists between being a senior student and beginning professional practice as a NGN (Romyn et al., 2009). In contrast to the literature indicating that nurses in practice want NGNs who can "hit the ground running" (Woods et al., 2015, p. 360) or to practice in a manner that at least does not impose a burden and who will contribute to the workload; a workload that is increasingly complex, unsurprisingly, phase two participants have indicated that NGNs will not be able to do so. Furthermore, without requisite skills performance, patients are at risk (Otoo, 2016), and errors causing morbidity and mortality can occur (Diatta, 2015).

NGNs cannot be viewed as novices, using Benner's 'novice to expert' framework, because the NGN does have experience in the situations in which they are expected to perform (i.e., experience across acute, primary and mental health care), albeit not RN experience. The novice lacks confidence to demonstrate safe practice and requires continual verbal and physical cues. The advanced beginner will "demonstrate marginally acceptable performance because the nurse has had prior experience in actual situations. He/she is efficient and skilful in parts of the practice area, requiring occasional supportive cues" (Benner, 1984) and the 'competent' nurse requires two-three years of experience to ensure safe and independent practice. At a minimum, a 12-month staged transition to

professional practice was found to bridge the NGN to professional practice (Duchscher, 2008). This raises the question: what patient safety risks are conceivable during the journey to competence and how fair is this on society? In other words, does the current transition process of the NGN beginning professional practice as part of the workforce still meet contemporary demands and changing health complexities? Furthermore, is the three-year programme structure adequate and appropriate for contemporary practice?

12. Summary

The WR framework demonstrates that the highest expectations of WR element performance aligns with the knowledge component (knowledge/knows to) suggesting that NZ nurses view the main purpose of preparing NGNs for beginning professional practice is knowledge for practice acquisition. The lowest scoring component was found in proficiency (accomplished and well-practised) and in over three-quarters of the WR elements NGNs are not expected to be accomplished and well-practised.

Decision-making, the cornerstone of the RN role, had few WR elements that reached the threshold for a YES consensus and those that did mainly focussed on recognising client health status changes and seeking assistance. The NZ nursing sector does not have high expectations of the NGN being able to manage conflict. This is despite bullying in health care practice and violence from the public remaining a significant concern. Furthermore, the NZ nursing sector does not have high expected levels of performance of team working skills and therefore the implementation of interprofessional learning pedagogies may not be successful. Leadership skills strongly met a NO consensus making a strong argument that NGNs are not work ready for beginning professional practice in the aged care sector. Chapter 9 will provide a conclusion to this research and make recommendations for undergraduate nursing education in NZ.

Chapter 9 Conclusion and Recommendations

1. Introduction

Chapters 7 and 8 have examined and discussed the findings of the research project. This chapter expounds a concluding statement from the research discussion. It subsequently identifies implications and makes recommendations for undergraduate nursing education in NZ. The limitations of the study are examined and final remarks offered.

Having situated myself centrally within the research project by bringing together various professional perspectives, interpreting/synthesising these and now establishing conclusions and recommendations, I have constantly examined and pursued a significant level of self-awareness (Houghton et al., 2013) to recognise any impact I may have had on the research project (Dowling, 2008). This reflexivity has been key to the co-creation of the NGN WR framework, a *bricolage* (Denzin & Lincoln, 2011) that brings together an agreement or consensus that represents the profession as a whole.

2. The NGN WR Framework

Due to the uncertainty of the underpinning theoretical framework, the Delphi's pragmatic and flexible methodology means it offers a snapshot in time which can be used to inform further thinking, practice or theory. The consensus of WR elements enabled the construction of a framework; a set of inter-related items supporting the collaborative view of NGN WR. The 143-item NGN WR framework, comprising the essential WR elements with expected associated levels of knowledge, proficiency, independence, timeliness and confidence has been co-constructed by the nursing sector responding to calls over the past two decades for collaborative working in nursing education.

The most commonly used definition for work readiness is "as the extent to which graduates are perceived to possess the attitudes and attributes that make them prepared or ready for success in the work environment" (Walker et al., 2013, p. 116); an ever-increasing changing, complex and unsafe health environment. The framework describes the 'extent', signals the contemporary nursing sector's 'perception', articulates the 'attitudes' (*expert settled way of thinking)* and 'attributes' (*expert qualities)*' of WR.

a. Strengths of the NGN WR Framework

1. It has been co-constructed by the NZ nursing sector and therefore is relevant to the NZ health care and education system

2. Groups of nurses across the sector have participated (with the exception of MoH and NCNZ) and therefore nursing representation is broad

3. It is a comprehensive framework, including attitudes as well as attributes which relate to the practice of nursing

4. The associated levels of performance give salience to the WR discussion of NGNs

5. The use of WR elements (rather than concepts) provides a pragmatic structure for ongoing professional debate

6. NCNZ competency requirements for registration, were found not to be well aligned with WR elements, thus meeting NZNC competence does not necessarily mean being work-ready

7. Comparison of WR elements required at the point of registration with those needing development as a NGN was highlighted, in particular clinical decision-making, quality and leadership

8. The greatest consensus and highest performing elements related to the expert learner and attainment of professional attitudes

9. There was significant development of, consensus in and relatively high-performance levels identified in cultural WR elements

10. Although achieving WR consensus, low levels of performance were found with the current NZ government focus on mental health care, the aging population (including end-of-life care) and health education/promotion with implications for the role of the NGN in these areas

11. Most of the leadership WR elements reached a NO consensus with implications particularly for the aged care sector

12. The fact that NGNs are being employed into an environment whereby conflict management skills with colleagues (but not patients/members of the public) reached consensus but with low levels of performance has implications for NGN safety

13. It recognises the contribution of the local regional Taranaki Nurse Leaders' vision for WR of NGN

b. WR elements excluded from the framework

The four WR elements meeting a NO consensus fell under the category of leadership and were excluded from the WR framework. That the NZ nursing sector has no NGN leadership expectations has implications for direction and delegation particularly in the aged care sector. Leadership elements may therefore need to be part of the first year of practice structure along with those elements not reaching consensus. Twenty WR elements did not reach consensus. These elements were mainly related to decision-making, quality improvement, leadership, and organisation working structures. The first year of practice also needs a focus on increasing levels of performance.

3. Significance of the study

Given the dearth of NZ NGN WR literature, this study has provided a snapshot of and started the discussion and debate regarding the expectations of the NGN in the Aotearoa NZ context. Using a consensus-gaining research methodology fulfils and responds to calls for greater nursing sector collaboration, particularly between education and practice on matters of nursing education (HWAC, 2003; KPMG Consulting & NCNZ, 2001; NZNO, 2013). The co-creation of the NGN WR framework is significant contribution to nursing education, practice and to society as a whole.

The WR evidence-base and ongoing investigations can be used to develop more consistent outcomes in nursing education across the country. NZ undergraduate nursing education sits within the public education system where individual institute decision-making is facilitated through weak horizontal professional nursing programme coordination. It may be time to re-visit the concept of a formal Nurse Education and Training Board (Cook, 2009) that would benefit the oversight and improvement of the leadership, timely responsiveness to health practice as well as the quality of nursing education at undergraduate level in NZ. The currently disparate nature of BN programme graduate profiles across the country (Fergusson, 2019a) are due to individual organisational values and philosophies as well as national tertiary education performance indicators and outcomes. Although there are some graduate profile commonalities, which may be unsurprising given the requirements of all of these programmes to meet NCNZ requirements, there were significant gaps such as how the NZ Health Strategy and health targets are being addressed (Fergusson, 2019a). Furthermore, there was only one institute (WITT) that focussed on WR. Some educational institutes demand specific embedded values, such as Otago Polytechnic

where sustainability practices are required. Although it can be argued that global climate and sustainability does concern nurses (Ministry of Health, 2016b; Sinclair, 2019), it is the education sector rather than the nursing profession who have determined these BN programme outcomes. Such disparities are further borne out in the report on variable BN programme details, where it is reported that pre-registration nursing programmes are currently unmanaged: there are uncontrolled enrolments with varied entry criteria and teaching, learning and authentic assessment processes and programme outcomes (Central Region's Technical Advisory Services Limited, 2019).

The expected levels of WR performance results show that the majority of WR elements need further practice suggesting that the extended clinical experience of 360 hours minimum in the final semester of the BN programme is insufficient. Given that practising as a student differs from that of a RN (Missen et al., 2015), there is an important argument about whether this 'practice' should be extended in the current programme or in another format such as a four-year programme which includes an internship year; not a student and not yet an NGN but a new contemporary, appropriate and relevant transition role. Evidence has shown that a 12-month period is required for attainment of competence (Duchscher, 2008). The internship model is seen with other health professionals such a medical staff. The clients receiving health care need to know the capability of those health care professionals providing accountable professional practice.

Currently the first year of professional practice post-employment supports the NGN transitioning to the RN role, most commonly via the NEtP programmes. The WR framework can support this transition with a focus on WR elements not yet achieving the highest level of performance expectations, as well as those WR elements not meeting consensus as relevant to the clinical practice area. Given the significant amount of performance learning (particularly to proficiency) that the NGN needs to develop and demonstrate to meet a 'competent' level (Taranaki DHB, 2016) of RN practice, embedding postgraduate study into the first year of professional practice may be cause for debate because it can take a year for a NGN to transition to a competent RN (Duchscher, 2008; Institute of Medicine of the National Academies, 2011).

Senior nursing students and NGNs participate in an interview process for successful recruitment into a RN position. Utilising the WR framework could ensure this is a robust and fair process. NZ nurses have determined that undergraduate course grades are less important than clinical references. Expected levels of performance may be different; higher or lower for different clinical practice areas and how the senior student is

performing may form the basis for the clinical references and interview process. Given the mandate for the Ministry of Health (2018d) to explore options for the employment of all NGNs, a more transparent and equitable process would be useful.

This study contributes to new knowledge of WR of NGN in the Aotearoa NZ context. It provides a beginning framework and evidence to base decisions for change in nursing education outcomes, safe and WR NGN practice and improve health outcomes for citizens of Aotearoa NZ.

4. Undergraduate nursing education curriculum

Having a practice focus, the NGN WR framework can be perceived as a model of 'thinking like, acting like, and being a nurse' thereby proffering an evidence-based nursing language to guide undergraduate nursing education. A curricular design with a vision (a concise statement on the demonstration of WR) and mission (an explanation of the steps to achieve WR) sets the philosophical framework. The curricular framework organises the plan of how the student nurse develops thinking like, acting like and being a nurse, meeting WR attributes and attitudes. Finally, programme outcomes (outcomes reliably demonstrated at the end of the programme that have been aligned with WR, using evidence-based nursing pedagogies and authentic assessment) can be re-formulated using this professional language to create a common curriculum to achieve improved, consistent and quality, managed outcomes. The WR framework begins to provide professional consensus about high quality nursing education. Nurse educators now need to identify the models, frameworks and pedagogies to support such a curriculum design with particular attention to staircasing and scaffolding learning.

An undergraduate nursing education programme that uses a nursing philosophical and pedagogical framework such as the MA more than meets the NZ nursing sector view on WR of NGNs. Such a model permits flexibility in facilitating the lay person to learn to think like, act like and then be a nurse in a manner that reflects clinical nursing practice. Traditional content-structured programmes often become overloaded with theory as the health care system becomes increasingly complex. Facilitating learning of a holistic/person-centred/patient centred/whānau ora/family centred nursing practice is antithetical to siloed theoretical curricula wherein there is increased pressure to add more and more content. It has been nearly a decade since the call was made by one of nursing's most renowned and respected nurse academics for the radical transformation of nursing education (Benner et al., 2010).

Such transformation demands privileging nursing education and client outcomes over the outcomes of educational institutions (Benner et al., 2010) and competing stakeholder agendas. With the current education system impacted by a business market model, the structure of professional programmes is often influenced by institutional rather than professional interests. The prioritising of research activity over teaching and learning, control of the semester and programme/course structure for the purposes of organisational expediency rather than learning to be a nurse is commonly experienced in tertiary education in NZ. Furthermore, pedagogies such as online learning are sometimes driven by the need for increased student numbers and decreased teacher-student contact time rather than by strong evidence supporting practice of best learning to become a nurse.

NGN WR is different from, and more than, meeting the NCNZ Competencies for RN SoP having undertaken a programme with the NCNZ Education Programme Standards for the RN content. The NZ nursing sector consensus of the expected levels of WR element performance indicates that achievement of the senior student nurse meeting the NCNZ Competencies for RN SoP is questionable, suggesting that these are no longer appropriate for meeting either safety or WR standards. Therefore, a different framework for the senior nursing student, one that comprises greater detail and transparency for all interested parties may help to demonstrate WR at the point of registration to professional practice. The WR framework was not intended as a checklist for achievement in practice, rather informs further thinking in the development of a more suitable tool. The WR framework supports the recent work in the UK developing the Future Nurse Standards of Proficiency for the RN, published by the Nursing and Midwifery Council (2018), although levels of performance remain unclear.

5. Implications and recommendations

The study has identified several implications and recommendations for further action that are recommendations for consideration by the nursing profession. These are framed around implications for nursing education, nursing practice, nursing policy and further research.

6.1 Recommendations for nursing education

i. The nursing profession re-claim the rights to determine undergraduate nursing education and use the WR framework to:

- Agree, define and describe high quality nurse education in NZ;
- Specify how WR is demonstrated at the point of registration
- Identify and implement evidence-based nursing pedagogies, models, and frameworks such as the MA; and
- Determine a re-designed nursing curricular mission, vision, framework, structures, programme outcomes, and authentic assessments and insist that the education sector meets these requirements.

6.2 Recommendations for nursing policy

i. The NCNZ education standards and requirements for nurses entering the profession are reviewed and:

- Are extended, further detailed, more transparent and informed by elements of WR;
- Use evidence-based *nursing* curriculum and *nursing* pedagogical structures; and
- Use the WR framework to create a final undergraduate semester framework for the student nurse related to, but different from, those for the RN SoP but achievable as a senior student nurse.

ii. The senior nursing student and NGN have a carefully constructed journey to achieving high levels of WR performance by:

- Re-aligning NEtP programmes so that the WR framework informs a consistent, national first year of professional practice with measurable successful transition-to-RN outcomes:
  or
- Developing and implementing a 4th year internship model to ensure the mastery of performance levels (particularly proficiency) prior to full registration as an RN.

iii. There is national equitable opportunity for all nursing students to meet WR with the establishment of:

- A nursing body responsible for leadership, oversight, responsiveness to rapid, contemporary health care changes and quality of nursing education; and
- A single evidence-based flexible nursing programme with consideration to managed enrolments, entry criteria, teaching, learning and authentic assessment processes, programme outcomes and local or regional needs.

6.3 Recommendations for nursing practice

i. NGN recruitment processes use the WR framework:

- For transparency of advertised RN NGN role requirements; and
- As a tool for national equal opportunities, including the ACE process.

6.4 Recommendations for further research

i.   Conduct studies to establish an evidence-base for scaffolding and structuring learning to be a nurse; how learning can be divided up and scaffolded for effective progression to WR

ii. Undertake investigations into nursing pedagogies that meet WR requirements both pre-registration and post-employment, including professional nursing attitudes, expert learning skills, decision-making and conflict management skills

iii. Investigate reliable practices of embedding WR foundational concepts across the programme rather than as siloed learning, such as bi-culturalism, cultural competence and safety, and professional nursing attitudes

iv. Undertake a collaborative investigation to determine what the effective relationship between nursing education and practice looks like

v.   Investigate a nursing internship within a 4-year undergraduate programme that ensures WR prior to registration as an RN

6. Limitations

The Delphi methodology used in this research project has co-constructed a WR framework. Nevertheless, limitations have been identified. Given the uncertainty regarding the underpinning theoretical framework, research integrity can be criticised. Although it has been proposed that the Delphi methodology emerged from a time when the importance of a theoretical basis or underpinning philosophy was less significant (Guzys et al., 2015), the pragmatic flexibility versus the scientific robustness determines a position that the Delphi does "not offer indisputable facts and instead they offer a snapshot of expert opinion from that group at that particular time which can be used to inform thinking, practice or theory" (Hasson & Keeney, 2011, p. 1701).

The expert opinion in this study was elicited from nurses from across the sector who were responsible for employing or supporting NGNs; undergraduate curriculum design; examining/advising on professional/cultural nursing issues or were NGNs themselves. Sixty-one nurses (67%) participated. Although there is no consensus on numbers of

participants (Diamond et al., 2014; Hsu & Sandford, 2007; Keeney et al., 2006; Keeney et al., 2001), reliability is enhanced with larger panels. However, this can also result in greater variance, decreasing the level of accuracy and generalisability (Hasson & Keeney, 2011). Regardless of the size, if the survey was completed by another group, there is no guarantee the same results would be obtained (Hasson et al., 2000; Keeney et al., 2001). Furthermore, only 42% of invited primary health care nurses participated, potentially weakening their perspective. There may be a small risk that heterogeneity of the participant group may be affected. Additionally, only one NGN participant (17%) identified as Māori, albeit I aimed for 50% of NGN participants to identify as Māori. Altering the ethnicity balance may have given different perspectives.

Nine WR elements missed convergence to consensus by up to only 5%, a threshold figure that could be changed by a greater number of participants. Additionally, in six WR items, the percentage of participants' scores was the same in each of *two* expected NGN performance levels within one or two components. Although I decided that the lower score provides a greater level of consensus because all participants agreed with the level of performance at least to this minimal level, a greater number of participants may alter the expected levels of performance in these elements.

A further survey round may have resulted in greater convergence to consensus or changes in perceptions of expected levels of NGN performance. The Delphi contributes to concurrent validity due to successive rounds as participants have identified and agreed the components (Arthurs, 2015). However, there is considerable risk of attrition with more survey rounds. Supporting participation and good response rates increases validity of the results (Hasson et al., 2000), reduces sampling bias, and supports generalisability of findings.

7. Final remarks

The co-constructed NGN WR framework presents a comprehensive and significant view of the NGN when first entering professional practice in the increasingly complex and ever-changing NZ health care system. It shows promise for informing and re-shaping the substance of undergraduate nursing education in NZ and using such frameworks as the MA. WR of the NGN ensures patient safety, job satisfaction and career development as well as workforce retention. The recommendations from this study focus on the confident NGN practice being safe, evidence-based, culturally safe, high quality, holistic, independent, proficient, and timely, enabling effective contribution to the health and

wellbeing of the citizens of Aotearoa New Zealand. Like Benner, I believe it is time for change:

> Re-designing nursing education is an urgent societal agenda. Profound changes in nursing practice calls for equally profound changes in education of nurses and preparation of nurses to teach nursing. The current climate rewards short-term focus, efficiency, and cost-savings that compromise the quality of nursing education and patient care. The challenge will be to create health care [education] institutions and management systems that educate nurses in a climate fostering professional attentiveness, responsibility, and excellence, where students learn that they have the authority, not just the responsibility, to practice. (Benner et al., 2010, p. 16)

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Appendices

Appendix A: Phase One AUTEC Approval Letter

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

23 May 2016

Deb Spence
Faculty of Health and Environmental Sciences

Dear Deb

Re Ethics Application: 16/116 What are the elements of work readiness of new graduate nurses in the New Zealand health care context?

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 23 June 2019.

This approval is for the first stage of the research only. Full information about the other stages needs to be provided to and approved by AUTEC before recruitment and data collection for those stages commence.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 23 June 2019;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 23 June 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Diana Fergusson d.fergusson@witt.ac.nz

203

Appendix B: Phase One Recruitment Protocol

Recruitment Protocol

The names of those nursing leaders who participated in the development of the undergraduate nursing programme will be identified by the student researcher from existing documents within the education institute.

The nursing leaders email addresses will be identified from the curriculum development and Local Advisory Committee documentation held in the education institute. These email addresses are not held for the purposes of research and consent has not been sought to use them for the purposes of research. The email addresses are professional email addresses linked to the place of work; they are not personal email addresses.

The names and email addresses will be given to the student researcher's supervisor Dr Deb Spence who will email the potential candidates with the following message:

> *'My name is Dr Deb Spence and I am supervising a Doctor of Health Science student, Diana Fergusson who would like to invite you to be a participant in her research project. I am seeking your consent for her to contact you using this email address to invite you to participate. Please could you respond by return email to inform me of your decision to of whether or not you give consent'*

Dr Deb Spence will then provide the consenting names with accompanying email addresses to the student researcher to then contact the potential participants as per the attached research protocol.

Appendix C: Phase One Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

11 May 2016

Project Title

What are the elements of work readiness of new graduate nurses in the New Zealand health care context?

An Invitation

My name is Diana Fergusson and I am currently undertaking the Doctor of Health Science (DHSc) degree at the Auckland University of Technology.

I would like to invite you to participate in my research project. Participation is entirely voluntary and you may withdraw at any time prior to the day of the focus group discussion on **THURSDAY 23RD JUNE 2016 0830-1000 hours** in the Boardroom at WITT. There is no requirement to share all aspects of your perspective during the research if you feel uncomfortable doing so, without consequences and without giving a reason. It is entirely your decision on whether or not you wish to participate and our professional relationship will not be advantaged or disadvantaged by your decision.

What is the purpose of this research?

The purpose of this doctoral research project is to gain a consensus from nurses working in education, practice, professional and regulatory bodies about the components of work readiness of new graduate nurses. The elements will be identified using a national Delphi consensus process and then explored in relation to the WITT Bachelor of Nursing 'Modern Apprenticeship' model.

The research project will be reported as a thesis to meet the requirements for the award of Doctor of Health Science. I also expect to gain publications in professional journals and present the work at appropriate conferences.

How was I identified and why am I being invited to participate in this research?

I am contacting the Taranaki nursing leaders, such as yourself, who have previously participated in the development of the WITT undergraduate nursing programme, to invite you participate in Phase 1 of the study. This will take the form of a focus group discussion in relation to your perspective of graduate nurse work readiness.

I have used your email address from the time of the undergraduate degree development and your role in ongoing advisory capacity to the School of Nursing to make contact with you and issue the invitation.

What will happen in this research?

There are approximately 8 nursing leaders invited to participate in a round table focus group discussion. The focus of the discussion will be your perspective and perception of work readiness of new graduate nurses. Topics for discussion are likely to include the work readiness attributes that you associated with, influencing your perspective on shaping the undergraduate programme.

Light refreshments will be provided.

The information gathered from the focus group will be integrated with the literature to generate a set of items for the first questionnaire round of the Delphi survey.

The Delphi study will provide an opportunity for nurses across the sector nationally to inform a consensus in identifying the elements of work readiness of new graduate nurses. You may also be invited to participate in the second part of the study.

What are the discomforts and risks?

It is not anticipated that there will be any discomfort or risk to yourself.

What are the benefits?

The benefits of undertaking the research include:

- Adding to the body of knowledge of graduate nurse work readiness
- Provide a collaborative opportunity across the sector
- Gain a NZ consensus on elements that form the construct of work readiness

- Provide relevant data leading to the development an evaluative tool for undergraduate nursing programmes
- Provide a positive contribution to health care delivery in NZ
- Advance the discipline of nursing
- Completion of my Doctor of Health Science qualification

How will my privacy be protected?

With your permission, I would like to digitally record the interview. This information will be transcribed verbatim by myself. All information will be confidential and you will not be identified personally in any way.

Once the analysis of the information is completed, tapes will be stored securely in the Faculty of Health and Environmental Science at AUT for a period of six years and will then be destroyed. The consent forms will also be stored securely in the Faculty of Health and Environmental Science at AUT for a period of six years but separately to the tape. They too will then be destroyed.

The final results will not be able to be linked to you; there will be no identifying material and the identity of participants will be protected.

Focus group interviews can limit the confidentiality in that group discussion content may be shared during the interview. Participants will therefore be expected to keep the identity of fellow participants, the discussions and information in the focus group confidential to the group.

Given that the final results will be integrated with the literature to develop the first questionnaire in the Delphi study, you will not be able to be identified in Part 2 of the research project.

What are the costs of participating in this research?

The focus group is expected to take between 60-90 minutes. There will also be travelling time for you. There are no other costs anticipated. A car park can be arranged for you.

What opportunity do I have to consider this invitation?

I would like to request a response within 10 working days. This can be by return email or by telephone. After 10 working days, I will telephone you to ask if you received the email invitation and had sufficient time to read the Information Sheet. Further, I will ask if you have any questions which need to be clarified before signing the Consent Form.

How do I agree to participate in this research?

If you agree to participate, you are required to sign the consent form which can be found attached to the email invitation.

Will I receive feedback on the results of this research?

A copy of a report from the research will be made available. If you wish to have a copy, please indicate on the consent form. The report will be emailed to you once completed.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Deb Spence. She can be contacted by email deb.spence@aut.ac.nz or by telephone 09 9219999

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Diana Fergusson

Email: d.fergusson@witt.ac.nz Telephone: 0274660394

Project Supervisor Contact Details:

Dr Deb Spence

Email: deb.spence@aut.ac.nz Telephone: 09 9219999

Appendix D: Phase One Consent Form

Consent Form

Project title: What are the elements of work readiness of new graduate nurses in the New Zealand health care context?

Project Supervisor: Dr Deb Spence

Researcher: Diana Fergusson

○ I have read and understood the information provided about this research project in the Information Sheet dated 11 May 2016.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.

○ I understand that notes will be taken during the focus group and that it will also be digitally-taped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.

○ I agree to take part in this research.

○ I would like to have a car park made available (please tick one):   Yes○ No○

○ I wish to receive a copy of the report from the research (please tick one): Yes○   No○

Participant's signature:.......................………………………………………

Participant's name:.......................…………………………………………

Participant's Contact Details (if you wish to receive a copy of the report from the research):

Email :

Date:

Approved by the Auckland University of Technology Ethics Committee on 23rd May, 2016 AUTEC Reference number 16/116.

Note: The Participant should retain a copy of this form.

Appendix E: Phase One Research Protocol

Focus Group Research Protocol

Recruiting Email:

Dear / Kia ora XXXX

I am writing to invite you to participate in my doctoral research. I have attached an information sheet which contains information on the project. Once you have had an opportunity to read this, you may have some questions and queries before you agree to participate. I am very happy to respond to the queries either by email or on the telephone.

Once you have sufficient information and agree to participate, you will need to sign the consent form which is also attached.

Please do not hesitate to contact me to discuss further.

Kind regards / Nga mihi

Diana

Focus Group

Venue: Boardroom preparation

- Tables re-arranged to create a round-table structure
- Ventilation of the room attended to
- Refreshments including water with glasses positioned conveniently
- Ensure the primary researcher acting in the role as moderator is seated so that all participants can see and be clearly seen
- Digital recording device checked and then positioned as unobtrusively as possible

Focus Group Plan

- Greet all participants (they have all had a whakatau previously)
- Commence the session with WITT karakia
- Thank the participants
- Car parking arrangements satisfactory
- Health and safety
- Repeat the privacy issues of confidentiality
- Confirm the use of a digital recorder
- Respond to any queries
- Provide an overview of the process of the development of the undergraduate programme, noting key issues such as
  - o Collaborative approach
  - o Aims of the development of the programme (increase work readiness of the graduates)
  - o Aspects of the programme they were adamant about e.g.: amount of clinical practice
- Overview of discussion guidelines:
  - o Want to capture all perspectives
  - o One person speaking at a time

- o No interruption except where necessary (going off-track)
- Indicative questions
  - o How do you perceive the term 'work readiness'? [Overall perception]
  - o Is this a view of your organisation / managers? [Whose perception?]
  - o What are the attitudes, attributes and skills required? [Attributes]
  - o How would you define that attribute / attitude / skill? Can you give an example? [The standard]
  - o Who is responsible for judging that these attribute / attitude / skills meet the standard? [Where does the responsibility lie?]
  - o How do you judge that a graduate nurse has successfully transitioned into the work environment? [What is 'success in the work environment'/]
  - o What are the graduates are meant to be ready for?
  - o What else is work readiness known as?
  - o What criteria does your organisation use to recruit new graduates [Does the perspective match the practice]
  - o Are there any other comments or statements you would like to make? [Ensure all perspectives are captured]
- Conclude session
  - o Thank participants
  - o State again what will now happen with the data
  - o Close with karakia

Digital recording:

- Ensure participants are warned of the recorder being switched on and then off at the end

Moderator role:

- Promote interaction if required
- Ensure all participants feel their views are valuable
- Ensure the participants stay on the topic
- Ask for clarity where appropriate
- Ask for examples where appropriate
- Ask for underpinning meaning where appropriate
- Probe for further information and elaboration
- Paraphrase for purposes of summing up and ensuring all key points captured

DF 2/2/16

Appendix F: Phase Two Survey One AUTEC Approval Letter

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

12 March 2018

Deb Spence
Faculty of Health and Environmental Sciences

Dear Deb

Re Ethics Application: **18/73 What are the elements of work readiness of new graduate nurses in the New Zealand health care context? A professional consensus**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 12 March 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: d.fergusson@witt.ac.nz; Stephen Neville

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

29 October 2018

Deb Spence
Faculty of Health and Environmental Sciences

Dear Deb

Re: Ethics Application: **18/73 What are the elements of work readiness of new graduate nurses in the New Zealand health care context? A professional consensus**

Thank you for your request for approval of an amendment to your ethics application.

The second survey phase is approved.

I remind you of the **Standard Conditions of Approval**.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/research/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: d.fergusson@witt.ac.nz; Stephen Neville

Appendix G: Phase Two Recruitment Protocol

Recruitment Protocol

The aim of the recruitment protocol is to identify the names, contact details (email addresses are professional email addresses linked to the place of work) and methods of engagement of those nurses across the education, practice, professional and regulatory bodies sectors who would provide representation for those having knowledge of and a critical or vested interest in professional beginning practitioner workforce performance when employing new graduate nurses, ensuring professional heterogeneity across the country.

Step 1: Due to the nature of multiple surveys, a Delphi can experience significant attrition among participants. Gaining and retaining participation is important. The nursing sector is well represented within the *National Nursing Organisation* (NNO). This is a group of nursing leaders, representing national organisations comprising representatives from employers, educators, professional bodies, the regulator, and the Office of the Chief Nurse, whose focus includes workforce development. A letter explaining the research project will be sent to this committee to raise awareness of the study.

Kia ora Jenny

I am writing to the National Nurses Organisation to inform the group of my doctoral research project. The purpose of my study is to determine the elements of work readiness of new graduate nurses in the New Zealand context, using an online consensus-building approach from nurses working across the sector.

Nurses from practice, education, professional the regulatory body will be invited to participate, providing an opportunity for cross-sector collaboration. The benefits of undertaking the research include:

- Add to the body of knowledge of graduate nurse work readiness
- Provide an opportunity across for nursing sector collaboration
- Gain a NZ consensus on elements that inform the construct of work readiness
- Provide a positive contribution to health care delivery in NZ
- Advance the discipline of nursing

> - Completion of my Doctor of Health Science qualification
>
> Nursing leaders across the sector will soon be contacted to identify key nurses who will be invited to participate. Advertising for new graduate nurses, with approximately one year experience is also underway.
>
> The purpose of my letter is to inform this national leadership group of my work, thereby raising awareness.
>
> Please do not hesitate to contact me if you have any questions regarding my research project. I would be very happy to discuss it further.
>
> Regards
>
> Diana Fergusson

Letter to the National Nursing Organisation (NNO)

Step 2: An introductory letter will be sent, by email, to nursing leaders of the following organisations, using email contact (number of potential participants in brackets):

- Nursing Council of New Zealand - contact details available on NCNZ website www.ncnz.org.nz (1)
- Tertiary Education Schools of Nursing – 17 schools with 21 programmes - contact details available on NETS website www.nurseducation.org.nz (21)

- ❖ Invitation for each of the programmes:
  - ✓ Bachelor of Nursing
  - ✓ Bachelor of Nursing (Māori)
  - ✓ Bachelor of Nursing (Pacific)

  - o Western Institute of Technology at Taranaki (WITT)
  - o Waikato Institute of Technology (WINTEC)
  - o Eastern Institute of Technology (EIT)
  - o Toi Ohomai
  - o Northtec
  - o Whitireia
  - o Universal College of Learning (UCOL)
  - o Nelson Marlborough Institute of Technology (NMIT)
  - o Otago Polytechnic

- o Southern Institute of Technology (SIT)
- o Unitec Institute of Technology (UNITEC)
- o Te Whare Wananga o Awanuiarangi
- o Auckland University of Technology (AUT)
- o University of Auckland (UoA)
- o Massey University
- o Manukau Institute of Technology (MIT)
- o Ara Institute of Canterbury (Ara)

- District Health Boards – 20 DHBs - contact details available through the Ministry of Health website www.health.govt.nz (40)

  - ❖ Invitation for 2 from each DHB for each of the following:
    - ✓ general services
    - ✓ mental health

    - o Auckland (ADHB)
    - o Bay of Plenty (BOPDHB)
    - o Canterbury (CDHB)
    - o Capital & Coast (CCDHB)
    - o Counties Manakau (CM Health)
    - o Hawkes Bay (HBDHB)
    - o Hutt Valley (Hutt Valley DHB)
    - o Lakes
    - o Mid Central (MDHB)
    - o Nelson Marlborough (NMDHB)
    - o Northland (NDHB)
    - o South Canterbury (SCDHB)
    - o Southern (Southern DHB)
    - o Tairawhiti
    - o Taranaki (TDHB)
    - o Waikato (Waikato DHB)
    - o Wairarapa (Wairarapa DHB)
    - o Waitemata (Waitemata DHB)
    - o West Coast (WCDHB)
    - o Whanganui (WDHB)
- Primary Health Care Organisations (30) – The Ministry of Health website provides a list of primary health care organisations. The organisations websites were checked to verify they remained providing the services described. From thirty-three listed, thirty were

identified for the study. All contact details for these organisations could be found on their websites.

- o Alliance Health Plus Trust
- o Auckland PHO Limited
- o Central Primary Health Organisation
- o Christchurch PHO Limited
- o Compass Health
- o East Health Trust
- o Eastern Bay Primary Health Alliance
- o Hauraki PHO
- o Health Hawke's Bay Limited
- o Kimi Hauora Wairau (Marlborough PHO Trust)
- o Manaia Health PHO Limited
- o Midlands Health Network
- o National Māori PHO Coalition Incorporated
- o Nelson Bays Primary Health
- o Nga Mataapuna Oranga Limited
- o Ngati Porou Hauora Charitable Trust
- o Ora Toa PHO Limited
- o Pegasus Health (Charitable) Limited
- o Procare Networks Limited
- o Rotorua Area Primary Health Services Limited
- o Rural Canterbury PHO
- o WellSouth Primary Health Network
- o Te Awakairangi Health Network
- o Te Tai Tokerau PHO Ltd
- o Total Healthcare Charitable Trust
- o Waitemata PHO Limited
- o Well Health Trust
- o West Coast PHO
- o Western Bay of Plenty Primary Health Organisation Limited
- o Whanganui Regional PHO

- Hospice - **contact details available on Hospice website** www.hospice.org.nz (1)

- Plunket - contact details available on Plunket website www.plunket.org.nz (1)

- Southern Cross Hospitals - contact details available on Southern Cross website https://hospitals.southerncross.co.nz (1)

- Occupational Health Nurses Association (OHNA) - contact details available on the Occupational Health Nurse website www.nzohna.org.nz (1)

- Aged Care (5)

  ❖ five largest selected which accounts for approximately 50% of the residential care market (JLL, 2015)

    o Bupa - contact details available on Bupa website www.bupa.co.nz
    o Oceania - contact details available on Oceania website www.oceaniahealthcare.co.nz
    o Summerset - contact details on Summerset website www.summerset.co.nz
    o Metlifecare - contact details on Metlifecare website www.metlifecare.co.nz
    o Ryman - contact details available on Ryman website www.rymanhealthcare.co.nz

- Professional bodies

  o Ministry of Health Office of the Chief Nurse - contact details available on MoH website www.moh.govt.nz (1)

  o New Zealand Nurses Organisation (NZNO) - contact details available on NZNO website www.nzno.org.nz (2)

    ▪ 2 participants (Māori and non-Māori)

  o College of Nurses Aotearoa (NZ) - contact details available on CoN website www.nurse.org.nz (2)

    ▪ 2 participants (Māori and non-Māori)

  o Te Ao Maramatanga New Zealand College of Mental Health Nurses - contact details available on College website www.nzcmhn.org.nz (2)

    ▪ 2 participants (Māori and non-Māori)

  o Te Kaunihera o Ngā Neehi Māori (National Council of Māori Nurses) - contact details available on Māori Nursing Council website www.maorinursingcouncil.org.nz (1)

A total of 109 potential participants have been identified from across the health sector.

The purpose of the introductory email is to introduce the research project, provide information and ask them to identify staff member(s) who would meet the stated inclusion criteria and relay the information to them. Those individuals will be asked to contact the Primary Researcher directly. Where a response has not been received from an organisation within 10 days, they will be contacted again by the primary researcher to remind them of the request to participate.

Eligibility criteria:

Those selected participants must be willing to participate, able to commit to two rounds of questionnaires, have access to a computer, computer literacy to complete online surveys as well as having met one of the following criteria:

- Responsible for undergraduate curriculum design
- Responsible for undergraduate programme accreditation and monitoring
- Responsible for employing / supporting new graduate nurses
- Responsible for examining /advising on professional / cultural nursing issues

Kia ora

I am writing to you to inform you of my doctoral research project. I am seeking to determine the elements of work readiness of new graduate nurses in the New Zealand context, using an online consensus-building approach from nurses working across the sector.

Nurses from practice, education, professional bodies and the regulatory body will be invited to participate, providing an opportunity for cross-sector collaboration. The benefits of undertaking the research include:

- Add to the body of knowledge of graduate nurse work readiness
- Provide an opportunity across for nursing sector collaboration
- Gain a NZ consensus on elements that inform the construct of work readiness
- Provide a positive contribution to health care delivery in NZ
- Advance the discipline of nursing
- Completion of my Doctor of Health Science qualification

Nursing leaders across the sector are being contacted to consider contributing to this research by identifying key nurses who could be invited to participate. The research project information sheet is attached. The potential participant(s) from your organisation must meet the following criteria:

- Has access to a computer and ability to complete online surveys
- Willing to participate and commit to two questionnaire rounds
- *Insert - Meets one of the above entry criteria*

Please could you identify potential participant(s) and relay this research project information to them. Those individuals interested are asked to contact me directly for an information sheet.

My contact details are:

Email: gnk6132@aut.ac.nz

Phone: 0275613313

These nurses will join other colleagues in New Zealand who will remain anonymous. Together, all responses will form a national perspective on work readiness, therefore these nurse's responses are important in contributing to the end result. The participant may be yourself *and / or* another nursing colleague.

Where 2 participants invited for bi-cultural approach – Insert - Two participants, eliciting perspectives from Māori and non-Māori is being sought.

Where 2 participants invited for general and mental health – Insert - Two participants, eliciting perspectives from general services and mental health is being sought.

Where 2-3 participants invited for BN Māori and BN Pacifika programmes as well as BN programme - – Insert - Two / three participants, eliciting perspectives from the Bachelor of Nursing programme, Bachelor of Nursing programme (Māori), Bachelor of Nursing programme (Pacific) is being sought.

I would like to send an invitation to participate within the next 10 days. Please do not hesitate to contact me if you have any questions regarding my research project. I would be very happy to discuss it further. Thank you in anticipation.

Regards

Diana Fergusson

Nursing Leader Introduction to the research   * choose one

If a response has not been received after 10 working days, Nursing Leaders will be contacted to ask if they have received the email invitation and had sufficient time to read the information sheet. They will then be asked if they have any questions or issues for clarification and requested to re-issue the invitation to potential participants.

Step 3:

Recruitment for new graduates' participation will be undertaken by advertising in local professional journals, including Kai Tiaki Nursing New Zealand and Nursing Review. New graduate nurses will be invited to participate until all places are full. Once places are full, those new graduates enquiring will be thanked for their interest and declined.

Eligibility criteria:

Those selected participants must be willing to participate, able to commit to two rounds of questionnaires, have access to a computer, computer literacy to complete online surveys as well as having met one of the following criteria:

- Two (Māori and non-Māori) NZ new graduate nurse having just completed approximately one year of practice, from each of the following:
    - Nurse Entry to Practice (NEtP),
    - Nurse Entry to Specialty Practice (NEtSP)
    - Aged Residential Care Nurse Entry to Practice programme (ARC NEtP)
- Two (Māori and non-Māori) NZ new graduate nurse having just completed approximately one year of practice, outwith a NEtP, NEtSP or ARC NEtP programme

---

New graduate registered nurses.

I need your help with a research project 'Work readiness of new graduate nurses in NZ'.

The purpose of my doctoral research project is to determine the elements of work readiness of new graduate nurses in the New Zealand context, using an online consensus-building approach from nurses working across the sector.

If you would be willing to participate, able to commit to two rounds of questionnaires, have access to a computer, computer literacy to complete online surveys and meet one of the following criteria, please contact me for an information sheet and the survey link:

1. A NZ new graduate nurse having just completed approximately one year of practice, including a NEtP programme and who identifies as non-Māori.
2. A NZ new graduate nurse having just completed approximately one year of practice, including a NEtP programme and who identifies as Māori.
3. A NZ new graduate nurse having just completed approximately one year of practice, including a NESP programme and who identifies as non-Māori.
4. A NZ new graduate nurse having just completed approximately one year of practice, a including a NESP programme and who identifies as Māori.
5. A NZ new graduate nurse having just completed approximately one year of practice, a including an Aged Residential Care Nurse Entry to Practice programmes (ARC NEtP) and who identifies as Māori.

---

6. A NZ new graduate nurse having just completed approximately one year of practice, a including an Aged Residential Care Nurse Entry to Practice programmes (ARC NEtP) and who identifies as non - Māori.

7. A NZ new graduate nurse having just completed approximately one year of practice (without a NEtP, NESP or ARC NEtP programme) and who identifies as non-Māori.

8. A NZ new graduate nurse completed approximately one year of practice (without a NEtP, NESP or ARC NEtP programme) and who identifies as Māori.

My contact details are:

Email: gnk6132@aut.ac.nz

Phone: 0275613313

Please do not hesitate to contact me if you have any questions regarding my research project. I would be very happy to discuss it further. Thank you in anticipation.

Diana Fergusson

Doctoral Candidate, AUT

Journal advertisement

Step 4:

The participant invitation and link to the survey will then be emailed to the participants.

Work readiness of new graduate nurses research project. I need your assistance.

Kia ora

The purpose of my doctoral research project is to determine the elements of work readiness of new graduate nurses in the New Zealand context, using an online consensus-building approach from nurses working across the sector. You been invited to participate in recognition of your role in *Insert entry criteria here*

You will join other colleagues in New Zealand who will remain anonymous. Together, all responses will form a national perspective on work readiness, therefore your responses are important in contributing to the end result. Your responses and judgements will remain confidential.

The research project information sheet is attached. Please consider the information before responding. The link to the first online web survey can be found below. Your participation will involve completing two rounds of online surveys, each taking approximately sixty minutes to

complete. Undertaking the survey can be at a time and place convenient to you within the requested time frame.

All responses for the first survey received by xxxx will be analysed. Thank you in anticipation.

Regards

Diana Fergusson

Participant Invitation

If a response has not been received after 10 working days, potential participants will be contacted to ask if they have received the email invitation and had sufficient time to read the information sheet. They will then be asked if they have any questions or issues for clarification.

Reference

JLL (2015) New Zealand Retirement Village Database (NZRVD) November 2015 Whitepaper December 2015. Retrieved from
http://www.rvranz.org.nz/uploads/4/3/9/2/43925677/village_database_2015.pdf

Appendix H: Phase Two Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

7th February, 2018

Project Title

What are the elements of work readiness of new graduate nurses in the New Zealand health care context? A professional consensus.

An Invitation

My name is Diana Fergusson and I am currently undertaking the Doctor of Health Science (DHSc) degree at the Auckland University of Technology.

I would like to invite you to participate in my research project. Participation is entirely voluntary and it is your decision on whether or not you wish to participate.

What is the purpose of this research?

The purpose of this doctoral research project is to gain a consensus from nurses working in education, practice, professional and regulatory bodies about the components of work readiness of new graduate nurses. The project has identified elements of work readiness from the literature and a nursing leader focus group interview. These items have been reviewed and are now presented to you for judging in order to co-construct a consensus framework of elements of work readiness of new graduate nurses in New Zealand.

The research project will be reported as a thesis to meet the requirements for the award of Doctor of Health Science. I also expect to gain publications in professional journals and present the work at appropriate conferences.

How was I identified and why am I being invited to participate in this research?

I am contacting those, such as yourself, who *Insert entry criteria relevant to the participant*, to invite you to respond to an electronic survey, regarding your perceptions and level of agreement with those elements provided. Your response will contribute to a national consensus-building approach.

I have used your email address from your register of interest to make contact with you and issue the invitation.

How do I agree to participate in this research?

Your consent to participate is implied by the completion of the electronic surveys. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data is not possible.

What will happen in this research?

Your participation in this research project will involve completing two rounds of online surveys, each taking approximately sixty minutes to complete. Undertaking the survey can be at a time and place convenient to you within the requested time frame. The surveys will be emailed out at intervals, allowing analysis to be undertaken after each round, seeking to gain consensus. Each round of surveys is based entirely on participant responses.

The data collected in the surveys will only be used for the purpose of this study.

What are the discomforts and risks?

It is not anticipated that there will be any discomfort or risk to yourself, associated with your participation in this project. You may feel slightly anxious at the thought of making a judgement on work readiness of graduate nurses. However, whilst it is not my intention to make you relive potentially uncomfortable experiences, I would like to know your perspectives on work readiness.

How will these discomforts and risks be alleviated?

If taking part in this research study makes you feel uncomfortable, you will be free to withdraw at any time without consequence.

What are the benefits?

The benefits of undertaking the research include:

- Adding to the body of knowledge of graduate nurse work readiness

- Providing an opportunity for sector collaborative work

- Gaining a NZ consensus on elements that inform the construct of work readiness

- Providing a positive contribution to health care delivery in NZ

- Advancing the discipline of nursing

- Assisting completion of my Doctor of Health Science qualification

How will my privacy be protected?

All information will be confidential and you will not be identified personally in any way. You will join other NZ nursing colleagues who will remain anonymous. The final results will not be able to be linked to you; there will be no identifying material and the identity of participants will be protected. The data from the study will be reported as a combined set of information.

As the primary researcher, I know who the participants are and their responses. However, I can assure you that your responses and judgments will remain completely confidential. I will check the names of the participants who have not responded to the survey. This information will be required only so that a reminder message can be sent to encourage a response. You will also receive individual feedback between surveys so that you can view your own responses in light of the rest of the participant group. Once all responses are complete and the data collection is complete, the statistical analysis will be undertaken anonymously.

Once the analysis of the information is completed, the survey data will be stored securely in the Faculty of Health and Environmental Science at AUT for a period of six years and will then be destroyed.

What are the costs of participating in this research?

Each survey is expected to take approximately sixty minutes. There are no other costs anticipated.

What opportunity do I have to consider this invitation?

I am hoping for a response to the first survey within 10 working days. I will send a reminder to you if you have not responded within this timeframe.

Will I receive feedback on the results of this research?

A copy of a report from the research will be made available to you.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor,

Dr Deb Spence. She can be contacted by email deb.spence@aut.ac.nz or by telephone 09 9219392

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Diana Fergusson

Email: gnk6132@aut.ac.nz Telephone: 0275613313

Project Supervisor Contact Details:

Dr Deb Spence

Email: deb.spence@aut.ac.nz Telephone: 09 9219392

Approved by the Auckland University of Technology Ethics Committee on *xxxxx*, AUTEC Reference number *xxxxxx*.

Appendix I: Phase Two Survey One

Work readiness of new graduate nurses in New Zealand

Kia ora participant

The purpose of this study is to determine the elements of work readiness of new graduate nurses in the New Zealand context, using an online consensus-building approach from nurses working across the sector. You will join other colleagues in New Zealand who will remain anonymous. Together, all responses will form a national perspective on work readiness, therefore your responses are important in contributing to the end result. Your responses and judgements will remain confidential. The survey is a questionnaire which should take you no longer than 60 minutes to complete. By completing the questionnaire, you will have given consent to participate.

The first part of this survey will ask some demographic questions and the second part will ask you to make a judgement regarding the work readiness items.

Part 1. Demographic information

1. Please select your current nursing practice area (check one)
   - ☐ Nursing Council of New Zealand
   - ☐ Tertiary Education School of Nursing
      District Health Board
   - ☐ General services
   - ☐ Mental health
   - ☐ Primary Health Care
   - ☐ Rest home sector
   - ☐ Plunket
   - ☐ Occupational health
   - ☐ Hospice
   - ☐ Private - Southern Cross
   - ☐ New graduate nurse
   - ☐ Ministry of Health Office of the Chief Nurse
   - ☐ New Zealand Nurses Organisation
   - ☐ College of Nurses Aotearoa (NZ)
   - ☐ Te Ao Maramatanga New Zealand College of Mental Health Nurses

2. Please indicate the highest academic level of study you have attained (check one)
   - ☐ Certificate
   - ☐ Degree
   - ☐ Post-graduate certificate
   - ☐ Post-graduate diploma
   - ☐ Masters
   - ☐ PhD / Doctorate

3. Did you complete your RN education in New Zealand? (check one)
   ☐ Yes   ☐ No

4. How many years have you been registered with Nursing Council of New Zealand as an RN?
   _

5. Please indicate your gender (check one)
   ☐ Female   ☐ Male   ☐ Other

6. Please indicate your age group (check one)
   - ☐ Under 25
   - ☐ 25-34
   - ☐ 35-49
   - ☐ 50 and above

7. Please choose all ethnicities you most closely identify with
   - ☐ Māori
   - ☐ Pākehā
   - ☐ Pacific
   - ☐ Other

☐ Te Kaunihera o Ngā Neehi Māori (National Council of Māori Nurses)

Part 2. The survey

A list of work readiness items is presented to you to make a judgement. This list is accompanied by a set of assumptions about the new graduate nurse and yourself as a participant in the study. These assumptions are listed here for you to take into account when making your judgements.

9. Items are recognised as work readiness across *any and all* practice settings where new graduate nurses may be employed.
10. Items apply when *first* employed as an RN.
11. The new graduate nurse has *attained the level of knowledge and theory* as outlined in the NCNZ education standards. A copy of these standards can be found at the bottom of this survey.
12. The new graduate nurse has *attained technical ability in a range of basic nursing skills* (including dressings), as well as a range of assessment skills (including history, physical examination, and vital signs) and medication management across a range of settings
13. The new graduate nurse *knows the RN role and practises* according to code of conduct and within scope of practice, professional boundaries, legal and ethical frameworks (including confidentiality and privacy)
14. The new graduate nurse has *provided evidence of meeting the NCNZ competencies* for registered nurse scope of practice (as a Transition student), agreed by both the tertiary education and practice sector
15. Your judgement is based on your knowledge and experience of new graduate nurses entering the workforce, not on what you might think I want to see or what is in the literature
16. Your judgement is relatively impartial and provides a valid opinion from your knowledge and experience

Instructions to complete the survey

A list of items has been provided. You are first asked to answer whether or not you agree that the item is part of new graduate work readiness by indicating 'yes' or 'no'. A 'no' score requires no further judgement for that item and you are invited to proceed to the next item. If you have scored a 'yes' you are asked to judge the level of ability the new graduate would be expected to demonstrate to be work-ready in each section of knowledge base, level of independence, proficiency, timeliness, and confidence. There are options within each section for you to choose from. Two examples are shown. You will see that some items do not have or have a restricted level of expectation and therefore you will not be asked to make judgement on the level in these. These items are identified by the blacking out of boxes.

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? **Select No or Yes by clicking on the box ☐**		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
EXAMPLE 1. Performs brain surgery	☒	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
EXAMPLE 2. Practices within legal frameworks	☐	☒	2	3	3	2	2

THE SURVEY

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐			From your professional perspective and opinion, what is *the expected performance level of this item,* **when the new graduate RN is first employed?** *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
Workload								
1.	Manages a full workload of low acuity clients after completing orientation	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
2.	Manages a full workload of mixed acuity clients after completing orientation	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
3.	Copes with practising shifts / different work patterns across the week	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Provision of care								
4.	Provides mental health care	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
5.	Provides end-of-life care	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
6.	Performs personal care / activities of daily living (ADLs) for clients	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
7.	Demonstrates a mind-set whereby can transfer skills to another clinical setting	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
8.	Applies learnt knowledge and can readily answer clinical questions	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

228

	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge	Independence	Proficiency	Timeliness	Confidence
				2. Sufficient knowledge/knows to	**3.** Independent and safe	**3.** Accomplished and well-practised	**2.** Takes appropriate amount of time	**2.** Feels assured of own capability
				1. Will need to develop knowledge	**2.** Will need some direction	**2.** Will need further practice		
					1. Will need further development / supervision	**1.** Will need to learn to practice	**1.** Will need extra time	**1.** Will not yet feel assured of own capability
9.	Accesses and retrieves electronic data necessary for client care	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
10.	Practises with knowledge of and ability to use technology in health	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
11.	Advocates for the client	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
12.	Maintains client dignity	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
13.	Practises using an understanding of client rights	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
14.	Interprets subjective and objective assessment data	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
15.	Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
16.	Utilises common clinical technologies e.g.: pumps, monitors	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Making decisions								
17.	Writes nursing care plans or plans of care	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
18.	Interprets the multi-disciplinary team orders / plans	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed?

Select **No** or **Yes** by clicking on the box ☐

From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?*

Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐			From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
19.	Manages the balance between patient want and need	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
20.	Bases practice on evidence rather than routine	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
21.	Bases decision-making on the nursing process or plan of care	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
22.	Demonstrates ability to start tasks	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
23.	Sets and justifies priorities	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
24.	Re-sets priorities	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
25.	Always thinks about patient outcomes	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
26.	Is prepared for the unexpected to occur	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
27.	Identifies from a mass of detail the core issues in any situation	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
28.	Uses previous experience to figure out what is going on when a current situation takes an unexpected turn	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
29.	Judges urgency of changing situations	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? **Select No or Yes by clicking on the box ☐**			From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
30.	Changes focus when a crisis situation that needs attention arises	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
31.	Recognises when something is abnormal to what they expected and get it corrected	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
32.	Judges the need to escalate care through additional forms of focussed observation from observing and noticing to the use of a particular assessment tool	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
33.	Readjusts a plan of action in the light of what happens as it is implemented	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
34.	Re-assesses client's responses / situation and nursing interventions; conducts appropriate follow-up	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
35.	Sees how apparently unconnected activities are linked and make up an overall picture	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
36.	Traces out and assesses the consequences of alternative courses of action and, from this, pick the one most suitable	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
37.	Recognises patterns in a complex situation	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
38.	Is comfortable (not embarrassed) to ask questions when unsure / doesn't know about something	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
39.	Recognises when to ask for assistance	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
40.	Develops and uses networks of colleagues to assist in solving problems	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
41.	Tries to solve problems themselves	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Chroose an item.
42.	Listens to different points of view before coming to a decision	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
43.	Willing and able to use collegial support to critically think and make decisions, protecting self as a beginning practitioner	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Learning								
44.	Develops practical knowledge from reflecting on / self-assessing own knowledge, practice and competence	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
45.	Is experienced in and knows how to learn	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
46.	Demonstrates ability to look things up	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
47.	Demonstrates ability to learn quickly	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

		From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
48.	Faces and learns from mistakes	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
49.	Keeps up to date with current realities and changes	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
50.	Listens openly, accepts and applies constructive feedback	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
51.	Is pro-active and keen to learn	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
52.	Demonstrates personal growth through learning	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
53.	Practises using an understanding that learning is progressive; they don't know everything	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
54.	Learns a lot from colleagues	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
55.	Approaches senior people to learn from	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
56.	Recognises and maximises opportunities for learning	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
57.	Willingly and actively seeks and asks about clinical practices	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	<u>Knowledge</u> **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	<u>Independence</u> **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	<u>Proficiency</u> **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	<u>Timeliness</u> **2.** Takes appropriate amount of time **1.** Will need extra time	<u>Confidence</u> **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
58.	Learns from other RN role-modelling to understand how an RN thinks and acts like a nurse	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
59.	Helps others to learn	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
60.	Demonstrates ability to learn advanced skills	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Health education								
61.	Teaches clients and families	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
62.	Evaluates client learning	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
63.	Makes effective presentations to clients	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
64.	Advocates for policy changes that promote health of individuals, families or communities	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
65.	Teaches prevention, health promotion activities and effects of lifestyle on health	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
66.	Utilises community resources to enhance client care	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Quality								
67.	Demonstrates an ethical outlook	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

		From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
68.	Demonstrates concern for clients	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
69.	Identifies actual or potential client safety risks	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
70.	Takes appropriate measures to prevent or minimize risk of injury to self	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
71.	Takes appropriate measures to prevent or minimize risk of injury to clients	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
72.	Acts in familiar situations	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
73.	Declines to undertake unfamiliar activities	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
74.	Recognises own unsafe practice	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
75.	Judges when not to undertake planned or prescribed interventions	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
76.	Recognises unsafe practice in others	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
77.	Questions and challenges another nurses practice	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
78.	Questions and challenges the wider system	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
79.	Practises with an understanding of quality improvement methodologies	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐			From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
80.	Thrives on completing tasks and achieving results	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
81.	Demonstrates an eye for detail	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Communication								
82.	Feels comfortable using a range of communication skills with clients and their families	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
83.	Expresses self easily	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
84.	Makes appropriate impromptu speeches	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
85.	Communicates changes in client condition	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
86.	Manages conflict with colleagues	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
87.	Manages conflict with clients	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
88.	Shows initiative	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
89.	Motivates others	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Leadership								
90.	Is approached for original ideas	☐	☐					
91.	Can run a shift / work period	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
92.	Assigns clients to staff	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? **Select No or Yes by clicking on the box ☐**			From your professional perspective and opinion, what is *the expected performance level of this item,* when the new graduate RN is first employed? *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
93.	Acts as a resource	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
94.	Manages personal problems in the team	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Time management								
95.	Keeps track of multiple responsibilities	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
96.	Uses tools to self-organise and plan daily routines	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
97.	Practises with an understanding of pressures of the practice setting	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Team working								
98.	Practises as an effective nursing team member	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
99.	Practises as an effective multi-disciplinary team member	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
100.	Chairs and participates constructively in meetings	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
101.	Contributes to team discussion	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
102.	Presents information at case reviews and ward rounds	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
103.	Gives handover	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

		From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box □		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
104.	Works with senior staff without being intimidated	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
105.	Able to co-operate (assist / comply with requests)	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
106.	Practises with an understanding of population generational differences	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
107.	Practises knowing where he/she fits within the team	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
108.	Manages interpersonal relationships with colleagues, including understanding and managing own emotions	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
109.	Practises with an understanding and sharing of feelings / emotions of others	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
110.	Practises with knowledge and understanding of self, including knowing own strengths and weaknesses	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
111.	Willing to pitch in and undertake menial tasks when needed	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
112.	Recognises the need to get along with others	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
113. Practises with an understanding of the different roles of RNs in different treatment or care settings	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
114. Gives constructive feedback to work colleagues and others without engaging in personal blame	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Organisation							
115. Practises with an understanding of how the organisation operates	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
116. Practises with an understanding of the rules, hierarchy and place in the organisation	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
117. Practises with an understanding of how the different groups that make up the organisation operate and how much influence they have in different situations	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
118. Practises with an understanding of organisational processes and protocols	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
119. Practises with a knowledge of the routine of the clinical setting e.g.: handover procedure,	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box □		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
	ward round, clinical setting ways of doing things, the purpose and care delivery model						
120.	Practises with an understanding of how and where to access clinical resources and information	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Resilience								
121.	Likes the idea of change	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
122.	Adapts to new and changing circumstances in health care	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
123.	Does not become overwhelmed by challenging circumstances	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
124.	Copes with multiple and competing demands	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
125.	Remains calm under pressure or when things go wrong; does not panic	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
126.	Willing to persevere when things are not working out as anticipated	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Health care								

		From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	<u>Knowledge</u> **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	<u>Independence</u> **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	<u>Proficiency</u> **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	<u>Timeliness</u> **2.** Takes appropriate amount of time **1.** Will need extra time	<u>Confidence</u> **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
127.	Practises with an understanding of the health care system, social determinants of health, inequities and inequalities	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
128.	Practises with an understanding of and ability to work in different health care models	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
129.	Willing to work holistically and person-centred (not just the illness), including providing preventative and mental health care in same setting	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
130.	Practises with an understanding of where health care is heading in the future with changing models of care	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Culture								
131.	Bases practice on knowledge of Māori health	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
132.	Bases practice on knowledge of tikanga	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
133.	Correctly pronounces te reo (particularly client names)	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
134.	Practises with knowledge of local iwi	☐	☐	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
135.	Is willing to learn more cultural knowledge	☐	☐	■	Choose an item.	■	Choose an item.	Choose an item.

241

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? **Select No or Yes by clicking on the box □**			From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
136.	Is willing to participate and embrace indigenous models for better health outcomes	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
137.	Is willing to take responsibility to change health outcomes for Māori	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
138.	Provides cultural care as part of clinical health care	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
Career								
139.	Undergraduate transition experience is the same / similar setting as new graduate RN position clinical setting	□	□					
140.	Is satisfied with choosing nursing as a career	□	□					Choose an item.
141.	Feels ready for the professional nursing role	□	□					Choose an item.
142.	Sees it as very important to be the best nurse	□	□					Choose an item.
143.	Able to keep working life in perspective	□	□	Choose an item.	Choose an item.	Choose an item.		Choose an item.
144.	Is focussed on career	□	□	Choose an item.	Choose an item.	Choose an item.		Choose an item.
145.	Eager to throw self into work	□	□		Choose an item.	Choose an item.	Choose an item.	Choose an item.

		From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box □		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time	Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
146.	Looks forward to the opportunity to learn and grow	□	□		Choose an item.			Choose an item.
147.	Practises with knowledge that personal values will shape their decision-making	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
148.	Demonstrates a concept and understanding of service; puts others before self	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
149.	Considers that nothing is too much for the client	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
150.	General behaviour and conduct is appropriate (including use of language, mobile phone and social media, appearance and attire)	□	□	Choose an item.	Choose an item.	Choose an item.	Choose an item.	Choose an item.
151.	Does not take days off ad hoc	□	□					
152.	Is willing to commit to the practice setting	□	□					Choose an item.
153.	Wants to produce as good a job as possible	□	□		Choose an item.			Choose an item.
154.	Is a very nice person	□	□					
155.	Is passionate	□	□					
156.	Is punctual	□	□					Choose an item.

243

	From your professional perspective and opinion, do you agree this item is a component of work readiness across any and all practice settings where and when new graduate RNs are first employed? Select **No** or **Yes** by clicking on the box ☐		From your professional perspective and opinion, what is *the expected performance level of this item, when the new graduate RN is first employed?* *Select one option in each section by clicking on the box and choosing one of the items from the drop-down menu.*				
	Items of work readiness	**No**, this is not a work ready item. *Please go to the next item ↓*	**Yes,** this is a work ready item to some level. *Please choose the level in the next columns →*	<u>Knowledge</u> **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge	<u>Independence</u> **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision	<u>Proficiency</u> **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice	<u>Timeliness</u> **2.** Takes appropriate amount of time **1.** Will need extra time	<u>Confidence</u> **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability
157.	Demonstrates a sense of humour	☐	☐					Choose an item.
158.	Demonstrates a mature view on life	☐	☐					Choose an item.
159.	Demonstrates an open and friendly approach	☐	☐					Choose an item.
160.	Is humble	☐	☐					
161.	Is reliable	☐	☐				Choose an item.	Choose an item.
162.	Is curious	☐	☐					
163.	Respects authority figures	☐	☐					Choose an item.
164.	Respects colleagues	☐	☐					Choose an item.
165.	Demonstrates personal attributes, values and guiding principles that fit with the practice area	☐	☐					
166.	Achieved good undergraduate programme grades	☐	☐					
167.	Achieved good undergraduate clinical references	☐	☐					

Thank you for your participation. Following analysis of all the findings, the second survey will be sent to you.

NCNZ Education Standards

2.3 The programme specifically requires students to demonstrate, in practice at a graduate level, the following:

- pharmacology knowledge and medicine management
- comprehensive health consumer assessment skills and clinical decision-making skills supported by knowledge of pathophysiology
- therapeutic communication with health consumers
- working within a health care team; providing direction and delegation in practice
- the use of information technology and health information management.

2.9 The curriculum is focussed on the profession of nursing, contemporary nursing practice and the Council's *Competencies for the registered nurse scope of practice*. The curriculum content comprehensively addresses, but is not limited to, the following:

- professional responsibility: professional conduct, nursing practice and professional, ethical and legal responsibilities; understanding of health policy and health regulation; the application of the Treaty of Waitangi in clinical practice; culturally safe care and understanding of cultural safety; accountability and the direction and supervision of second-level nurses; health consumer safety and environmental risk assessment
- management and delivery of nursing care: the planning, delivery and evaluation of nursing care; comprehensive health consumer assessment and decision making; health consumer-centred care and partnership; application of concepts such as informed consent, health consumer rights and advocacy; use of information technology, information management and documentation; health promotion and health education; chronic disease state management; lifespan approach; health continuum approach; lifelong learning, professional development and ongoing competence responsibilities
- interpersonal relationships: development of therapeutic relationships with health consumers; effective communication within the health care team and documentation; information management; understanding of partnership and collaboration; quality assurance practices
- interprofessional health care and quality improvement: co-ordination of health consumer care within the health care team including discharge planning, interprofessional collaboration and communication; advocacy for the nursing contribution; respect for all members of the health care team; quality improvement and research activities; leadership; teaching and mentoring within the team.

Appendix J: Phase Two Survey Two AUTEC Approval Letter

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

29 October 2018

Deb Spence
Faculty of Health and Environmental Sciences

Dear Deb

Re: Ethics Application: 18/73 What are the elements of work readiness of new graduate nurses in the New Zealand health care context? A professional consensus

Thank you for your request for approval of an amendment to your ethics application.

The second survey phase is approved.

I remind you of the **Standard Conditions of Approval**.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/research/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: d.fergusson@witt.ac.nz; Stephen Neville

Appendix K: Phase Two Survey Two

Work readiness of new graduate nurses in New Zealand

Kia ora participant,

Thank you for your participation in the first survey round. 67% of the items in the first round have achieved consensus. Consensus has been reached when 80% or more of you and your colleagues have indicated a YES or NO, i.e.: 80% YES means that the item <u>is</u> a work readiness item and 80% NO means the item <u>is not</u> a work readiness item.

Percentage values that did not reach 80% means that consensus has not yet been reached. The remaining 33% of items (*n=54*) not reaching consensus in the first survey have been placed into the second survey. I am returning your survey with your first responses so that you can now participate in the second round of this survey. You will see that, alongside your own response to each remaining work readiness item, there is the collective responses of your colleagues.

- For the *items of work readiness* (participants had the option of YES or NO), you will see your response and alongside that the percentage of the total responses of all of your colleagues.
- For the *expected performance levels*, your response and the percentage of the collective responses has been provided for each level (1,2,3). Consensus levels have not been measured.

You will be able to see where your responses stand in relation to your colleagues. You are now invited to reflect on the results, view how your ratings compare with others and make changes if you wish.

Instructions to complete the survey

If you decide that you want to change your mind and alter your answers, make your changes in the boxes provided below each work readiness item, where it states *Make your change here*. You can make any changes that you like, and the following are examples.

1. If you decide to change a work readiness item from NO to YES, please make the change in the box '*Make your change here'*. Please also indicate *the level of expected performance* in each of the five sections; knowledge, independence, proficiency, timeliness and confidence in the '*Make your change here'* box.
2. If you already have a YES response to the work readiness item, you may choose to only change one or more of *the levels of expected performance*.
3. If you change from YES to NO, you do not have to then delete the levels of performance. I will do that when analysing the survey.

4. If you decide not to make any changes, this will confirm your final response and you are not required to do anything further with that item. You may then go to the next item.

This survey only records changes that you make. You may note that the percentage points do not always add up to 100%. This will be due to the rounding effect and / or participants who did not respond to that particular point.

The tables below show examples of the following options:

EXAMPLE 1 shows the participant deciding to make a change to the work readiness item from NO to YES. The participant then indicates *the expected level of performance* for each of the five sections.

EXAMPLE 2 shows the participant deciding not to make a change to the work readiness item YES response but does decide to change two of the sections of *expected level of performance* (independence and proficiency)

EXAMPLE 3 shows the participant deciding not to make any changes thus confirming their final response.

EXAMPLE:

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes		Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response		Your colleagues' collective response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response
EXAMPLE 1.	☒	☐	YES 70% NO 30%	Choose an item.	2=50% 1=50%	Choose an item.	3=40% 2=40%	Choose an item.	3=40% 2=40%	Choose an item.	2=50% 1=50%	Choose an item.	2=50% 1=50%

248

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes	Your colleagues' collective response	Knowledge 2.Sufficient knowledge/knows to 1. Will need to develop knowledge		Independence 3. Independent and safe 2. Will need some direction 1. Will need further development / supervision		Proficiency 3. Accomplished and well-practised 2. Will need further practice 1. Will need to learn to practice		Timeliness 2. Takes appropriate amount of time 1. Will need extra time		Confidence 2. Feels assured of own capability 1. Will not yet feel assured of own capability	
	Your response		Your colleagues' collective response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response
Performs brain surgery							1=20%		1=20%				
Make your change here	☐	☒		*2*		*3*		*2*		*2*		*2*	
IN THE ABOVE EXAMPLE, the participant decided to CHANGE the item response from NO to YES and then, rated the levels of work readiness													
EXAMPLE 2. Practices within moral frameworks	☐	☐	**YES 60%** **NO 40%**	2	2=60% 1=40%	2	3=55% 2=40% 3=5%	2	3=55% 2=40% 3=5%	2	2=60% 1=40%	2	2=60% 1=40%
Make your change here	☐	☐		*Choose an item.*		*3*		*3*		*Choose an item.*		*Choose an item.*	
IN THE ABOVE EXAMPLE, the participant decided to CHANGE only TWO of the levels of work readiness ratings													
EXAMPLE 3. Practices within legal frameworks	☐	☒	**YES 50%** **NO 50%**	2	2=60% 1=40%	2	3=55% 2=40% 3=5%	2	3=55% 2=40% 3=5%	2	2=60% 1=40%	2	2=60% 1=40%

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED											
Items	No	Yes		Knowledge 2.Sufficient knowledge/knows to 1. Will need to develop knowledge		Independence 3. Independent and safe 2. Will need some direction 1. Will need further development / supervision		Proficiency 3. Accomplished and well-practised 2. Will need further practice 1. Will need to learn to practice		Timeliness 2. Takes appropriate amount of time 1. Will need extra time		Confidence 2. Feels assured of own capability 1. Will not yet feel assured of own capability	
	Your response		Your colleagues' collective response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response
Make your change here	☐	☐		Choose an item.		Choose an item.		Choose an item.		Choose an item.		Choose an item.	
IN THE ABOVE EXAMPLE, the participant decided NOT to make any changes													

THE SURVEY

ITEMS OF WORK READINESS				*THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM,* WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	**No**	**Yes**	**Your colleagues' collective response**	Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response		**Your colleagues' collective response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
Workload													
1 Manages a full workload of mixed acuity clients after completing orientation	☐	☐	No = 33% Yes =67%		2 = 20% 1 = 80%		3 = 2% 2 = 69% 1 = 29%		3 = 4% 2 = 80% 1 = 16%		2 = 18% 1 = 82%		2 = 13% 1 = 87%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
2 Provides end-of-life care	☐	☐	No =28% Yes =72%		2 = 13% 1 = 85%		3 = 2% 2 = 46% 1 = 50%		3 = 2% 2 = 60% 1 = 35%		2 = 17% 1 = 81%		2 = 4% 1 = 94%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
3. Demonstrates a mind-set whereby can transfer skills to another clinical setting	☐	☐	No = 27% Yes =73%		2 = 31% 1 = 69%		3 = 18% 2 = 57% 1 = 24%		3 = 14% 2 = 67% 1 = 18%		2 = 22% 1 = 78%		2 = 27% 1 = 73%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Making decisions													

251

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items				Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	No	**Yes**											
	Your response		**Your colleagues' collective response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
4. Identifies from a mass of detail the core issues in any situation	☐	☐	No = 36% Yes =64%		2 = 32% 1 = 68%		3 = 5% 2 = 54% 1 = 41%		3 = 7% 2 = 56% 1 = 37%		2 = 20% 1 = 80%		2 = 20% 1 = 80%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
5. Uses previous experience to figure out what is going on when a current situation takes an unexpected turn	☐	☐	No = 33% Yes =67%		2 = 42% 1 = 58%		3 = 5% 2 = 65% 1 = 30%		3 = 2% 2 = 74% 1 = 23%		2 = 26% 1 = 74%		2 = 21% 1 = 79%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
6. Judges urgency of changing situations	☐	☐	No = 25% Yes =75%		2 = 27% 1 = 73%		3 = 6% 2 = 52% 1 = 42%		3 = 6% 2 = 65% 1 = 29%		2 = 19% 1 = 81%		2 = 13% 1 = 88%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
7. Sees how apparently unconnected activities are linked and make up an overall picture	☐	☐	No = 44% Yes =56%		2 = 28% 1 = 72%		3 = 8% 2 = 42% 1 = 50%		3 = 8% 2 = 42% 1 = 50%		2 = 25% 1 = 75%		2 = 19% 1 = 81%

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes	Your colleagues' collective response	Knowledge 2.Sufficient knowledge/knows to 1. Will need to develop knowledge		Independence 3. Independent and safe 2. Will need some direction 1. Will need further development / supervision		Proficiency 3. Accomplished and well-practised 2. Will need further practice 1. Will need to learn to practice		Timeliness 2.Takes appropriate amount of time 1. Will need extra time		Confidence 2. Feels assured of own capability 1. Will not yet feel assured of own capability	
	Your response			**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
8. Traces out and assesses the consequences of alternative courses of action and, from this, pick the one most suitable	☐	☐	No = 41% Yes =59%		2 = 37% 1 = 63%		3 = 8% 2 = 53% 1 = 39%		3 = 8% 2 = 50% 1 = 42%		2 = 24% 1 = 76%		2 = 21% 1 = 79%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
9. Recognises patterns in a complex situation	☐	☐	No = 60% Yes =40%		2 = 24% 1 = 76%		3 = 4% 2 = 40% 1 = 56%		3 = 8% 2 = 40% 1 = 52%		2 = 12% 1 = 88%		2 = 12% 1 = 88%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
10. Tries to solve problems themselves	☐	☐	No = 21% Yes =79%		2 = 46% 1 = 52%		3 = 16% 2 = 62% 1 = 20%		3 = 18% 2 = 64% 1 = 16%		2 = 44% 1 = 54%		2 = 30% 1 = 70%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Learning													

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items				Knowledge 2.Sufficient knowledge/knows to 1. Will need to develop knowledge		Independence 3. Independent and safe 2. Will need some direction 1. Will need further development / supervision		Proficiency 3. Accomplished and well-practised 2. Will need further practice 1. Will need to learn to practice		Timeliness 2.Takes appropriate amount of time 1. Will need extra time		Confidence 2. Feels assured of own capability 1. Will not yet feel assured of own capability	
	No	Yes											
	Your response		Your colleagues' collective response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response
11. Helps others to learn	☐	☐	No = 23% Yes =77%		2 = 59% 1 = 41%		3 = 39% 2 = 45% 1 = 16%		3 = 31% 2 = 53% 1 = 14%		2 = 57% 1 = 43%		2 = 47% 1 = 53%
Make your change here	▱	▱		Choose an item.		Choose an item.		Choose an item.		Choose an item.		Choose an item.	
12. Demonstrates ability to learn advanced skills	☐	☐	No = 32% Yes =68%		2 = 51% 1 = 49%		3 = 23% 2 = 60% 1 = 16%		3 = 19% 2 = 70% 1 = 12%		2 = 33% 1 = 67%		2 = 35% 1 = 65%
Make your change here	▱	▱		Choose an item.		Choose an item.		Choose an item.		Choose an item.		Choose an item.	
Health education													
13. Makes effective presentations to clients	☐	☐	No = 33% Yes =67%		2 = 74% 1 = 24%		3 = 33% 2 = 52% 1 = 12%		3 = 29% 2 = 64% 1 = 5%		2 = 60% 1 = 38%		2 = 45% 1 = 52%
Make your change here	▱	▱		Choose an item.		Choose an item.		Choose an item.		Choose an item.		Choose an item.	
14. Advocates for policy changes that promote health of individuals, families or communities	☐	☐	No = 63% Yes =38%		2 = 42% 1 = 54%		3 = 25% 2 = 50% 1 = 21%		3 = 25% 2 = 42% 1 = 29%		2 = 46% 1 = 50%		2 = 42% 1 = 54%

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	**No**	**Yes**		Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response		**Your colleagues' collective response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
15. Teaches prevention, health promotion activities and effects of lifestyle on health	☐	☐	No = 22% Yes =78%		2 = 59% 1 = 41%		3 = 33% 2 = 57% 1 = 10%		3 = 33% 2 = 57% 1 = 10%		2 = 49% 1 = 51%		2 = 45% 1 = 55%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
16. Utilises community resources to enhance client care	☐	☐	No = 23% Yes =77%		2 = 47% 1 = 53%		3 = 18% 2 = 61% 1 = 20%		3 = 18% 2 = 61% 1 = 20%		2 = 41% 1 = 59%		2 = 39% 1 = 61%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Quality													
17. Questions and challenges the wider system	☐	☐	No = 52% Yes =48%		2 = 40% 1 = 57%		3 = 10% 2 = 47% 1 = 43%		3 = 7% 2 = 57% 1 = 33%		2 = 33% 1 = 63%		2 = 23% 1 = 77%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
18. Practises with an understanding of quality	☐	☐	No = 42% Yes =58%		2 = 65% 1 = 35%		3 = 16% 2 = 62%		3 = 8% 2 = 76%		2 = 38% 1 = 57%		2 = 38% 1 = 59%

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED										
Items	No	Yes	Your colleagues' collective response	Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response			**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
improvement methodologies							1 = 19%		1 = 14%				
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
19. Demonstrates an eye for detail	☐	☐	No = 22% Yes =78%		2 = 57% 1 = 43%		3 = 31% 2 = 61% 1 = 8%		3 = 27% 2 = 65% 1 = 6%		2 = 47% 1 = 53%		2 = 41% 1 = 59%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Communication													
20. Makes appropriate impromptu speeches	☐	☐	No = 59% Yes =41%		2 = 58% 1 = 38%		3 = 31% 2 = 46% 1 = 19%		3 = 19% 2 = 62% 1 = 15%		2 = 50% 1 = 46%		2 = 46% 1 = 50%
21. Manages conflict with colleagues	☐	☐	No = 32% Yes =68%		2 = 40% 1 = 60%		3 = 14% 2 = 42% 1 = 44%		3 = 14% 2 = 51% 1 = 35%		2 = 35% 1 = 65%		2 = 21% 1 = 79%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
22. Manages conflict with clients	☐	☐	No = 27% Yes =73%		2 = 39% 1 = 61%		3 = 13% 2 = 52% 1 = 35%		3 = 9% 2 = 63% 1 = 28%		2 = 33% 1 = 67%		2 = 17% 1 = 83%

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes		Knowledge **2.** Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.** Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response		**Your colleagues' collective response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
23. Motivates others	☐	☐	No = 32% Yes =68%		2 = 53% 1 = 47%		3 = 30% 2 = 56% 1 = 14%		3 = 23% 2 = 60% 1 = 16%		2 = 56% 1 = 44%		2 = 49% 1 = 51%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Leadership													
24. Is approached for original ideas	☐	☐	No = 57% Yes =43%										
Make your change here	☐	☐											
25. Acts as a resource	☐	☐	No = 66% Yes =34%		2 = 45% 1 = 55%		3 = 14% 2 = 41% 1 = 45%		3 = 14% 2 = 45% 1 = 41%		2 = 32% 1 = 68%		2 = 45% 1 = 55%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Time management													
26. Keeps track of multiple responsibilities	☐	☐	No = 34% Yes =66%		2 = 35% 1 = 65%		3 = 20% 2 = 45% 1 = 35%		3 = 13% 2 = 58% 1 = 30%		2 = 25% 1 = 75%		2 = 23% 1 = 78%

257

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes	Your colleagues' collective response	Knowledge **3.** _(see note)_ **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response		**Your colleagues' collective response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Team working													
27. Chairs and participates constructively in meetings	☐	☐	No = 79% Yes =21%		2 = 31% 1 = 69%		3 = 15% 2 = 62% 1 = 23%		3 = 23% 2 = 46% 1 = 31%		2 = 31% 1 = 69%		2 = 31% 1 = 69%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
28. Presents information at case reviews and ward rounds	☐	☐	No = 32% Yes =68%		2 = 55% 1 = 45%		3 = 21% 2 = 64% 1 = 12%		3 = 19% 2 = 67% 1 = 12%		2 = 45% 1 = 50%		2 = 36% 1 = 64%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
29. Works with senior staff without being intimidated	☐	☐	No = 21% Yes =79%		2 = 65% 1 = 35%		3 = 31% 2 = 59% 1 = 8%		3 = 33% 2 = 59% 1 = 8%		2 = 63% 1 = 35%		2 = 47% 1 = 53%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
30. Practises with an understanding of	☐	☐	No = 24% Yes =76%		2 = 79% 1 = 21%		3 = 53% 2 = 38% 1 = 9%		3 = 45% 2 = 51% 1 = 4%		2 = 81% 1 = 19%		2 = 68% 1 = 32%

258

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes		Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response		**Your colleagues' collective response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
population generational differences													
Make your change here	⧠	⧠		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
31. Practises with an understanding and sharing of feelings / emotions of others	□	□	No = 22% Yes =78%		2 = 80% 1 = 20%		3 = 41% 2 = 51% 1 = 8%		3 = 33% 2 = 61% 1 = 6%		2 = 69% 1 = 31%		2 = 61% 1 = 39%
Make your change here	⧠	⧠		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
32. Gives constructive feedback to work colleagues and others without engaging in personal blame	□	□	No = 35% Yes =65%		2 = 54% 1 = 46%		3 = 17% 2 = 61% 1 = 22%		3 = 12% 2 = 66% 1 = 22%		2 = 54% 1 = 46%		2 = 37% 1 = 63%
Make your change here	⧠	⧠		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Organisation													
33. Practises with an understanding of how the organisation operates	□	□	No = 32% Yes =68%		2 = 42% 1 = 58%		3 = 14% 2 = 58% 1 = 26%		3 = 14% 2 = 63% 1 = 23%		2 = 58% 1 = 40%		2 = 42% 1 = 56%

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items				Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	No	**Yes**	**Your colleagues' collective response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
	Your response												
Make your change here	⬚	⬚		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
34. Practises with an understanding of the rules, hierarchy and place in the organisation	☐	☐	No = 26% Yes =74%		2 = 54% 1 = 43%		3 = 24% 2 = 57% 1 = 15%		3 = 22% 2 = 61% 1 = 15%		2 = 54% 1 = 41%		2 = 41% 1 = 52%
Make your change here	⬚	⬚		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
35. Practises with an understanding of how the different groups that make up the organisation operate and how much influence they have in different situations	☐	☐	No = 54% Yes =46%		2 = 31% 1 = 66%		3 = 17% 2 = 66% 1 = 17%		3 = 17% 2 = 55% 1 = 24%		2 = 52% 1 = 45%		2 = 38% 1 = 62%
Make your change here	⬚	⬚		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
36. Practises with an understanding of organisational processes and protocols	☐	☐	No = 22% Yes =78%		2 = 41% 1 = 57%		3 = 22% 2 = 53% 1 = 24%		3 = 16% 2 = 61% 1 = 20%		2 = 45% 1 = 53%		2 = 39% 1 = 59%

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes	Your colleagues' collective response	Knowledge 2.Sufficient knowledge/knows to 1. Will need to develop knowledge		Independence 3. Independent and safe 2. Will need some direction 1. Will need further development / supervision		Proficiency 3. Accomplished and well-practised 2. Will need further practice 1. Will need to learn to practice		Timeliness 2.Takes appropriate amount of time 1. Will need extra time		Confidence 2. Feels assured of own capability 1. Will not yet feel assured of own capability	
	Your response			Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response
Make your change here	☐	☐		Choose an item.		Choose an item.		Choose an item.		Choose an item.		Choose an item.	
Resilience													
37. Likes the idea of change	☐	☐	No = 30% Yes =70%		2 = 82% 1 = 18%		3 = 43% 2 = 57% 1 = 0%		3 = 36% 2 = 61% 1 = 2%		2 = 66% 1 = 34%		2 = 55% 1 = 45%
Make your change here	☐	☐		Choose an item.		Choose an item.		Choose an item.		Choose an item.		Choose an item.	
38. Does not become overwhelmed by challenging circumstances	☐	☐	No = 35% Yes =65%		2 = 44% 1 = 56%		3 = 20% 2 = 46% 1 = 34%		3 = 10% 2 = 63% 1 = 27%		2 = 39% 1 = 61%		2 = 24% 1 = 73%
Make your change here	☐	☐		Choose an item.		Choose an item.		Choose an item.		Choose an item.		Choose an item.	
39. Copes with multiple and competing demands	☐	☐	No = 38% Yes =62%		2 = 44% 1 = 56%		3 = 18% 2 = 46% 1 = 36%		3 = 15% 2 = 54% 1 = 31%		2 = 28% 1 = 72%		2 = 28% 1 = 72%
Make your change here	☐	☐		Choose an item.		Choose an item.		Choose an item.		Choose an item.		Choose an item.	

261

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items				Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	No	**Yes**	**Your colleagues' collective response**										
	Your response			**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
40. Remains calm under pressure or when things go wrong; does not panic	☐	☐	No = 24% Yes =76%		2 = 44% 1 = 56%		3 = 21% 2 = 52% 1 = 27%		3 = 19% 2 = 58% 1 = 23%		2 = 42% 1 = 56%		2 = 31% 1 = 67%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Health care													
41. Practises with an understanding of and ability to work in different health care models	☐	☐	No = 27% Yes =73%		2 = 63% 1 = 35%		3 = 24% 2 = 63% 1 = 13%		3 = 24% 2 = 72% 1 = 4%		2 = 61% 1 = 37%		2 = 50% 1 = 50%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
42. Practises with an understanding of where health care is heading in the future with changing models of care	☐	☐	No = 42% Yes =58%		2 = 44% 1 = 50%		3 = 17% 2 = 53% 1 = 28%		3 = 19% 2 = 58% 1 = 19%		2 = 53% 1 = 44%		2 = 33% 1 = 64%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Culture													

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes		Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
Items	**Your response**		**Your colleagues' collective response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
43. Correctly pronounces te reo (particularly client names)	☐	☐	No = 24% Yes =76%		2 = 63% 1 = 38%		3 = 46% 2 = 35% 1 = 19%		3 = 35% 2 = 52% 1 = 13%		2 = 75% 1 = 25%		2 = 67% 1 = 33%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
44. Practises with knowledge of local iwi	☐	☐	No = 46% Yes =54%		2 = 35% 1 = 59%		3 = 21% 2 = 65% 1 = 15%		3 = 18% 2 = 68% 1 = 15%		2 = 62% 1 = 38%		2 = 32% 1 = 68%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
45. Is willing to take responsibility to change health outcomes for Māori	☐	☐	No = 35% Yes =65%		2 = 59% 1 = 41%		3 = 39% 2 = 37% 1 = 24%		3 = 34% 2 = 41% 1 = 22%		2 = 63% 1 = 37%		2 = 51% 1 = 49%
Make your change here	▱	▱		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
Career													
46. Undergraduate transition experience is the same / similar setting as new	☐	☐	No = 59% Yes =41%										

263

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED								
Items	No	Yes		Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response		Your colleagues' collective response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response
graduate RN position clinical setting													
Make your change here	☐	☐											
47. Is focussed on career	☐	☐	No = 30% Yes =70%		2 = 70% 1 = 30%		3 = 48% 2 = 45% 1 = 7%		3 = 45% 2 = 48% 1 = 7%				2 = 66% 1 = 32%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*				*Choose an item.*	
48. Eagar to throw self into work	☐	☐	No = 21% Yes =79%				3 = 59% 2 = 35% 1 = 6%		3 = 55% 2 = 39% 1 = 6%		2 = 76% 1 = 24%		2 = 67% 1 = 31%
Make your change here	☐	☐				*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
49. Demonstrates a concept and understanding of service; puts others before self	☐	☐	No = 31% Yes =69%		2 = 77% 1 = 20%		3 = 50% 2 = 32% 1 = 18%		3 = 48% 2 = 41% 1 = 9%		2 = 75% 1 = 23%		2 = 68% 1 = 30%
Make your change here	☐	☐		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes	Your colleagues' collective response	Knowledge 2.Sufficient knowledge/knows to 1. Will need to develop knowledge		Independence 3. Independent and safe 2. Will need some direction 1. Will need further development / supervision		Proficiency 3. Accomplished and well-practised 2. Will need further practice 1. Will need to learn to practice		Timeliness 2.Takes appropriate amount of time 1. Will need extra time		Confidence 2. Feels assured of own capability 1. Will not yet feel assured of own capability	
	Your response			Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response	Your response	Your colleagues' response
50. Considers that nothing is too much for the client	☐	☐	No = 42% Yes =58%		2 = 81% 1 = 19%		3 = 50% 2 = 39% 1 = 8%		3 = 53% 2 = 42% 1 = 6%		2 = 72% 1 = 25%		2 = 67% 1 = 33%
Make your change here	⬜	⬜		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*		*Choose an item.*	
51. Is a very nice person	☐	☐	No = 36% Yes =64%										
Make your change here	⬜	⬜											
52. Demonstrates a sense of humour	☐	☐	No = 22% Yes =78%										2 = 88% 1 = 8%
Make your change here	☐	☐											*Choose an item.*
53. Is humble	☐	☐	No = 34% Yes =66%										
Make your change here	⬜	⬜											

ITEMS OF WORK READINESS				THE EXPECTED PERFORMANCE LEVEL OF THIS ITEM, WHEN THE NEW GRADUATE RN IS FIRST EMPLOYED									
Items	No	Yes	Your colleagues' collective response	Knowledge **2.**Sufficient knowledge/knows to **1.** Will need to develop knowledge		Independence **3.** Independent and safe **2.** Will need some direction **1.** Will need further development / supervision		Proficiency **3.** Accomplished and well-practised **2.** Will need further practice **1.** Will need to learn to practice		Timeliness **2.**Takes appropriate amount of time **1.** Will need extra time		Confidence **2.** Feels assured of own capability **1.** Will not yet feel assured of own capability	
	Your response			**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**	**Your response**	**Your colleagues' response**
54. Achieved good undergraduate programme grades	☐	☐	No = 43% Yes =57%										
Make your change here	▱	▱											

Thank you for your participation. Your time and effort is much appreciated. You will receive a copy of the final report in due course.

Regards

Diana Fergusson

Doctoral candidate (AUT)

Appendix L: Work Readiness Framework Consensus Scores

Number	Section / Item	Consensus		Knowledge			Independence				Proficiency				Timeliness			Confidence		
		% yes	% no	Level 1 - %	Level 2 - %	No Response - %	Level 1 - %	Level 2 - %	Level 3 - %	No Response - %	Level 1 - %	Level 2 - %	Level 3 - %	No Response - %	Level 1 - %	Level 2 - %	No Response - %	Level 1 - %	Level 2 - %	No Response - %
WORKLOAD																				
1	Manages a full workload of low acuity clients after completing orientation	91	9	34	66	0	16	70	13	0	13	79	8	0	57	43	0	67	31	1
2	Manages a full workload of mixed acuity clients after completing orientation	73	27	84	16	0	20	78	2	0	10	84	6	0	82	18	0	88	12	0
3	Copes with practising shifts / different work patterns across the week	84	16	39	61	0	13	54	34	0	13	63	25	0	45	55	0	59	41	0
PROVISION OF CARE																				
4	Provides mental health care	82	18	71	29	0	35	55	11	0	20	75	5	0	84	16	0	84	16	0
5	Provides end-of-life care	85	15	82	14	3	53	40	2	4	30	63	2	4	77	19	3	89	5	4
6	Performs personal care / activities of daily living (ADLs) for clients	91	9	8	92	0	3	25	72	0	3	34	62	0	16	84	0	18	82	0
7	Demonstrates a mind-set whereby can transfer skills to another clinical setting	87	13	72	24	3	21	66	12	1	12	72	10	3	74	21	4	74	24	1
8	Applies learnt knowledge and can readily answer clinical questions	88	12	46	54	0	7	68	25	0	3	76	20	0	44	56	0	53	47	0
9	Accesses and retrieves electronic data necessary for client care	95	5	34	65	1	3	52	42	3	2	61	34	3	37	60	3	40	56	3

Note: "Levels of Performance" spans the Knowledge, Independence, Proficiency, Timeliness, and Confidence column groups.

#																			
10	Practises with knowledge of and ability to use technology in health	92	8	45	55	0	12	57	30	1	12	58	30	0	52	48	0	53	47	0
11	Advocates for the client	95	5	31	69	0	10	56	34	0	8	63	29	0	42	58	0	58	42	0
12	Maintains client dignity	100	0	5	95	0	3	12	85	0	0	22	78	0	8	92	0	74	26	0
13	Practises using an understanding of client rights	98	2	11	89	0	2	42	56	0	2	41	58	0	17	83	0	23	77	0
14	Interprets subjective and objective assessment data	88	12	51	49	0	7	72	21	0	7	77	16	0	65	35	0	79	21	0
15	Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse	97	3	11	89	0	3	33	63	0	2	46	52	0	25	75	0	27	73	0
16	Utilises common clinical technologies e.g.: pumps, monitors	82	18	36	64	0	11	57	32	0	9	55	36	0	49	51	0	57	43	0
MAKING DECISIONS																				
17	Writes nursing care plans or plans of care	98	2	30	70	0	9	56	34	0	2	59	39	0	44	56	0	47	53	0
18	Interprets the multi-disciplinary team orders / plans	88	12	40	60	0	14	69	17	0	9	78	14	0	55	45	0	60	40	0
19	Manages the balance between patient want and need	84	16	60	40	0	9	70	21	0	11	72	17	0	49	51	0	70	30	0
20	Bases practice on evidence rather than routine	88	13	36	64	0	7	64	27	1	7	73	20	0	61	39	0	61	39	0
21	Bases decision-making on the nursing process or plan of care	95	5	28	70	1	5	62	31	1	2	69	28	1	41	57	1	57	41	1
22	Demonstrates ability to start tasks	97	3	11	89	0	3	40	56	0	2	58	40	0	34	66	0	47	53	0
23	Sets and justifies priorities	88	13	48	52	0	11	79	11	0	9	79	13	0	61	39	0	79	21	0
24	Re-sets priorities	87	13	47	53	0	13	69	18	0	15	69	16	0	58	42	0	73	27	0
25	Always thinks about patient outcomes	91	9	34	66	0	12	57	31	0	10	59	31	0	47	53	0	55	45	0
26	Is prepared for the unexpected to occur	80	20	65	33	1	37	51	10	1	27	63	8	1	76	22	1	78	20	1
27	Identifies from a mass of detail the core issues in any situation	67	33	77	23	3	37	60	5	1	33	60	7	3	84	16	3	84	16	3

No	Statement																			
28	Uses previous experience to figure out what is going on when a current situation takes an unexpected turn	78	22	62	28	3	26	64	4	3	18	74	3	1	76	18	3	78	16	3
29	Judges urgency of changing situations	80	20	71	29	0	41	55	4	0	25	69	6	0	80	20	0	88	12	0
30	Changes focus when a crisis situation that needs attention arises	81	19	59	41	0	37	55	8	0	29	65	6	0	78	22	0	78	22	0
31	Recognises when something is abnormal to what they expected and get it corrected	89	11	36	61	3	21	59	16	3	16	66	14	3	55	41	3	70	27	3
32	Judges the need to escalate care through additional forms of focussed observation from observing and noticing to the use of a particular assessment tool	81	19	38	60	1	27	48	21	3	27	56	15	1	52	46	1	69	29	1
33	Readjusts a plan of action in the light of what happens as it is implemented	83	17	60	38	1	23	57	19	1	17	64	17	1	58	36	4	66	32	1
34	Re-assesses client's responses / situation and nursing interventions; conducts appropriate follow-up	91	9	40	59	1	21	52	26	1	21	50	28	1	52	47	1	66	33	1
35	Sees how apparently unconnected activities are linked and make up an overall picture	58	42	73	27	0	49	43	8	0	51	41	8	0	76	24	0	78	19	1
36	Traces out and assesses the consequences of alternative courses of action and, from this, pick the one most suitable	67	33	70	30	0	42	51	7	0	44	49	7	0	79	21	0	81	19	0
37	Recognises patterns in a complex situation	35	65	86	14	0	64	41	0	0	64	32	5	0	95	5	0	91	9	0
38	Is comfortable (not embarrassed) to ask questions when unsure / doesn't know about something	98	2	13	87	0	10	40	50	0	8	40	52	0	29	71	0	39	61	0
39	Recognises when to ask for assistance	100	0	11	89	0	8	35	57	0	6	38	56	0	17	83	0	30	68	1
40	Develops and uses networks of colleagues to assist in solving problems	85	15	34	64	1	11	55	32	1	9	55	34	1	36	62	1	47	49	3
41	Tries to solve problems themselves	87	13	58	40	1	20	67	11	1	15	73	11	1	60	38	1	73	24	0
42	Listens to different points of view before coming to a decision	92	8	39	61	0	20	53	27	0	10	61	29	0	41	59	0	49	51	0
43	Willing and able to use collegial support to critically think and make decisions, protecting self as a beginning practitioner	95	5	28	70	1	16	41	41	1	13	43	43	1	38	61	1	34	64	1
LEARNING																				
44	Develops practical knowledge from reflecting on / self-assessing own knowledge, practice and competence	95	5	21	77	1	5	57	36	1	2	61	36	1	41	56	3	41	57	1
45	Is experienced in and knows how to learn	97	3	6	92	1	3	26	69	1	2	27	69	1	16	81	3	15	84	1

#																			
46	Demonstrates ability to look things up	98	2	5	94	1	2	30	67	1	0	27	71	1	14	83	3	11	87	1
47	Demonstrates ability to learn quickly	91	9	12	86	1	3	34	59	3	2	33	62	3	24	72	3	19	76	4
48	Faces and learns from mistakes	98	2	24	74	1	10	45	42	3	8	47	42	3	27	69	3	39	58	3
49	Keeps up to date with current realities and changes	83	17	19	77	3	2	55	38	4	0	53	42	4	19	75	4	28	66	4
50	Listens openly, accepts and applies constructive feedback	100	0	19	80	1	5	47	45	3	0	53	44	3	22	75	3	33	64	3
51	Is pro-active and keen to learn	98	2	11	86	3	2	29	65	4	0	33	62	4	17	78	4	17	78	4
52	Demonstrates personal growth through learning	95	5	11	87	1	3	37	56	3	2	42	53	3	18	79	3	27	68	4
53	Practises using an understanding that learning is progressive; they don't know everything	95	5	8	90	1	5	33	59	3	3	39	54	3	20	77	3	16	80	3
54	Learns a lot from colleagues	98	2	11	87	1	6	32	59	3	3	27	67	3	17	79	3	25	71	3
55	Approaches senior people to learn from	95	5	13	84	3	3	38	54	4	2	39	54	4	15	80	4	31	64	4
56	Recognises and maximises opportunities for learning	94	6	13	85	1	3	50	43	3	2	48	45	4	32	65	3	28	68	3
57	Willingly and actively seeks and asks about clinical practices	97	3	15	82	3	6	31	60	3	5	32	60	3	21	76	3	23	76	1
58	Learns from other RN role-modelling to understand how an RN thinks and acts like a nurse	95	5	18	81	1	6	37	55	1	2	42	53	3	24	74	1	34	66	0
59	Helps others to learn	84	16	43	56	1	15	50	33	1	11	59	26	3	41	57	1	59	39	1
60	Demonstrates ability to learn advanced skills	79	21	56	44	0	16	66	18	0	10	76	14	0	76	24	0	74	26	0
HEALTH EDUCATION																				
61	Teaches clients and families	95	5	52	48	0	11	69	20	0	8	72	20	0	62	38	0	62	38	0
62	Evaluates client learning	88	13	50	50	0	18	55	27	0	14	63	23	0	59	41	0	61	39	0
63	Makes effective presentations to clients	79	21	22	72	4	10	60	24	4	4	70	20	4	32	62	4	60	34	4

#																				
64	Advocates for policy changes that promote health of individuals, families or communities	36	64	61	35	0	22	57	17	0	30	48	17	0	61	35	0	70	26	0
65	Teaches prevention, health promotion activities and effects of lifestyle on health	85	15	40	60	0	11	64	25	0	11	60	29	0	56	47	0	58	42	0
66	Utilises community resources to enhance client care	84	16	57	41	1	19	63	17	1	19	63	17	1	65	33	1	69	30	1

QUALITY

#																				
67	Demonstrates an ethical outlook	95	5	31	69	0	10	49	41	0	8	59	31	1	39	59	1	44	54	1
68	Demonstrates concern for clients	100	0	14	86	0	2	30	67	1	2	31	64	3	17	80	3	25	72	3
69	Identifies actual or potential client safety risks	98	2	37	63	0	13	54	32	1	10	57	30	3	40	57	3	48	49	3
70	Takes appropriate measures to prevent or minimize risk of injury to self	100	0	20	80	0	6	44	48	1	8	50	39	3	22	75	3	34	63	3
71	Takes appropriate measures to prevent or minimize risk of injury to clients	98	2	24	76	0	8	46	44	1	6	51	40	3	30	67	3	40	57	3
72	Acts in familiar situations	92	8	7	92	1	2	31	66	1	2	32	64	1	17	81	1	17	81	1
73	Declines to undertake unfamiliar activities	81	19	25	75	0	15	40	44	0	13	40	44	1	38	60	1	46	52	1
74	Recognises own unsafe practice	94	6	31	69	0	8	62	28	1	8	59	30	3	39	57	3	46	51	3
75	Judges when not to undertake planned or prescribed interventions	86	14	53	47	0	20	60	18	1	18	60	18	3	58	36	4	67	29	3
76	Recognises unsafe practice in others	91	9	34	64	1	12	57	28	3	9	62	24	4	45	50	4	53	41	4
77	Questions and challenges another nurses practice	81	19	56	44	0	23	67	10	0	23	67	8	1	62	37	1	79	19	1
78	Questions and challenges the wider system	45	55	62	31	3	48	41	7	1	38	48	7	3	72	21	3	79	17	1
79	Practises with an understanding of quality improvement methodologies	66	34	33	65	1	16	67	12	3	14	77	5	3	67	26	4	70	28	1
80	Thrives on completing tasks and achieving results	86	14	19	81	0	6	37	56	1	2	48	48	1	44	56	0	44	56	0
81	Demonstrates an eye for detail	84	16	43	54	3	4	69	24	3	6	69	20	4	56	41	3	65	31	3

271

COMMUNICATION

#																				
82	Feels comfortable using a range of communication skills with clients and their families	89	11	34	66	0	5	55	39	0	7	63	30	0	41	59	0	54	46	0
83	Expresses self easily	86	14	19	81	0	13	31	56	0	11	48	39	1	31	69	0	37	63	0
84	Makes appropriate impromptu speeches	40	60	36	60	0	20	44	32	0	16	60	20	0	44	52	0	48	48	0
85	Communicates changes in client condition	97	3	23	77	0	11	44	44	0	7	61	33	0	33	67	0	46	54	0
86	Manages conflict with colleagues	74	26	65	31	1	40	44	13	1	33	50	13	1	69	27	1	75	21	1
87	Manages conflict with clients	78	22	62	38	1	32	54	14	1	28	64	8	1	72	28	1	80	20	1
88	Shows initiative	97	3	23	77	0	3	55	42	0	3	61	35	0	31	69	0	45	55	0
89	Motivates others	80	20	40	56	3	17	56	23	3	17	62	17	3	40	56	3	56	40	3

LEADERSHIP

#																				
90	Is approached for original ideas	44	56																	
91	Can run a shift / work period	11	89	57	43	0	29	43	29	0	29	43	29	0	71	29	0	57	43	0
92	Assigns clients to staff	11	89	43	57	0	14	71	14	0	29	57	14	0	71	29	0	71	29	0
93	Acts as a resource	33	67	64	32	0	55	32	9	0	36	50	9.1	0	77	27	0	59	36	0
94	Manages personal problems in the team	17	83	55	45	0	18	55	27	0	18	64	18	0	55	45	0	55	36	1

TIME MANAGEMENT

#																				
95	Keeps track of multiple responsibilities	73	27	73	23	0	35	46	15	0	29	58	8.3	0	75	19	2	79	17	0
96	Uses tools to self-organise and plan daily routines	92	8	29	69	1	7	57	34	1	5	67	24	3	50	48	1	52	47	1
97	Practises with an understanding of pressures of the practice setting	82	18	47	51	1	20	57	22	1	18	63	18	1	59	37	3	67	31	1

TEAM WORKING

#																			
98	Practises as an effective nursing team member	90	10	26	74	0	11	54	35	0	9	59	30	1	44	54	1	48	52	0
99	Practises as an effective multi-disciplinary team member	87	13	48	50	1	13	67	20	0	11	69	20	0	48	52	0	69	31	0
100	Chairs and participates constructively in meetings	17	83	82	18	0	27	64	9	0	36	45	18	0	73	27	0	82	18	0
101	Contributes to team discussion	98	2	39	61	0	10	56	34	0	7	62	31	0	31	67	1	56	44	0
102	Presents information at case reviews and ward rounds	71	29	43	57	0	13	65	17	3	13	72	13	1	54	41	3	74	26	0
103	Gives handover	95	5	19	80	1	7	41	51	1	3	44	51	1	31	68	1	41	58	1
104	Works with senior staff without being intimidated	89	11	36	62	1	12	60	24	3	12	60	26	1	34	62	3	59	40	1
105	Able to co-operate (assist / comply with requests)	98	2	13	87	0	5	33	62	0	3	38	59	0	26	74	0	23	75	1
106	Practises with an understanding of population generational differences	85	15	20	76	3	9	36	51	3	5	53	38	3	20	76	3	33	64	3
107	Practises knowing where he/she fits within the team	89	11	31	69	0	9	40	49	1	5	55	40	0	24	75	1	36	64	0
108	Manages interpersonal relationships with colleagues, including understanding and managing own emotions	87	13	31	67	1	13	54	31	1	13	67	19	1	28	69	3	52	46	1
109	Practises with an understanding and sharing of feelings / emotions of others	86	14	20	77	3	11	52	34	3	9	63	25	3	27	71	3	36	61	3
110	Practises with knowledge and understanding of self, including knowing own strengths and weaknesses	98	2	17	83	0	5	49	46	0	3	54	41	1	27	71	1	38	62	0
111	Willing to pitch in and undertake menial tasks when needed	95	5	8	92	0	3	20	77	0	3	18	78	0	13	87	0	13	87	0
112	Recognises the need to get along with others	97	3	5	93	1	2	13	84	1	2	21	75	1	7	92	1	10	89	1
113	Practises with an understanding of the different roles of RNs in different treatment or care settings	84	16	28	70	1	9	51	38	1	8	57	34	1	26	72	1	34	66	0
114	Gives constructive feedback to work colleagues and others without engaging in personal blame	69	31	38	58	3	18	64	13	3	20	67	9	3	42	53	3	69	27	3

ORGANISATION

273

#	Description																		
115	Practises with an understanding of how the organisation operates	69	31	71	29	0	27	60	11	1	22	67	11	0	42	56	1	67	31	1
116	Practises with an understanding of the rules, hierarchy and place in the organisation	80	20	40	56	3	13	60	21	4	15	63	17	3	37	58	4	58	35	6
117	Practises with an understanding of how the different groups that make up the organisation operate and how much influence they have in different situations	42	58	74	22	1	22	67	11	0	26	59	11	1	41	56	1	70	30	0
118	Practises with an understanding of organisational processes and protocols	86	14	61	34	4	21	55	20	3	18	64	13	4	55	39	4	63	32	4
119	Practises with a knowledge of the routine of the clinical setting e.g.: handover procedure, ward round, clinical setting ways of doing things, the purpose and care delivery model	94	6	48	52	0	15	60	25	0	15	65	18	1	50	50	0	60	40	0
120	Practises with an understanding of how and where to access clinical resources and information	90	10	33	67	0	9	53	37	1	9	54	37	0	35	65	0	40	60	0

RESILIENCE

#	Description																		
121	Likes the idea of change	82	18	19	75	4	2	62	30	4	4	62	28	4	32	62	4	42	53	4
122	Adapts to new and changing circumstances in health care	84	16	25	74	1	13	51	34	1	11	60	26	1	28	68	3	45	51	3
123	Does not become overwhelmed by challenging circumstances	68	32	64	36	0	30	52	18	0	25	68	7	0	70	30	0	77	20	1
124	Copes with multiple and competing demands	65	35	64	36	0	31	52	17	0	29	57	14	0	74	26	0	71	29	0
125	Remains calm under pressure or when things go wrong; does not panic	83	17	63	33	3	22	59	15	3	20	63	13	3	63	31	4	70	24	4
126	Willing to persevere when things are not working out as anticipated	91	9	34	66	0	19	52	28	1	17	57	26	0	52	47	1	55	41	3

HEALTH CARE

#	Description																		
127	Practises with an understanding of the health care system, social determinants of health, inequities and inequalities	95	5	30	70	0	12	50	38	0	10	55	35	0	35	65	0	40	60	0
128	Practises with an understanding of and ability to work in different health care models	82	18	34	62	3	13	66	19	1	8	70	21	1	34	62	3	51	47	1
129	Willing to work holistically and person-centred (not just the illness), including providing preventative and mental health care in same setting	89	11	23	75	1	9	58	32	1	11	60	28	1	37	60	3	39	60	1
130	Practises with an understanding of where health care is heading in the future with changing models of care	64	36	54	44	1	22	59	17	1	17	61	20	1	37	61	1	63	34	1

CULTURE																				
131	Bases practice on knowledge of Māori health	90	10	33	67	0	11	56	33	0	7	65	28	0	37	61	1	49	51	0
132	Bases practice on knowledge of tikanga	86	14	33	65	1	13	48	37	1	6	61	31	1	37	61	1	48	50	1
133	Correctly pronounces te reo (particularly client names)	86	14	36	63	1	18	34	46	1	14	55	29	1	23	75	1	34	64	1
134	Practises with knowledge of local iwi	65	35	67	29	3	17	67	14	1	17	69	12	1	36	60	3	71	24	3
135	Is willing to learn more cultural knowledge	97	3				11	44	44	1					34	65	1	45	52	3
136	Is willing to participate and embrace indigenous models for better health outcomes	84	16	32	68	0	9	47	43	0	11	51	36	1	34	66	0	49	51	0
137	Is willing to take responsibility to change health outcomes for Māori	78	22	35	61	0	24	39	33	3	22	47	25	4	33	63	3	47	49	3
138	Provides cultural care as part of clinical health care	94	6	32	68	0	15	37	46	1	12	58	31	0	39	61	0	51	49	0
CAREER																				
139	Undergraduate transition experience is the same / similar setting as new graduate RN position clinical setting	33	67																	
140	Is satisfied with choosing nursing as a career	87	13															26	70	3
141	Feels ready for the professional nursing role	89	11															30	66	3
142	Sees it as very important to be the best nurse	81	19															27	71	1
143	Able to keep working life in perspective	83	17	46	54	0	21	50	29	0	21	54	25	0				60	38	1
144	Is focussed on career	82	18	30	68	1	11	45	42	1	13	51	34	1				30	66	3
145	Eagar to throw self into work	89	11				9	32	56	3	9	35	53	3	25	72	3	33	61	4
146	Looks forward to the opportunity to learn and grow	94	6				2	44	51	3								34	59	6
147	Practises with knowledge that personal values will shape their decision-making	85	15	19	79	1	10	42	48	0	8	44	48	0	25	73	1	31	69	0

#	Item																				
148	Demonstrates a concept and understanding of service; puts others before self	74	26	14	82	3	14	31	53	1	8	37	51	3	18	78	3	27	69	3
149	Considers that nothing is too much for the client	66	34	19	79	1	12	29	55	3	10	31	57	1	24	71	3	29	69	1
150	General behaviour and conduct is appropriate (including use of language, mobile phone and social media, appearance and attire)	90	10	12	86	1	4	19	75	1	4	21	74	1	11	88	1	11	88	1
151	Does not take days off ad hoc	84	16																	
152	Is willing to commit to the practice setting	94	6															21	78	1
153	Wants to produce as good a job as possible	95	5				3	43	52	1								23	75	1
154	Is a very nice person	75	25																	
155	Is passionate	84	16																	
156	Is punctual	94	6															5	92	3
157	Demonstrates a sense of humour	85	15															7	85	6
158	Demonstrates a mature view on life	87	13															16	78	4
159	Demonstrates an open and friendly approach	95	5															8	85	6
160	Is humble	72	28																	
161	Is reliable	97	3								2	21	72	4				5	93	1
162	Is curious	90	10																	
163	Respects authority figures	87	13															9	89	1
164	Respects colleagues	98	2															11	87	1
165	Demonstrates personal attributes, values and guiding principles that fit with the practice area	93	7																	

166	Achieved good undergraduate programme grades	62	38																
167	Achieved good undergraduate clinical references	88	12																

Appendix M: Work Readiness Framework

		Knowledge 1. Will need to develop knowledge 2. Sufficient knowledge/knows to	Independence 1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	Proficiency 1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	Timeliness 1. Will need extra time 2. Takes appropriate amount of time	Confidence 1. Will not yet feel assured of own capability 2. Feels assured of own capability	WITT Modern Apprenticeship BN Programme		
							TAUGHT	PRACTISED	ASSESSED
Workload									
1	Manages a full workload of low acuity clients after completing orientation	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
2	Manages a full workload of mixed acuity clients after completing orientation	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
3	Copes with practising shifts / different work patterns across the week	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
Provision of care									
4	Provides mental health care	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
5	Provides end-of-life care	Will need to develop knowledge	Will need further development / supervision	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
6	Performs personal care / activities of daily living (ADLs) for clients	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
7	Demonstrates a mind-set whereby can transfer skills to another clinical setting	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
8	Applies learnt knowledge and can readily answer clinical questions	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
9	Accesses and retrieves electronic data necessary for client care	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
10	Practises with knowledge of and ability to use technology in health	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
11	Advocates for the client	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
12	Maintains client dignity	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
13	Practises using an understanding of client rights	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
14	Interprets subjective and objective assessment data	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
15	Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
16	Utilises common clinical technologies e.g.: pumps, monitors	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
Making decisions									
17	Writes nursing care plans or plans of care	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
18	Interprets the multi-disciplinary team orders / plans	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
19	Manages the balance between patient want and need	Will need to develop knowledge	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
20	Bases practice on evidence rather than routine	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
21	Bases decision-making on the nursing process or plan of care	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
22	Demonstrates ability to start tasks	Sufficient knowledge / knows to	Independent and safe	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
23	Sets and justifies priorities	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
24	Re-sets priorities	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
25	Always thinks about patient outcomes	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
26	Is prepared for the unexpected to occur	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
27	Uses previous experience to figure out what is going on when a current situation takes an unexpected turn	Will need to develop knowledge	Will need some direction	Will need some direction	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
28	Judges urgency of changing situations	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
29	Changes focus when a crisis situation that needs attention arises	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
30	Recognises when something is abnormal to what they expected and get it corrected	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
31	Judges the need to escalate care through additional forms of focussed observation from observing and noticing to the use of a particular assessment tool	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
32	Readjusts a plan of action in the light of what happens as it is implemented	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
33	Re-assesses client's responses / situation and nursing interventions; conducts appropriate follow-up	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
34	Is comfortable (not embarrassed) to ask questions when unsure / doesn't know about something	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
35	Recognises when to ask for assistance	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
36	Develops and uses networks of colleagues to assist in solving problems	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
37	Tries to solve problems themselves	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
38	Listens to different points of view before coming to a decision	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	**TAUGHT**	**PRACTISED**	**ASSESSED**
39	Willing and able to use collegial support to critically think and make decisions, protecting self as a beginning practitioner	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
Learning									
40	Develops practical knowledge from reflecting on / self-assessing own knowledge, practice and competence	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
41	Is experienced in and knows how to learn	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
42	Demonstrates ability to look things up	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
43	Demonstrates ability to learn quickly	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
44	Faces and learns from mistakes	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
45	Keeps up to date with current realities and changes	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
46	Listens openly, accepts and applies constructive feedback	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
47	Is pro-active and keen to learn	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
48	Demonstrates personal growth through learning	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
49	Practises using an understanding that learning is progressive; they don't know everything	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
50	Learns a lot from colleagues	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
51	Approaches senior people to learn from	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
52	Recognises and maximises opportunities for learning	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
53	Willingly and actively seeks and asks about clinical practices	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
54	Learns from other RN role-modelling to understand how an RN thinks and acts like a nurse	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	**TAUGHT**	**PRACTISED**	**ASSESSED**
55	Helps others to learn	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
56	Demonstrates ability to learn advanced skills	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
Health education									
57	Teaches clients and families	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
58	Evaluates client learning	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
59	Makes effective presentations to clients	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
60	Teaches prevention, health promotion activities and effects of lifestyle on health	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
61	Utilises community resources to enhance client care	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
Quality									

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
62	Demonstrates an ethical outlook	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
63	Demonstrates concern for clients	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
64	Identifies actual or potential client safety risks	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
65	Takes appropriate measures to prevent or minimize risk of injury to self	Sufficient knowledge / knows to	Independent and safe	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
66	Takes appropriate measures to prevent or minimize risk of injury to clients	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
67	Acts in familiar situations	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
68	Declines to undertake unfamiliar activities	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
69	Recognises own unsafe practice	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge 1. Will need to develop knowledge 2. Sufficient knowledge/knows to	Independence 1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	Proficiency 1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	Timeliness 1. Will need extra time 2. Takes appropriate amount of time	Confidence 1. Will not yet feel assured of own capability 2. Feels assured of own capability	WITT Modern Apprenticeship BN Programme		
							TAUGHT	PRACTISED	ASSESSED
70	Judges when not to undertake planned or prescribed interventions	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
71	Recognises unsafe practice in others	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
72	Questions and challenges another nurses practice	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓		
73	Thrives on completing tasks and achieving results	Sufficient knowledge / knows to	Independent and safe	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
74	Demonstrates an eye for detail	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
Communication									
75	Feels comfortable using a range of communication skills with clients and their families	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
76	Expresses self easily	Sufficient knowledge / knows to	Independent and safe	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
77	Communicates changes in client condition	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
78	Manages conflict with colleagues	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
79	Manages conflict with clients	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
80	Shows initiative	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
81	Motivates others	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
Leadership									
Time management									
82	Keeps track of multiple responsibilities	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
83	Uses tools to self-organise and plan daily routines	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
84	Practises with an understanding of pressures of the practice setting	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
Team working									

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
85	Practises as an effective nursing team member	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
86	Practises as an effective multi-disciplinary team member	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
87	Contributes to team discussion	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
88	Presents information at case reviews and ward rounds	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
89	Gives handover	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
90	Works with senior staff without being intimidated	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	
91	Able to co-operate (assist / comply with requests)	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
92	Practises with an understanding of population generational differences	Sufficient knowledge / knows to	Independent and safe	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
93	Practises knowing where he/she fits within the team	Sufficient knowledge / knows to	Independent and safe	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
94	Manages interpersonal relationships with colleagues, including understanding and managing own emotions	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
95	Practises with an understanding and sharing of feelings / emotions of others	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
96	Practises with knowledge and understanding of self, including knowing own strengths and weaknesses	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
97	Willing to pitch in and undertake menial tasks when needed	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
98	Recognises the need to get along with others	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
99	Practises with an understanding of the different roles of RNs in different treatment or care settings	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
Organisation									

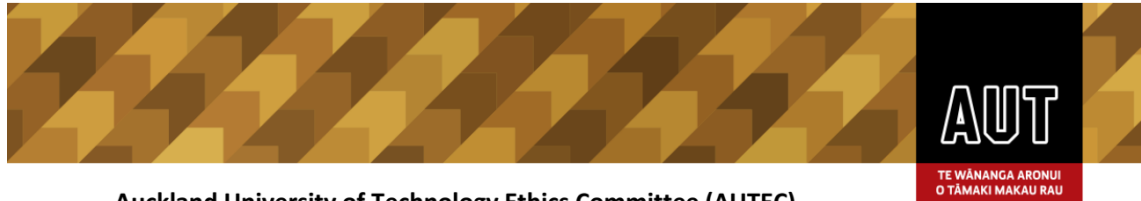|		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
100	Practises with an understanding of the rules, hierarchy and place in the organisation	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
101	Practises with an understanding of organisational processes and protocols	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
102	Practises with a knowledge of the routine of the clinical setting e.g.: handover procedure, ward round, clinical setting ways of doing things, the purpose and care delivery model	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
103	Practises with an understanding of how and where to access clinical resources and information	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
Resilience									
104	Likes the idea of change	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
105	Adapts to new and changing circumstances in health care	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
106	Remains calm under pressure or when things go wrong; does not panic	Will need to develop knowledge	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓

		Knowledge 1. Will need to develop knowledge 2. Sufficient knowledge/knows to	Independence 1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	Proficiency 1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	Timeliness 1. Will need extra time 2. Takes appropriate amount of time	Confidence 1. Will not yet feel assured of own capability 2. Feels assured of own capability	WITT Modern Apprenticeship BN Programme		
							TAUGHT	PRACTISED	ASSESSED
107	Willing to persevere when things are not working out as anticipated	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Will need extra time	Will not yet feel assured of own capability	✓	✓	✓
Health care									
108	Practises with an understanding of the health care system, social determinants of health, inequities and inequalities	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
109	Practises with an understanding of and ability to work in different health care models	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
110	Willing to work holistically and person-centred (not just the illness), including providing preventative and mental health care in same setting	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
Culture									
111	Bases practice on knowledge of Māori health	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
112	Bases practice on knowledge of tikanga	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
113	Correctly pronounces te reo (particularly client names)	Sufficient knowledge / knows to	Independent and safe	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
114	Is willing to learn more cultural knowledge		Will need some direction		Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
115	Is willing to participate and embrace indigenous models for better health outcomes	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
116	Is willing to take responsibility to change health outcomes for Māori	Sufficient knowledge / knows to	Will need some direction	Will need further practice	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
117	Provides cultural care as part of clinical health care	Sufficient knowledge / knows to	Independent and safe	Will need further practice	Takes appropriate amount of time	Will not yet feel assured of own capability	✓	✓	✓
Career									
118	Is satisfied with choosing nursing as a career					Feels assured of own capability	✓		
119	Feels ready for the professional nursing role					Feels assured of own capability	✓	✓	
120	Sees it as very important to be the best nurse					Feels assured of own capability	✓	✓	✓
121	Able to keep working life in perspective	Sufficient knowledge / knows to	Will need some direction	Will need further practice		Will not yet feel assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
122	Is focussed on career	Sufficient knowledge / knows to	Will need some direction	Will need further practice		Feels assured of own capability	✓	✓	✓
123	Eagar to throw self into work		Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	
124	Looks forward to the opportunity to learn and grow		Independent and safe			Feels assured of own capability	✓	✓	✓
125	Practises with knowledge that personal values will shape their decision-making	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Will need extra time	Feels assured of own capability	✓	✓	✓
126	Demonstrates a concept and understanding of service; puts others before self	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
127	General behaviour and conduct is appropriate (including use of language, mobile phone and social media, appearance and attire)	Sufficient knowledge / knows to	Independent and safe	Accomplished and well-practised	Takes appropriate amount of time	Feels assured of own capability	✓	✓	✓
128	Does not take days off ad hoc						✓	✓	✓
129	Is willing to commit to the practice setting					Feels assured of own capability	✓	✓	✓
130	Wants to produce as good a job as possible		Independent and safe			Feels assured of own capability	✓	✓	✓

294

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	**TAUGHT**	**PRACTISED**	**ASSESSED**
131	Is a very nice person								
132	Is passionate						✓	✓	
133	Is punctual					Feels assured of own capability	✓	✓	✓
134	Demonstrates a sense of humour					Feels assured of own capability	✓	✓	
135	Demonstrates a mature view on life					Feels assured of own capability	✓	✓	✓
136	Demonstrates an open and friendly approach					Feels assured of own capability	✓	✓	✓
137	Is humble						✓	✓	✓
138	Is reliable			Accomplished and well-practised		Feels assured of own capability	✓	✓	✓
139	Is curious						✓	✓	✓
140	Respects authority figures					Feels assured of own capability	✓	✓	✓
141	Respects colleagues					Feels assured of own capability	✓	✓	✓

		Knowledge	Independence	Proficiency	Timeliness	Confidence	WITT Modern Apprenticeship BN Programme		
		1. Will need to develop knowledge 2. Sufficient knowledge/knows to	1. Will need further development / supervision 2. Will need some direction 3. Independent and safe	1. Will need to learn to practice 2. Will need further practice 3. Accomplished and well-practised	1. Will need extra time 2. Takes appropriate amount of time	1. Will not yet feel assured of own capability 2. Feels assured of own capability	TAUGHT	PRACTISED	ASSESSED
142	Demonstrates personal attributes, values and guiding principles that fit with the practice area						✓	✓	✓
143	Achieved good undergraduate clinical references								

Appendix N: Phase Three AUTEC Approval Letter

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

4 April 2019

Deb Spence
Faculty of Health and Environmental Sciences

Dear Deb

Re Ethics Application: **19/90 What are the elements of work readiness of new graduate nurses in New Zealand health care context? A professional consensus**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 4 April 2022.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/research/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/research/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation, then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: dgchurcher@xtra.co.nz; Stephen Neville

297

Appendix O: Phase Three Recruitment Protocol

Recruitment Protocol

The participants are defined as those Tutors employed to teach on the Bachelor of Nursing programme at the Western Institute of Technology at Taranaki.

The names of the Tutors teaching on the programme are known by the primary researcher because the primary researcher and the Tutors are employed in the same tertiary institute. The Tutors email addresses are therefore accessible by the primary researcher via the employing organisation.

Authorisation to access the Bachelor of Nursing Tutors for research purposes will be obtained from the Western Institute of Technology at Taranaki Academic Director who is also the Research Committee Chair. The primary researcher's Primary Supervisor, Dr Deb Spence will contact the Academic Director with the following email message:

> *'My name is Dr Deb Spence and I am supervising a Doctor of Health Science student, Diana Fergusson. Diana would like authorisation to access the Bachelor of Nursing Tutors to invite them to participate in the final phase of her research project. I am seeking your authorisation for her to contact the Tutors using their WITT email addresses. Please could you respond by return email to inform me of your decision to of whether or not you authorise this access.*

Dr Deb Spence will then provide the authorisation to the primary researcher to then contact the potential participants as per the attached research protocol.

Appendix P: Phase Three Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

10 March 2019

Project Title

What are the elements of work readiness of new graduate nurses in the New Zealand health care context? A professional consensus.

An Invitation

My name is Diana Fergusson and I am currently undertaking the Doctor of Health Science (DHSc) degree at the Auckland University of Technology.

I would like to invite you to participate in my research project, in particular a focus group interview on Tuesday 30th April 2019, 1130-1330 hours in the Research Office D126 at WITT. There is no requirement to share all aspects of your perspective during the research if you feel uncomfortable doing so, without consequences and without giving a reason. It is entirely your decision on whether or not you wish to participate, and our professional relationship will not be advantaged or disadvantaged by your decision.

What is the purpose of this research?

The purpose of this doctoral research project is to gain a consensus from nurses working in education, practice, and professional bodies about the components of work readiness of new graduate nurses. The elements have been identified using a national Delphi consensus process and developed into a work readiness framework. This framework will now be explored in relation to the WITT Bachelor of Nursing 'Modern Apprenticeship' model.

The research project will be reported as a thesis to meet the requirements for the award of Doctor of Health Science. I also expect to gain publications in professional journals and present the work at appropriate conferences.

How was I identified and why am I being invited to participate in this research?

I have received approval from WITT to contact all the WITT Nursing Tutors, who teach on the WITT undergraduate nursing programme, to invite you to participate in this part of the study, a focus group discussion in relation to the work readiness framework that has been co-created by nurses across the sector in New Zealand.

I have used your email address at WITT to make contact with you and issue the invitation.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

You will be asked to sign a consent form to participate.

What will happen in this research?

There are 8 nursing Tutors invited to participate in a round table focus group discussion. The focus of the discussion will be to examine the work readiness framework and make a judgement on whether each of the elements are 'taught', 'practiced' by undergraduate nursing students, and 'assessed'.

You are invited to articulate your own Bachelor of Nursing teaching, learning and assessment experiences and practices in relation to the work readiness elements within the framework.

Lunch will be provided.

The information gathered will be used to discuss the relationship between the WITT Bachelor of Nursing 'Modern Apprenticeship' programme and the elements of work readiness as determined by the NZ nursing sector.

What are the discomforts and risks?

It is not anticipated that there will be any discomfort or risk to yourself.

What are the benefits?

The benefits of undertaking the research include:

- Adding to the body of knowledge of graduate nurse work readiness
- Provide relevant data leading to the development an evaluative tool for undergraduate nursing programmes
- Provide a positive contribution to health care delivery in NZ
- Advance the discipline of nursing
- Completion of my Doctor of Health Science qualification

How will my privacy be protected?

With your permission, I would like to digitally record the interview. This information will be transcribed verbatim by myself. Although I will know the contribution made by you, all information will be confidential to the public, and you will not be identified personally in any way.

Focus group interviews can limit the confidentiality in that group discussion content is shared during the interview. Participants will therefore be expected to keep the identity of fellow participants, the discussions and information in the focus group confidential to the group.

The final results will not be able to be linked to you; there will be no identifying material and the identity of participants will be protected.

Once the analysis of the information is completed, tapes will be stored securely in the Faculty of Health and Environmental Science at AUT for a period of six years and will then be destroyed. The consent forms will also be stored securely in the Faculty of Health and Environmental Science at AUT for a period of six years but separately to the tape. They too will then be destroyed.

What are the costs of participating in this research?

The focus group is expected to take between 90-120 minutes. There are no other costs anticipated.

What opportunity do I have to consider this invitation?

I would like to request a response within 10 working days. This can be by return email or by telephone. After 10 working days, I will telephone you to ask if you received the email invitation and had sufficient time to read the Information Sheet. Further, I will ask if you have any questions which need to be clarified before signing the Consent Form.

Will I receive feedback on the results of this research?

A copy of a report from the research will be made available. If you wish to have a copy, please indicate on the consent form. The report will be emailed to you once completed.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Deb Spence. She can be contacted by email deb.spence@aut.ac.nz or by telephone 09 9219999

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Diana Fergusson

Email: gnk6132@aut.ac.nz Telephone: 0275613313

Project Supervisor Contact Details:

Dr Deb Spence

Email: deb.spence@aut.ac.nz Telephone: 09 9219999

301

Appendix Q: Phase Three Consent Form

Consent Form

Project title: What are the elements of work readiness of new graduate nurses in the New Zealand health care context?

Project Supervisor: Dr Deb Spence

Researcher: Diana Fergusson

○   I have read and understood the information provided about this research project in the Information Sheet dated 10th March 2019.

○   I have had an opportunity to ask questions and to have them answered.

○   I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.

○   I understand that notes will be taken during the focus group and that it will also be digitally-taped and transcribed.

○   I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○   I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the focus group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○   I agree to take part in this research.

○   I wish to receive a summary of the research findings: work readiness framework (please tick one):

        Yes○   No○

Participant's signature: ....…………………………………………………………

Participant's name: ....…………………………………………………………

Participant's Contact Details (if you wish to receive a copy of the work readiness framework):

Email :

Date:

Approved by the Auckland University of Technology Ethics Committee on** 4th **April 2019** AUTEC Reference number **19/90

Note: The Participant should retain a copy of this form.

Appendix R: Phase Three Research Protocol

Focus Group Research Protocol

Recruiting Email:

Dear / Kia ora XXXX

I am writing to invite you to participate in my doctoral research. I have attached an information sheet which contains information on the project. Once you have had an opportunity to read this, you may have some questions and queries before you decide whether you wish to participate. I am very happy to respond to the queries either by email or on the telephone.

Once you have sufficient information and agree to participate, you will need to sign the consent form which is also attached. You can bring the form with you to the focus group.

Please do not hesitate to contact me to discuss further.

Kind regards / Nga mihi

Diana

Focus Group

Venue: X

- Tables re-arranged to create a round-table structure
- Ventilation of the room attended to
- Refreshments including water with glasses positioned conveniently
- Ensure the primary researcher acting in the role as moderator is seated so that all participants can see and be clearly seen
- Digital recording device checked and then positioned as unobtrusively as possible

Focus Group Plan

- Greet all participants (they have all had a whakatau previously)
- Commence the session with WITT karakia
- Thank the participants
- Health and safety
- Repeat the privacy issues of confidentiality
- Confirm the use of a digital recorder
- Respond to any queries
- Overview of discussion guidelines:
    - Want to capture all perspectives
    - One person speaking at a time
    - No interruption except where necessary (going off-track)
    - We will proceed through all the elements one at a time

- Indicative questions
  - In the Bachelor of Nursing programme is this element
    - Taught
    - Practiced (by the nursing student)
    - Assessed
  - Are there any other comments or statements you would like to make?
- Conclude session
  - Thank participants
  - State again what will now happen with the data
  - Close with karakia

Digital recording:

- Ensure participants are warned of the recorder being switched on and then off at the end

Moderator role:

- Promote interaction if required
- Ensure all participants feel their views are valuable
- Ensure the participants stay on the topic
- Ask for clarity where appropriate
- Ask for examples where appropriate
- Ask for underpinning meaning where appropriate
- Probe for further information and elaboration
- Paraphrase for purposes of summing up and ensuring all key points captured

DF 10/3/19

Appendix S: Nursing Council New Zealand Education Standards Map

Standard two: **The programme has a structured curriculum that enables students to achieve the programme outcomes and the Council's** *Competencies for the Registered Nurse Scope of Practice.*	**NCNZ Competencies for the RN Scope of Practice**	**NGN Work Readiness Elements**	**NGN Work Readiness Element - not mapped to NCNZ standards**
2.3 The programme specifically requires students to demonstrate, in practice at a graduate level, the following:			
Pharmacology knowledge and medicine management			
Comprehensive health consumer assessment skills and clinical decision-making skills supported by knowledge of pathophysiology	**Competency 2.2** Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings.	- Sets and justifies priorities - Re-sets priorities - Is prepared for the unexpected to occur - Uses previous experience to figure out what is going on when a current situation takes an unexpected turn - Judges urgency of changing situations - Changes focus when a crisis situation that needs attention arises - Recognises when something is abnormal to what they expected and get it corrected - Judges the need to escalate care through additional forms of focussed observation from observing and noticing to the use of a particular assessment tool	

		• Readjusts a plan of action in the light of what happens as it is implemented • Re-assesses client's responses / situation and nursing interventions; conducts appropriate follow-up • Develops and uses networks of colleagues to assist in solving problems • Tries to solve problems themselves • Listens to different points of view before coming to a decision • Willing and able to use collegial support to critically think and make decisions, protecting self as a beginning practitioner • Judges when not to undertake planned or prescribed interventions • Re-assesses client's responses / situation and nursing interventions; conducts appropriate follow-up • Listens to different points of view before coming to a decision • Willing and able to use collegial support to critically think and make decisions, protecting self as a beginning practitioner • Judges when not to undertake planned or prescribed interventions	
Therapeutic communication with health consumers	**Competency 3.1** Establishes, maintains and concludes therapeutic interpersonal relationships with health consumers	• Feels comfortable using a range of communication skills with clients and their families • Expresses self easily	

Working within a health care team; providing direction and delegation in practice	**Competency 1.3** Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by enrolled nurses and others.		
The use of information technology and health information management.		• Accesses and retrieves electronic data necessary for client care • Practises with knowledge of and ability to use technology in health • Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse • Utilises common clinical technologies e.g.: pumps, monitors	
NCNZ Guidelines for Professional Practice	**NCNZ Competencies for the RN**	**NGN Work Readiness Elements**	**NGN Work Readiness Elements - not mapped to NCNZ standards**
the Council's *Guidelines for Cultural Safety, the Treaty of Waitangi, and Māori Health in Nursing Education and Practice*; *Code of conduct for nurses*; *Direction and delegation*	**Competency 1.2** Demonstrates the ability to apply the principles of the Treaty of Waitangi Te Tiriti o Waitangi to nursing practice. **Competency 1.3** Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by enrolled nurses and others. **Competency 1.5** Practises nursing in a manner that the health consumer determines as being culturally safe.	• Bases practice on knowledge of Māori health • Bases practice on knowledge of tikanga • Correctly pronounces te reo (particularly client names) • Is willing to learn more cultural knowledge • Is willing to participate and embrace indigenous models for better health outcomes • Is willing to take responsibility to change health outcomes for Māori • Provides cultural care as part of clinical health care Not reaching consensus: χ Practices with knowledge of local iwi	
NCNZ Standards: Programme Content	**NCNZ Competencies for the RN**	**NGN Work Readiness Elements**	**NGN Work Readiness Elements - not mapped to NCNZ standards**

1. The development of critical thinking and nursing inquiry throughout the programme		- Applies learnt knowledge and can readily answer clinical questions - Sets and justifies priorities - Re-sets priorities - Is prepared for the unexpected to occur - Uses previous experience to figure out what is going on when a current situation takes an unexpected turn - Judges urgency of changing situations - Changes focus when a crisis situation that needs attention arises - Recognises when something is abnormal to what they expected and get it corrected - Judges the need to escalate care through additional forms of focussed observation from observing and noticing to the use of a particular assessment tool - Readjusts a plan of action in the light of what happens as it is implemented - Re-assesses client's responses / situation and nursing interventions; conducts appropriate follow-up - Develops and uses networks of colleagues to assist in solving problems - Tries to solve problems themselves - Listens to different points of view before coming to a decision - Willing and able to use collegial support to critically think and	✓ Demonstrates a mind-set whereby can transfer skills to another clinical setting ✓ Thrives on completing tasks and achieving results ✓ Demonstrates an eye for detail ✓ Shows initiative ✓ Motivates others ✓ Practises with an understanding of pressures of the practice setting ✓ Practises with an understanding of how the organisation operates ✓ Practises with an understanding of the rules, hierarchy and place in the organisation ✓ Practises with an understanding of organisational processes and protocols ✓ Practises with a knowledge of the routine of the clinical setting e.g.: handover procedure, ward round, clinical setting ways of doing things, the purpose and care delivery model ✓ Practises with an understanding of how and where to access clinical resources and information ✓ Likes the idea of change ✓ Adapts to new and changing circumstances in health care ✓ Remains calm under pressure or when things go wrong; does not panic ✓ Willing to persevere when things are not working out as anticipated ✓ Is satisfied with choosing nursing as a career ✓ Feels ready for the professional nursing role

		• make decisions, protecting self as a beginning practitioner • Judges when not to undertake planned or prescribed interventions Not reaching consensus: χ Sees how apparently unconnected activities are linked and make up an overall picture χ Traces out and assesses the consequences of alternative courses of action and, from this, pick the one most suitable χ Recognises patterns in a complex situation χ Identifies from a mass of detail the core issues in any situation χ Does not become overwhelmed by challenging circumstances χ Copes with multiple and competing demands	✓ Sees it as very important to be the best nurse ✓ Able to keep working life in perspective ✓ Is focussed on career ✓ Eagar to throw self into work ✓ Looks forward to the opportunity to learn and grow ✓ Is willing to commit to the practice setting ✓ Wants to produce as good a job as possible ✓ Is a very nice person ✓ Is passionate ✓ Demonstrates a sense of humour ✓ Demonstrates a mature view on life ✓ Demonstrates an open and friendly approach ✓ Is humble ✓ Is reliable ✓ Is curious ✓ Demonstrates personal attributes, values and guiding principles that fit with the practice area ✓ Achieved good undergraduate clinical references
2. Professional responsibility: ○ professional conduct, ○ nursing practice and professional, ethical and legal responsibilities; understanding of health policy and health regulation; ○ the application of the Treaty of Waitangi in clinical practice; ○ culturally safe care and understanding of cultural safety; ○ accountability and the direction and supervision of second-level nurses;	**Competency 1.1** Accepts responsibility for ensuring that his/her nursing practice and conduct meet the standards of the professional, ethical and relevant legislated requirements. **Competency 1.2** Demonstrates the ability to apply the principles of the Treaty of Waitangi Te Tiriti o Waitangi to nursing practice. **Competency 1.3** Demonstrates accountability for directing, monitoring and evaluating nursing care that is provided by enrolled nurses and others.	• Maintains client dignity • Demonstrates an ethical outlook • Demonstrates concern for clients • Demonstrates a concept and understanding of service; puts others before self • Practises with knowledge that personal values will shape their decision-making • Identifies actual or potential client safety risks • Takes appropriate measures to prevent or minimize risk of injury to self	Did not reach consensus χ Practises with an understanding of how the different groups that make up the organisation operate and how much influence they have in different situations χ Undergraduate transition experience is the same / similar setting as new graduate RN position clinical setting

o health consumer safety and environmental risk assessment	**Competency 1.4** Promotes an environment that enables health consumer safety, independence, quality of life, and health. **Competency 1.5** Practises nursing in a manner that the health consumer determines as being culturally safe.	• Takes appropriate measures to prevent or minimize risk of injury to clients • Practises with an understanding of the health care system, social determinants of health, inequities and inequalities • Practises with an understanding of and ability to work in different health care models • General behaviour and conduct is appropriate (including use of language, mobile phone and social media, appearance and attire) • Does not take days off ad hoc • Is punctual • Bases practice on knowledge of Māori health • Bases practice on knowledge of tikanga • Correctly pronounces te reo (particularly client names) • Is willing to learn more cultural knowledge • Is willing to participate and embrace indigenous models for better health outcomes • Is willing to take responsibility to change health outcomes for Māori • Provides cultural care as part of clinical health care Not reaching consensus: • Practices with knowledge of local iwi	χ Achieved good undergraduate programme grades

310

		• Considers that nothing is too much for the client	

3.Management and delivery of nursing care:
 	
  o the planning, delivery and evaluation of nursing care;
  o comprehensive health consumer assessment and decision making;
  o health consumer-centred care and partnership;
  o application of concepts such as informed consent, health consumer rights and advocacy;
  o use of information technology, information management and documentation;
  o health promotion and health education;
  o chronic disease state management;
  o lifespan approach;
  o health continuum approach;
  o lifelong learning, professional development and ongoing competence responsibilities
	Competency 1.5
	Practises nursing in a manner that the health consumer determines as being culturally safe.
	
	Competency 2.1
	Provides planned nursing care to achieve identified outcomes.
	
	Competency 2.2
	Undertakes a comprehensive and accurate nursing assessment of health consumers in a variety of settings.
	
	Competency 2.3
	Ensures documentation is accurate and maintains confidentiality of information
	
	Competency 2.4
	Ensures the health consumer has adequate explanation of the effects, consequences and alternatives of proposed treatment options.
	
	Competency 2.6
	Evaluates health consumer's progress toward expected outcomes in partnership with health consumers.
	
	Competency 2.7
	Provides health education appropriate to the needs of the health consumer within a nursing framework.
	
	Competency 2.8
	Reflects upon, and evaluates with peers
		• Manages a full workload of low acuity clients after completing orientation
		• Manages a full workload of mixed acuity clients after completing orientation
		• Copes with practising shifts / different work patterns across the week
		• Provides mental health care
		• Provides end-of-life care
		• Performs personal care / activities of daily living (ADLs) for clients
		• Accesses and retrieves electronic data necessary for client care
		• Practises with knowledge of and ability to use technology in health
		• Practises using an understanding of client rights
		• Interprets subjective and objective assessment data
		• Uses hands-on assessment skills in conjunction with technology e.g.: assessment of pulse
		• Utilises common clinical technologies e.g.: pumps, monitors
		• Demonstrates ability to start tasks
		• Always thinks about patient outcomes
		• Is comfortable (not embarrassed) to ask questions when unsure / doesn't know about something
		• Recognises when to ask for assistance	

	and experienced nurses, the effectiveness of nursing care. **Competency 2.9** Maintains professional development. **Competency 3.2** Practises nursing in a negotiated partnership with the health consumer where and when possible.	• Develops practical knowledge from reflecting on / self-assessing own knowledge, practice and competence • Practises with knowledge and understanding of self, including knowing own strengths and weaknesses • Is experienced in and knows how to learn • Demonstrates ability to look things up • Demonstrates ability to learn quickly • Faces and learns from mistakes • Keeps up to date with current realities and changes • Listens openly, accepts and applies constructive feedback • Is pro-active and keen to learn • Demonstrates personal growth through learning • Practises using an understanding that learning is progressive; they don't know everything • Learns a lot from colleagues • Approaches senior people to learn from • Recognises and maximises opportunities for learning • Willingly and actively seeks and asks about clinical practices • Learns from other RN role-modelling to understand how an RN thinks and acts like a nurse • Demonstrates ability to learn advanced skills • Teaches clients and families • Evaluates client learning	

		• Makes effective presentations to clients • Teaches prevention, health promotion activities and effects of lifestyle on health • Utilises community resources to enhance client care • Acts in familiar situations • Uses tools to self-organise and plan daily routines • Keeps track of multiple responsibilities • Practises with an understanding of population generational differences • Willing to work holistically and person-centred (not just the illness), including providing preventative and mental health care in same setting Not reaching consensus: • Advocates for policy changes that promote health of individuals, families or communities • Practises with an understanding of where health care is heading in the future with changing models of care	

4.Interpersonal relationships:
 	
   ○ development of therapeutic relationships with health consumers;
   ○ effective communication within the health care team and documentation; information management;
	Competency 1.4
	Promotes an environment that enables health consumer safety, independence, quality of life, and health.
	
	Competency 2.5
	Acts appropriately to protect oneself and
		• Writes nursing care plans or plans of care
		• Interprets the multi-disciplinary team orders / plans
		• Manages the balance between patient want and need
		• Declines to undertake unfamiliar activities
		• Recognises own unsafe practice	

313

o understanding of partnership and collaboration; o quality assurance practices	others when faced with unexpected health consumer responses, confrontation, personal threat or other crisis situations. **Competency 3.1** Establishes, maintains and concludes therapeutic interpersonal relationships with health consumers **Competency 3.3** Communicates effectively with health consumers and members of the health care team.	• Recognises unsafe practice in others • Questions and challenges another nurses practice • Feels comfortable using a range of communication skills with clients and their families • Expresses self easily • Communicates changes in client condition • Practises as an effective nursing team member • Practises as an effective multi-disciplinary team member • Contributes to team discussion • Presents information at case reviews and ward rounds • Gives handover • Works with senior staff without being intimidated • Able to co-operate (assist / comply with requests) • Practises knowing where he/she fits within the team • Manages conflict with colleagues • Manages conflict with clients • Manages interpersonal relationships with colleagues, including understanding and managing own emotions • Practises with an understanding and sharing of feelings / emotions of others • Willing to pitch in and undertake menial tasks when needed • Recognises the need to get along with others	

		• Practises with an understanding of the different roles of RNs in different treatment or care settings Not reaching consensus • Chairs and participates constructively in meetings • Makes appropriate impromptu speeches • Gives constructive feedback to work colleagues and others without engaging in personal blame	

5.Interprofessional health care and quality improvement:
 	
    ○ co-ordination of health consumer care within the health care team including discharge planning, interprofessional collaboration and communication;
    ○ advocacy for the nursing contribution;
    ○ respect for all members of the health care team;
    ○ quality improvement and research activities;
    ○ leadership;
    ○ teaching and mentoring within the team.
	Competency 4.1
	Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care.
	
	Competency 4.2
	Recognises and values the roles and skills of all members of the health care team in the delivery of care.
	
	Competency 4.3
	Participates in quality improvement activities to monitor and improve standards of nursing.
		• Advocates for the client
		• Bases practice on evidence rather than routine
		• Bases decision-making on the nursing process or plan of care
		• Helps others to learn
		• Respects authority figures
		• Respects colleagues
		
		Leadership not reaching consensus:
		
		χ Is approached for original ideas
		χ Can run a shift / work period
		χ Assigns clients to staff
		χ Acts as a resource
		χ Manages personal problems in the team
		
		Quality improvement not reaching consensus:
		
		χ Questions and challenges the wider system	

		χ Practises with an understanding of quality improvement methodologies	

Appendix T: WITT BN MA Curriculum Structure Outline

Programme Structure 6 x 60 credit courses	Course Structure Each course is a praxis course	Themes across the programme
YEAR 1 *Semester 1* 1. Introduction to Nursing Praxis *Semester 2* 2. Developing Nursing Praxis YEAR 2 *Semester 3* 3. Introduction to client-centred Nursing Praxis *Semester 4* 4. Developing client-centred Nursing Praxis YEAR 3 *Semester 5* 5. Population Health and Complex Nursing Praxis *Semester 6* 6. Transition to Registered Nurse Praxis	• Clinical practice • Simulation • Team / group work • Tutorials • Blended learning, including online component • Self-directed learning	• Professional issues in nursing • Science: behavioural, social, human biology, microbiology, chemistry, pharmacology and disease states • Use of information technology • Academic communication • Te Tiriti o Waitangi • National Health Priorities • Clinical practice • Clinical skills • Māori health • Heritage studies • Team work • Evidence-based practice and research • Primary health care • Expert learner skills • Health communication • Emotional / social intelligence and resilience • Skills of inquiry and higher order thinking • Clinical judgement / reasoning • Cultural safety

YEAR 1	
Nursing concepts	*Each nursing concept content*
• Comfort • Health and safety • Vital signs • Pain • Nutrition • Falls • Hygiene • Skin integrity • Fluid balance • Client experience • Emergency (1 and 2) • General survey and interviewing • Comfort • Lifespan – child • Lifespan – older person • Oxygenation • Circulation • Mental health • Neurological assessment • Neuro-vascular assessment • Health promotion • Medication administration	• Clinical practice – ½ day per week (in each medical, surgical, paediatric and acute mental health) • Science • Cultural safety • Communication • Simulation • Tutorial • Online tasks • Textbook reading • Team work • Clinical scenarios • Legal, ethical professional issues • Treaty of Waitangi

YEAR 2	
Unfolding Case Studies	*Unfolding case study content*
1. Diabetes and Depression 2. COPD and delirium 3. Coronary and Bi-polar disease 4. Trauma and Drug and alcohol addiction 5. CVA and dementia (inc., rehab and death) 6. Cancer and a related mental health disorder	• Clinical practice – blocks of practice, rotating shifts with RN preceptor (acute mental and physical health care) • Journal Club • Simulation • Science • Cultural safety • Communication • Treaty of Waitangi • Pharmacology • Health Education • Acute child care • Epidemiology • Clinical practice • Sexuality • Spirituality • Genetics • Nurse theorists • IV therapy • Change management • Kaupapa Maori frameworks inc. research

YEAR 3		
Semester 1		Semester 2
Population health concepts	Concept content	
• Health systems • Community models of care • Social determinants of health • Family care • Chronic disease • Family Violence • Disability • End of life care	• Clinical practice – 2 blocks: one in aged care and one in the community • Action learning • Communication • Self-management • Clinical skills competence • Disability • Smoking cessation • Immunisations • Inequity of health care • Cultural safety • Health promotion resources • Family • Nutrition inc. breast feeding • Lifestyle changes • Epidemiology / MoH priorities • Mental health inc. depression • Ethical, legal and professional issues, inc. Code of Conduct, professional boundaries • Theory of how humans learn • Health education strategies • Change management • Research and EBP	• Clinical Practice – one 9-week block • Leadership • Quality and safety • Evidence-based practice • Professional boundaries and Code of Conduct • Employment strategies