

1991

New graduates' self-perceived preparedness to begin practice as registered nurses

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Vicci Lodge



December 1991

ACKNOWLEDGEMENTS

I would like to thank the following people:

Anthony Hussey, my supervisor, for his support and guidance throughout the preparation of this paper.

Amanda Blackmore, Research Consultant, for her tireless patience and invaluable assistance with the various aspects of thesis presentation.

Ann Hersey, for the unrestricted use of her personal computer during the preparation and presentation of this paper.

NEW NURSE GRADUATES' SELF-PERCEIVED
PREPAREDNESS TO BEGIN PRACTICE AS
REGISTERED NURSES

by

Vicci Lodge R.N.

A Thesis Submitted in Partial Fulfilment
of the Requirements for the Award of
Bachelor of Health Science (Nursing) Honours
at the School of Nursing,
Edith Cowan University

Date of Submission: 9th of December, 1991



ABSTRACT

The purpose of this study was to investigate new nurse graduates' perceptions of their preparedness to begin practice as registered nurses. The investigation included determining whether their perceptions changed over time and in which areas they perceived they were best and least prepared.

A longitudinal descriptive survey design was used for this study. Two self-administered questionnaires were used to gather data from all the students (79) who graduated with the Diploma of Health Science from Edith Cowan University at the end of Semester 1 for 1991.

Of these, 34 new nurse graduates completed and returned both questionnaires.

Both quantitative and qualitative data were collected.

The study findings revealed that there was no significant difference in the perceived level of preparedness over time. It was also shown that the identified variables, familiarity of work environment, previous nursing experience, and allocation of a preceptor, did not influence the subjects' perceived level of preparedness to begin practice. However significant differences between the seven categories of the questionnaire were identified. Further analysis revealed the area of Carrying out Ward Procedures-Leadership as the area that the subjects felt least prepared in, with the areas of Interpersonal Relationships-Communications as the areas they felt best prepared in. The qualitative data corroborated the quantitative results.

The statistical findings of this study together with the subjects' suggestions for change, tends to indicate the need for further research and review of nursing education programmes.

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CHAPTER I

INTRODUCTION

Nursing requires a broad range of knowledge, which is developed in a variety of settings, including laboratories, clinical areas, and the classroom. The range and variety of educational experiences are designed to enable nurse graduates to function competently and professionally when providing care, whether in hospital setting or within the community. This educational range and variety together with professional, technological and societal change, requires nursing education to be continuously evaluated to ensure that what is learned is congruent with current professional practice needs.

Evaluation of nursing education programmes has not been a popular exercise in the past, possibly due to the often misconceived idea that the evaluation will produce negative information, thus undermining nursing's autonomy and movement towards professionalism, according to Gallego (1987). McCormick and James (1983), cited by Gallego (1987, p. 232) assert that, "...the purpose of evaluation is three-fold: evaluation for accountability, evaluation for professional development and educational improvements, and evaluation for curriculum review." Therefore internal evaluation of educational programmes, together with the recognition and acknowledgement of indicated changes, can thus enhance the development and consolidation of nursing's professionalism and body of knowledge.

STATEMENT OF PROBLEM

According to Myrick (1991) many new nurse graduates from educational programmes in the United States, which appear similar in content and length to those conducted in W.A. and particularly at Edith Cowan University, expressed concern about their preparedness to commence practice in clinical settings as registered nurses. She suggests, that while there has been continual investigation of various curricula, a suitable solution to this dilemma has not been found.

Blanchard (1983) refers to Festinger's Theory of Cognitive Dissonance, when explaining this phenomenon, which he believes has developed through an emphasis being placed on the educating rather than on the doing. Blanchard also believes that this leaves the new graduate in a real life work situation that is very different from the ideal one their education espouses.

The present researcher, while a nursing student at Edith Cowan University, became aware that a number of new nurse graduates, also from this institution, expressed a similar concern about their ability to commence practice in the real world. To date, this concern has not been researched at Edith Cowan University.

In order to begin to address this concern, it is important to ascertain whether this phenomenon exists for the new nurse graduates of Edith Cowan University. It is also important to discover what areas of preparation produce the most concern and finally whether the concern persists over time.

RESEARCH PURPOSE

The aim of this study was to survey a group of new graduates at time of graduation and to ascertain their views about their preparedness to begin practice as registered nurses. The study also investigated whether their perceptions changed during the first 3 months of work experience following graduation and registration and what variables influenced their perceptions.

STUDY QUESTIONS

1. Will there be a difference in newly graduated nurses' perceived level of preparedness between graduation and 3 months after graduation?
2. Will nurses who begin work in the same clinical setting as their continuous practice setting, perceive that they were better prepared for practice than nurses who begin work in a different clinical setting from their continuous practice setting?
3. Will nurses with previous nursing experience (ie. Enrolled Nurses, Nursing Assistants or those with previous training) perceive that they were better prepared for practice in their new role than nurses with no previous nursing experience?
4. Will nurses who had a preceptor assigned during the 3 month interval perceive that they were better prepared for practice than nurses without a preceptor?
5. In which areas do new nurse graduates perceive they were best and least prepared for practice as registered nurses?

OBJECTIVES

1. To survey a pre-selected group of new graduate nurses, immediately post graduation and again after 3 months work experience and to ascertain their perceptions of their preparedness to practise as registered nurses.
2. To identify whether those perceptions change over time.
3. To examine the relationship between, previous nursing experience; preceptoring; continuous practice settings and the new graduates' perceptions.
4. To identify demographic variables that may have an influence on the outcome.

DEFINITION OF TERMS

OPERATIONAL

Newly graduated nurse.

A newly graduated nurse is defined as a nurse who has completed the Diploma of Health Science, is eligible for registration with the Nurses Board of Western Australia and is about to commence practice as a registered nurse.

Clinical setting.

A clinical setting is a hospital, ward or community nursing centre where nursing care is provided.

Continuous practice setting.

The continuous practice setting is the hospital ward or community nursing centre where sixth semester nursing students gained practical experience during the last five weeks of the Diploma of Health Science course.

Nursing Practice.

Nursing practice is defined as being full or part-time employment as a registered nurse, providing nursing care in a clinical setting.

Previous nursing experience.

Previous nursing experience is defined as previous experience as an Enrolled Nurse, Nursing Assistant or prior partial completion of a nursing education or training programme. The length of the experience is not a criterion of this definition.

Preceptor.

According to Maes (1983) a preceptor is a nurse with expertise in one health area, who is specifically assigned to the role of assisting the new nurse graduate with the adjustment to a new workplace and the attainment of professional goals.

Areas.

Areas is defined as the type of experience referred to in the study questionnaires' categories.

CONCEPTUAL

Preparedness.

Preparedness is defined as being in a suitable condition, fit for a certain purpose, being ready by practice (Hayward and Sparkes, 1982, p.897). In the present study preparedness will be measured by the new nurse graduates' perceptions of being prepared for practice.

Perception.

Perception is defined as, "...the process of perceiving, the mental action of knowing external things through the medium of sense presentations, intuitive apprehension." (Hayward and Sparkes, 1982, p. 843). In the present study perceptions are measured by self-report of the subjects.

CHAPTER II

LITERATURE REVIEW

Introduction

This literature review will cite studies which have investigated various aspects of nursing education. They include, educational programme evaluation, student and graduate participation in evaluation and the problems associated with the transition from student to Registered Nurse.

As nursing education varies from country to country and with research bringing continuous change, an attempt was made to confine the information for this study to Australian nursing literature in the period 1981-1991.

However as tertiary based nursing education is relatively new to Australia (first introduced in 1975), the amount and range of literature and related studies was limited. Therefore an international approach was taken by including nursing literature from the United States of America, England, New Zealand, Canada and Israel.

Educational Programme Evaluation

Lumby (1989) points out that since nursing education moved to tertiary institutions, there has developed a greater need to examine nursing and its education process in order to determine new graduates' competencies. She suggests that unless the nursing profession undertakes such evaluation, it may end up

with a similar problem to other courses in applied sciences, an imbalance between education and practice.

According to researchers studying nursing education, the evaluation of nursing education programmes involves a complex investigation of the many components that make up such programmes. (Parfitt, 1986; Ouellet & Rush, 1989; Watson & Herbener, 1990) These authors agree that investigating nursing education programmes would provide a challenge for researchers, particularly as this is an area that is often neglected due to the negative connotations associated with it.

A complex investigation of the kind suggested by these researchers, is beyond the scope of this study. However a possible consequence of this study may be to stimulate others to investigate either wholly or partially components of previous research. Thus providing continual evaluation of nursing education programmes.

Student Participation in Evaluation

Oullet & Rush (1989) present a review of an existing programme evaluation, while DiFlorio, Duncan, Martin & Middlemiss (1989) describe the formation and implementation of a similar evaluation of a nursing education programme. Both articles presented a concise overview of the evaluation methods employed, together with a recognition that the outcomes would provide a focus for review or modification of their individual programmes. However neither study incorporated an input from new graduates and only DiFlorio et al.'s study identified students

as a source of feedback. Jenkins (1986) highlighted the benefits of using students' input through continuing systematic curriculum evaluation to help improve the quality of their course content, when evaluating educational programmes.

A study by Ziv, Ehrenfeld & Hadani (1990) also looked at the area of evaluation and included feedback from students. The researchers asked 110 nursing students in a 4 year baccalaureate programme, to answer a questionnaire containing 72 closed and open-ended questions relating to various aspects of their educational programme. The study found that while students were generally satisfied with their curriculum, they felt there was a need for modification in some components of their programme. The suggested modifications included, increasing patient loads, increased practice in complicated procedures and skills, better integration of theory to practice and lengthening of certain clinical experiences. This information was made available to the students' curriculum review committee.

Student to Registered Nurse Transition

Schroeder, Cantor & Kurth (1981), Duncan (1987) & Horsburgh (1989) investigated the needs of the new graduate when entering the workforce. Schroeder et al.(1981) studied 146 new graduates, from four different programmes, to ascertain the orientation needs of new graduates entering the workplace. They constructed a series of testing instruments, made up of open-ended questions, to determine the learning needs of the new graduates. Duncan (1987) compared a group of tertiary based graduates with

a group of hospital based graduates, to determine whether their assimilation into the workplace differed. Her study group consisted of 144 new graduates, with 42 supervisors. The new graduates were asked to answer a questionnaire relating to their competencies and problems they encountered. The supervisors were asked to assess the graduates' performance, using a performance appraisal questionnaire. Horsburgh (1989) observed 10 new graduates over a 3-4 month period of initial employment. She also conducted interviews and obtained data by questionnaire to assess the new graduates' perceptions of their competencies. All these researchers identified problems such as fitting into ward routines, evaluating patients' condition, identification of significant nursing care problems, employers' expectations being greater than students' level of learning, inadequate feedback in regard to clinical performance, and an incongruity between nursing practice and graduates' expectations on moving from the role of student to registered nurse. Suggestions were made to help overcome identified problems. These included providing a thorough orientation programme, visible identification of new graduates and better liaison between educational bodies and the employing institutions.

All of the above variables and suggested ways to overcome the problems identified existed after or during the transition from student to registered nurse. However consideration must be given to the possibility of pre-existing variables affecting the ease of transition or the subjects perceptions of their preparedness. For example, if a new nurse graduate has already

worked in a particular environment as a student, then it would be expected that the transition from student to registered nurse would be easier. This could also be expected with the new nurse graduate who has had previous nursing experience or who has had a preceptor allocated.

Identification and investigation of the role of the preceptor and prior nursing experience in the present study (p.26), will help to determine the intervention necessary to overcome similar problems occurring for future new nurse graduates.

Graduate Participation in Evaluation.

Studies by Vanetzian & Higgins (1990) and Mackay, Brooke & Bruni (1981) investigated new graduates' perceptions of their preparedness to practice. However both studies introduced other factors for comparison. Mackay et al. used a longitudinal study to compare tertiary based graduates with hospital based graduates. Both groups answered a questionnaire relating to their competencies. The graduates were also assessed by observers who used a nursing performance instrument to collect data on the graduates performance. Vanetzian & Higgins' (1990) study was also a longitudinal survey. They used "The Six-Dimension Scale of Nursing Performance" by Schwirian (1978) to assess both the graduates' and their observers' opinions of the new graduates' performance. This study's aim was to determine the length of time required for the new graduates' self-evaluations to match the evaluation of their observers.

Based on the observers' higher ratings only, it was concluded that one year of practice would be an acceptable time for the assimilation of the new graduates' educational preparation with on-the-job education, socialisation and role performance expectations of their employers. However the findings of this study are not generalisable due to the small population, ultimately reduced from 103 to 38 because of the high attrition rate of the observers.

McArthur, Brooke & Bruni (1981) followed Mackay et al. (1981) with a similar study that evaluated graduates during their first year of employment as registered nurses. In this study graduates were asked, in a written questionnaire, for their perceptions of their educational preparation, including areas they perceived as weaker or stronger than others. These graduates were followed up after 3-7 months in the workplace. They were asked to re-evaluate their perceptions of their education and to identify any areas that had proved to be a problem. Again supervisors and observers provided information using an evaluative questionnaire on the graduates' performance. This longitudinal study identified areas the graduates anticipated as being problem areas, including their ability to perform organisational, administrative, and technical skills. Overall the graduates were satisfied with their education. Some made suggestions for change within the clinical practice area, which they perceived as the main problem area encountered. They also indicated that experience would develop their self-confidence. Both Mackay et al. and McArthur et al.

recommended that future replication of similar studies, incorporating graduates' opinions, would benefit tertiary based nursing education.

Conclusion.

All the reviewed literature indicated the need for ongoing evaluation of nursing education programmes. It also alluded to the importance of including new graduates' opinions in such evaluations. Some of the studies revealed that the problems encountered by new graduates were varied and not all had easy solutions available. The aim of the present study was to shed more light on these problems, with the aim of providing a stimulus for the development of possible solutions.

CHAPTER III

THEORETICAL RATIONALE

Festinger's 1957 Theory of Cognitive Dissonance is the theoretical basis for this study. While this theory comes from a Behavioural Science background, "...it has rather wide implications and applications to a variety of situations which on the surface look very different." (Festinger, 1970, p. 31)

Previous nursing studies carried out by Blanchard (1983) and Mitchell (1988) used Festinger's theory as a basis when researching inconsistencies between graduates' knowledge and their environment. Therefore it was considered appropriate to use Festinger's theory as the theoretical basis of the present study.

Festinger asserts that dissonance exists when an inconsistency between cognitions develops. He defines cognitions as being, "...any knowledge, opinion or belief about the environment, about oneself, or about one's behaviour." (p. 3) To clarify this further he says:

...elements of cognition correspond for the most part with what the person actually does or feels or with what actually exists in the environment. In the case of opinions, beliefs and values, the reality may be what others think or do, in other instances the reality may be what is encountered experientially or what others have told him. (p.11)

According to Wierda (1989) new nurse graduates believe that

an inconsistency exists between their ability (oneself) to begin practice as registered nurses and their employers' expectations (environment). This belief may have developed from what they have heard from more experienced registered nurses, from what they have observed during their educational process or from the anxiety associated with commencing a new role.

Festinger (p.271) argues that when there is a change in a person's way of life, some cognitive dissonance can occur. This is particularly relevant when this is a change of role, which has expectations associated with it, as when a new graduate changes role from student to registered nurse. Another factor adding to new graduates' dissonance would be the knowledge that their new role would involve experiences they had not yet encountered.

The importance of providing this information is emphasised by Festinger (1970, p.274) when he says:

Without the availability of others who are willing, and able, to exert influence in the direction which will reduce the dissonance created by the new situation, the ensuring dissonance reduction in the form of opinion change would not be able to occur so easily.

Discovering in what areas new graduates' dissonance is greatest will enable the educators to intervene and help reduce or eliminate the dissonance. It is also important to discover whether exposure to the new role helps to reduce or eliminate the dissonance over time. If, for example, the new nurse graduates reported that they felt inadequately prepared for

practice at graduation, but after 3 months work experience, reported that they felt their preparation was adequate, then this would suggest that the dissonance arose from the anxiety associated with commencing a new role. However, if the new nurse graduates' preceptions of the adequacy of their preparedness to begin practice do not change after 3 months work experience, then this would suggest that the dissonance exists between the graduates (oneself) and their environment.

VARIABLES

Independent variables.

1. Familiarity of practice environment. This variable has two levels: practice during the 3 months of the study in the same clinical setting as sixth semester continuous practice and work during the 3 months of the study in a different clinical setting from sixth semester continuous practice.
2. Previous nursing experience. This variable has two levels: previous nursing experience and no previous nursing experience.
3. Allocation of a preceptor. This variable has two levels: presence or absence of a preceptor during the 3-month interval of the study (Those nurses who had a preceptor were also asked whether their preceptor met their needs.)

Dependent variable.

1. Graduates' perceptions as measured by self-evaluation questionnaire.

ASSUMPTIONS

1. New graduates believe that a mismatch exists between their ability to begin practice and the expectations of their new employers.
2. New graduates will work in a clinical setting for at least 3 months following graduation.
3. Respondents to the questionnaire will answer truthfully and to the best of their ability.

CHAPTER IV

METHODOLOGY

STUDY DESIGN

This study used a descriptive, longitudinal survey design over a 3 month period. A questionnaire was devised which was a modified composite of The Delta Evaluation and The Nurse Competency Inventory (Ward and Fetler, 1979). The questionnaire was made up of 52 multiple-choice and 3 open-ended questions, to determine whether new graduates' perceptions of their preparedness to practice changed over time. The modifications for this questionnaire were made by the present researcher.

Detailed information regarding the validity and reliability of these instruments was not readily available to the present researcher. However a pilot study followed the questionnaire modifications to establish its reliability.

Seaman (1987, p. 185) points out that a descriptive design gives the researcher the scope to bring together a complex array of data, which can be compared, classified and described to give a holistic view of a phenomenon.

A longitudinal study was chosen because according to Brink and Wood (1988, p. 98) a longitudinal design allows for the examination of the same subjects over time, to determine whether changes occur. It also allows for continuity and control over the extraneous variables when a homogenous group is used, as it is with this present study.

A questionnaire survey was used to collect the data needed

for this study. This method of data collection is described by Macleod and Hockey (1989, p. 18) as providing the means of gaining access to a larger number of subjects than would be available in a case study. LoBiondo & Haber (1986, p. 130) add that it also allows the researcher to demonstrate how the study's findings can be applied to a larger population.

SAMPLE

The sample group was comprised of all the students who graduated with the Diploma of Health Science from Edith Cowan University at the end of Semester 1 for 1991.

There were 79 new graduate nurses in the group of which 74 were female and 5 male. All were eligible for registration with the Nurses Board of Western Australia.

INSTRUMENT

The questionnaire (Appendix A) was a modified composite of The Delta Evaluation and The Nurse Competency Inventory. (Ward and Fetler, 1979) It is comprised of 3 sections: The first asks questions related to planning nursing care, implementing nursing care (both general and specific), interpersonal relationships and communication (both patient-related and fellow health care workers), providing leadership and co-ordinating, and evaluating nursing care. (Table 1.) Participants were asked to rate their preparedness on a 5 point rating-scale, ranging from poorly prepared to excellently prepared. The second section asked for personal comments in response to 3 open-ended questions. The

third covers demographic data.

As the questionnaire was compiled from two American instruments and then modified to suit a Western Australian study, it was necessary to conduct a pilot study to determine its appropriateness and to establish its reliability. Five recent graduates from Edith Cowan University School of Nursing and the programme's sixth semester unit leader, were asked to review and comment on the proposed questionnaire. Adjustments were made in accordance with their comments and suggestions, which were as follows, bold type headings for each category; allowing room for adequate response to open-ended questions; completion time increased from 20 to 25 minutes; alteration to questions considered not appropriate to Western Australian practice e.g. conducts productive nursing care conferences, changed to participation in patient care planning at ward meetings.

PROCEDURE

Edith Cowan University School of Nursing Ethics Committee gave permission for this study to be undertaken. The names and addresses of the sample population were provided by the School of Nursing. It was not deemed necessary to seek approval from agencies, because the study involved the new nurse graduates' perceptions of their educational process only. The individual subjects were asked to participate on a voluntary basis and to sign a form indicating their agreement to participate (Appendix B).

Sections 1 and 2 of the questionnaire, with a covering letter (Appendix C) were posted to 79 subjects immediately after graduation, (July 16th 1991). As the reponse rate (32 replies) was poor, a reminder letter was sent on July 31st 1991. This increased the responses by 15, giving a total of 47 replies. Four questionnaires were returned unopened, indicating that these subjects had changed address.

After a 3-month interval, (on October 18th 1991) the same questionnaire, together with a covering letter (Appendix D) and additional demographic data questions, (Section 3) were posted to all respondents to the first questionnaire. Again the response rate was poor, with only 29 replies returned by October 30th. On this date the researcher telephoned the 19 first questionnaire respondents, who had not returned their completed questionnaires. This produced a further 5 replies, to give a total of 34 subjects who completed both questionnaires. One respondent withdrew from the study and one questionnaire was returned unopened.

ETHICAL CONSIDERATIONS

All participants received a covering letter (Appendix C) explaining the nature of the project, as well as details of its intended progress. The letter also pointed out the conditions of their involvement, which was purely voluntary with the option of withdrawing, at any time, without explanation or question.

The participants' anonymity was assured, as personal identification was not a requirement of the study. However each

questionnaire was coded to allow for a comparison to be made between the first and the second questionnaires. All returned questionnaires remained the property of the researcher and were destroyed on completion of the study.

The non-experimental, descriptive nature of this project posed no apparent risk to the participants.

LIMITATIONS OF STUDY

A methodological limitation of this study was that the sample consisted of only one graduating class of Edith Cowan University School of Nursing. This restricted the conclusions from this study to this sample only, thus limiting its generalisability.

Another limitation of this study was its use of new nurse graduates' self-assessment data only, as they may have been biased in their responses.

A further limitation, common in longitudinal studies, was subject attrition which can bias the results.

CHAPTER V

DATA ANALYSIS

Introduction.

This chapter will provide an interpretation of the results from this study. Included are the demographic particulars of the sample population, the analysis of the quantitative data associated with each research question, as well as a comparison between the quantitative results and the subjects' responses to qualitative open-ended questions. Finally an overview of the subjects' general comments will be presented.

Sample Characteristics

The 79 new nurse graduates from Edith Cowan University's first graduating group for 1991 were asked to assist with this study. Of these 60% (N=47) completed and returned the first questionnaire. Following a 3-month interval, the original respondents (N=47) were sent the second questionnaire and asked again to participate. The response to this request was 72% (N=34). This represented an overall response of 43% of the original respondents (N=47).

The demographic data collected from these participants showed that of the 34 subjects who answered both questionnaires, 32 were female and 2 were male. Their ages ranged from 21 to 41 years, with a mode of 21 years.

All respondents were employed during the 3-month interval,

predominately (76%,N=26) in major teaching hospitals. A total of 56% (N=19) of the respondents had had previous nursing experience, however 88% (N=30) were not working in the same clinical areas as their continuous practice clinical areas. Of the 56% (N=19) who were assigned a preceptor during the 3-month interval, 73% (N=14) felt the preceptor met their needs.

Quantitative Analysis

The Quantitative analysis of this study's data was undertaken using the Statistical Analysis System (SAS) and Minitab programmes. The study questionnaires' Section 1, used a 5 point scale to rate each question of its 7 categories. The scale-rating was from poorly prepared to excellently prepared. The 7 categories contained between 4 and 9 questions each, allowing for a minimum overall score for each category of between 4 and 9 and an overall maximum score of between 20 and 45.

Results of Research Questions

Question 1: Comparison between the two questionnaires.

The first research question asked, will there be a difference in newly graduated nurses' perceived level of preparedness between their graduation and 3 months after their graduation? A t-test was carried out on the overall scores from the first (\bar{M} =163.36) and second (\bar{M} =168.62) questionnaires showed that there was no significant difference in the perceived level of preparedness over time. $t(32)=0.56$, $p>.05$.

Question 2: Effects of continuity of clinical setting on perception.

This question asked: will nurses who begin work in the same clinical setting as their continuous practice setting perceive that they were better prepared for practice than nurses who begin work in a different clinical setting from their continuous practice setting? An interesting factor surfaced during this analysis, in that only 12% of respondents (N=4) worked in the same clinical setting as their continuous practice. In view of this small number, a t-test between the two groups was not possible. Therefore only the mean scores are presented. These showed that those graduates (N=30) who did not work in the same clinical setting as their continuous practice had a higher mean score on the questionnaire ($\bar{M}=171.7$) than those graduates (N=4) who did work in the same clinical setting as their continuous practice ($\bar{M}=145.3$). This suggests that those graduates who did not work in the same clinical setting as their continuous practice, perceived that they were better prepared for practice than those graduates who did work in the same clinical setting as their continuous practice. However this suggestion would need to be tested with a larger group.

Question 3: Effects of previous nursing experience on perceptions.

This question asked: will nurses with previous nursing experience perceive that they were better prepared for practice in their new role than nurses with no previous nursing experience? Because the various types of previous experience

(e.g. Enrolled nurse, Nursing assistant and Previous training) had very small N values, they were grouped together for ease of analysis. This made two groups: those with previous experience (N=19) and those without previous experience (N=15). Once again a t-test showed that no significant difference in perceptions occurred between those graduates with previous nursing experience ($\bar{M}=166.7$) and those graduates without ($\bar{M}=170.1$). $t(31)=0.36, p>.05$.

Question 4: Effects of a preceptor on perceptions.

This question asked: will nurses who had a preceptor assigned during the 3-month interval perceive that they were better prepared for practice than nurses without a preceptor? Of the group, 56% (N=19) had a preceptor assigned during their 3-month interval, and of this 56%, 74% (N=14) felt their preceptor met their needs whereas the remainder, 16% (N=5) did not perceive a significant difference. $t(12)=1.89, p>.05$.

Although this result was not significant, it approached significance and a further study with a larger group of subjects may find that the presence of a preceptor, who meets new graduate nurses' needs, affects their perceptions of their preparedness.

Question 5: Best and least prepared areas.

This question asked: in which areas did new nurse graduates perceive they were best and least prepared for practice as registered nurses?

As the results of research Question 1 showed, there was no

significant difference in perception between the two questionnaires. The larger response of the first questionnaire was thus used for the data analysis relating to this question.

To establish for which areas the subjects considered they were best and least prepared, a one-way repeated measures analysis of variance was carried out on the 7 categories of Section 1. of the questionnaire. (Table 1.)

TABLE 1.

QUESTIONNAIRE CATEGORIES

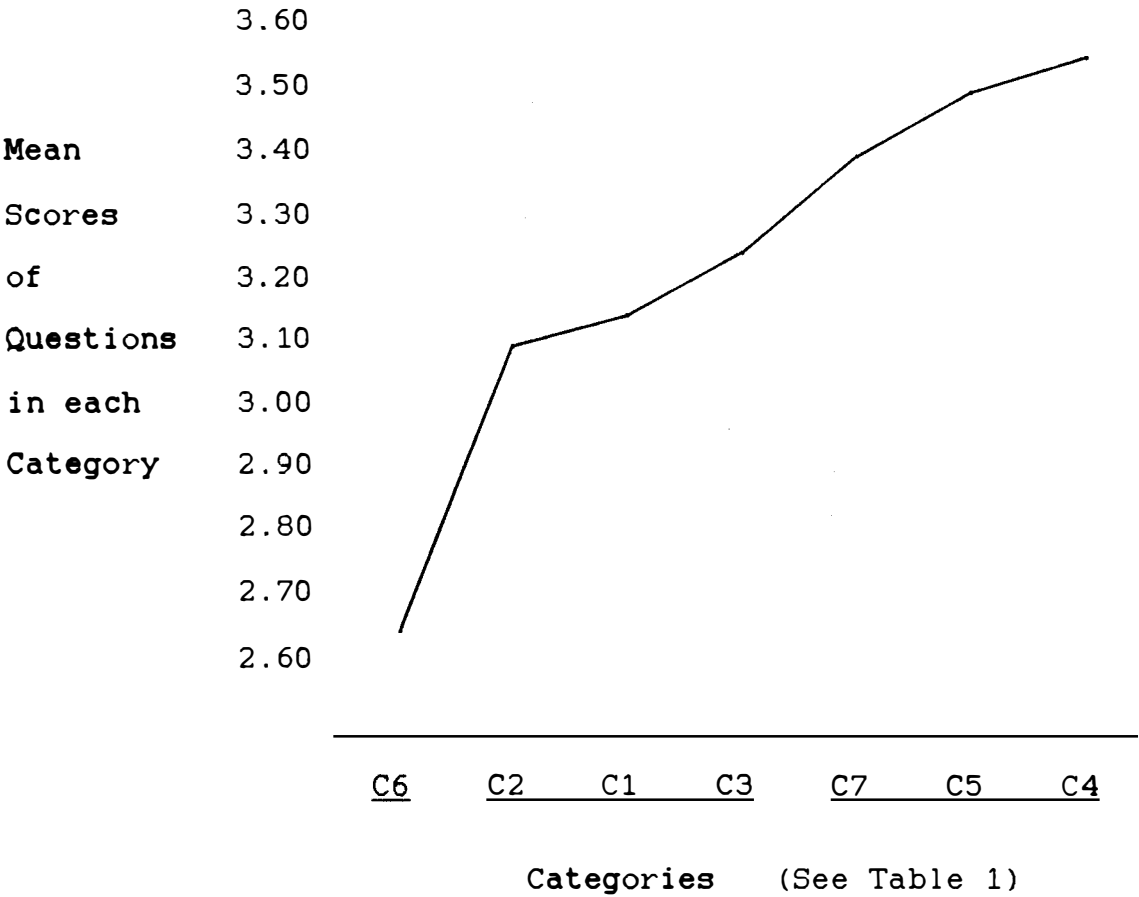
Category

1. Planning for Nursing Care
2. Implementing Nursing Care-General Applications
3. Implementing Nursing Care-Specific Applications
4. Interpersonal Relationships and Communication-Patient Relationships
5. Interpersonal Relationships and Communication-Relationships with Superiors
6. Carrying out Ward Procedures-Leadership
7. Evaluating Nursing Care

Figure 1 shows the gradient of the mean scores of each category, giving an indication of the range of perception between the categories from least to best areas of preparation. The mean scores were obtained by dividing the totals of each category by the number of questions in each of the categories.

FIGURE 1.

ONE-WAY REPEATED MEASURES ANALYSIS OF VARIANCE



Categories grouped non-consecutively to demonstrate cluster correlation.

The one-way repeated measures analysis of variance revealed a significant difference between the seven categories, $F(6,46)=32.90, p<.0001$.

It was found that the subjects rated themselves as significantly less prepared for Carrying out Ward Procedures-Leadership (Category 6) than for any of the other categories. The next highest preparedness score was, Implementing Nursing Care-General Applications (Category 2). The difference between Category 6 and Category 2 was significant, $F(1,46)=51.33, p<.001$.

The six highest categories fell into two clusters: Implementing Nursing Care-General Applications (Category 2), Planning for Nursing Care (Category 1) and Implementing Nursing Care-Specific Applications (Category 3) correlate and showed no significant difference between Category 2 and Category 3, $F(1,46)=2.77, p>.05$; and Evaluating Nursing Care (Category 7), Interpersonal Relationships and Communication- Relationships with Superiors (Category 5) and Interpersonal Relationships and Communication-Patient Relationships (Category 4) correlating with no significant difference between Category 7 and Category 4, $F(1,46)=2.04, p>.05$. However there was a significant difference between the two sets of categories. (Categories 1 and 7 were significantly different, $F(1,46)=13.9, p<.001$.)

The categories within the two clusters are shown to be both statistically and theoretically related. That is, Categories 2, 1 and 3, in the first cluster, are concerned with the Planning and Implementing of nursing Care, ie. practical skills, whereas

Categories 7, 5 and 4, in the second cluster, are concerned with verbal and written communication skills. (Table 1.)

Qualitative Data Analysis.

In the qualitative section (Section 2) of the questionnaire subjects were asked to comment on the areas they felt they were best and least prepared for. Many of the respondents did not use the same terminology as the author to describe specific areas of preparation, but described the areas they felt best and least prepared for practice in their own words. In order to simplify the data analysis and to connect the qualitative data to the quantitative data the present author collated the respondents comments with the 7 categories of the questionnaire.

As with the quantitative data, the responses to the two questionnaires were not significantly different. Therefore the data from the first questionnaire was used for this analysis.

Least Prepared Areas.

The subjects' quantitative responses were supported by the subjects qualitative comments. It was found that 19 subjects thought they were least prepared for practice in Carrying out Ward Procedures-Leadership (Category 6). Eighteen subjects thought they were least prepared for practice in Implementing Nursing Care-General Application (Category 2), and 15 subjects perceived they were least prepared for practice in Planning for Nursing Care (Category 1).

The remaining comments were made by only one or two

subjects, which may reflect individual concerns rather than general concerns. However for interest they are listed in Appendix E.

Best Prepared Areas.

The areas the subjects felt they were best prepared in included: Interpersonal Relationships and Communication-Patient Relationships (Category 4) (19 subjects), Interpersonal Relationships and Communication-Relationships with Superiors (Category 5) (14 subjects), and Evaluating Nursing Care (Category 7) (13 subjects). As with the responses to the least prepared areas, the remaining comments to this question were confined to one or two subjects and are listed in Appendix F.

General Comments.

Part of the questionnaires qualitative section (Section 2) gave the new graduates an opportunity to make comments on any aspect of their educational process.

Once again the responses of both questionnaires were not significantly different from each other and data from the first questionnaire was used in this section.

The most common response (37 comments) related to practical experience and patient contact, with comments such as the following:

...not enough emphasis was placed on practical knowledge and skills.

I feel more practical experience was required throughout

the course to reinforce theory taught.

More practical hours would have been beneficial.

I feel I needed 3 months practical instead of 5 weeks to consolidate my practical skills.

Increase time spent on wards.

Similar responses were found with the suggestions for change. Examples are:

...one continual week of practice instead of two days for four weeks.

More patients allocated during training would have been useful-instead of just being assigned to one patient.

...beneficial to have blocks of theory and practical, ie. 4 weeks of each.

The last semester should be all practice.

Some of the respondents also felt that pharmacology needed reinforcing in the clinical setting (4 respondents) and that practical skills should be tested in the clinical setting.(4 respondents)

While the majority of comments related to what the graduates thought was wrong with the programme, there were some positive comments, including:

Overall the programme is very good.

Very comprehensive.

...it was broad, and it opened new horizons for my thinking.

good basic knowledge which can be expanded upon.

The wide variety of comments given in response to this question could not be categorized into a few groups, therefore a more comprehensive list of comments is available in Appendix G.

Factor Analysis

The apparent grouping among the seven categories (see Table 1.) during analysis led to a factor analysis being performed on the data to ascertain whether there were 3 factors to reflect the 3 groups of categories shown in Figure 1. However the factor analysis showed only 1 factor with an eigen value greater than 1.(4.84). All categories loaded highly on Factor 1 (see Table 2). This showed good internal consistency in the questionnaire.

TABLE 2.

LOADINGS OF THE SEVEN CATEGORIES ON FACTOR 1

<u>Factor Pattern</u>	
<u>Categories</u>	<u>Factor 1</u>
C1	0.82
C2	0.91
C3	0.89
C4	0.85
C5	0.80
C6	0.66
C7	0.85

CHAPTER VI

DISCUSSION

Introduction

This study was an investigation of new nurse graduates' perceptions of their preparedness to commence practice as registered nurses, and whether their perceptions changed over time.

The results revealed that the new nurse graduates' perceptions did not change over the 3-month interval of this study. The study also revealed the areas in which new nurse graduates felt they were best and least prepared for practice.

Question 1: Change in perception over time.

The first research question was: Will there be a difference in newly graduated nurses' perceived level of preparedness between graduation and 3 months after graduation? A t-test comparing the two questionnaires showed no significant difference in the perceived level of preparedness over time. This suggests that the new nurse graduates' original perceptions were realistic.

It could be argued that a 3-month period would not be sufficient time to assess the adequacy of educational preparedness. However in the reality of a busy workplace, very little time is required by new nurse graduates to ascertain the effectiveness of their preparation for practice and it is

unlikely that their views would have altered greatly in another 3 or 6 months.

The theoretical basis for this study was Festingers' theory of Cognitive Dissonance.

During analysis of data it was found that the new nurse graduates' perceptions did not change over time, and that they continued to feel an inconsistency between their ability (oneself) to begin practice as registered nurses and their employers' expectations (environment).

It was argued earlier (page 24) that if the new nurse graduates' perceptions of inadequate preparedness disappeared following 3-months work experience, then it would suggest that the dissonance arose from the anxiety associated with commencing a new role. However if the new nurse graduates' perceptions of the adequacy of their preparedness to begin practice did not change after 3 months work experience, then it would suggest a dissonance existed between the graduates (oneself) and their environment. Therefore, as this study showed, the lack of significant change in the new graduates' perceptions over the 3-month interval of this study reinforces the premise that dissonance existed between the graduates' ability (oneself) and their employers' expectations (environment) and that their perceptions were not due merely to anxiety associated with commencement of a new role. Consequently it must be accepted that the dissonance is related to the graduates' preparation for practice, ie. educational process, and it is there that the intervention to reduce the dissonance should be focused.

Question 2: Effects of continuity of clinical setting.

The second research question concerned the effects on perception of continuity of clinical setting. It was found that only 12% of respondents worked in the same clinical setting as their continuous practice. This small number made analysis by t-test between the two groups impossible. A comparison of the mean scores suggested that those graduates who did not work in the same clinical setting as their continuous practice perceived that they were better prepared for practice than those graduates who did work in the same clinical setting as their continuous practice.

These results were surprising considering the study by Duncan (1987), which compared hospital based graduates with tertiary based graduates, and found that the hospital based graduates encountered less difficulty on entering the workforce, as registered nurses, than the tertiary based graduates. These results were attributed to the hospital based graduates being familiar with their environment, as would be expected in the case of new nurse graduates who worked in the same clinical setting as their continuous practice. Therefore the suggestion arising from the present study cannot be considered conclusive in regard to the effects of continuity of clinical setting on perceptions until retesting is carried out on a larger sample.

Unfortunately as with the study by Vanetzian and Higgins (1990) a high subject attrition reduced the generalisability of the present study's results. Perhaps researchers need to place greater emphasis on the importance of participation in studies

like this, to encourage more subjects to participate in studies relevant to the nursing profession.

Question 3: Effects of previous nursing experience.

Research question 3 was: Will nurses with previous nursing experience (ie. as Enrolled Nurses, Nursing Assistant or with Previous training) perceive that they were better prepared for practice than nurses with no previous nursing experience? A t-test comparing the two groups (nurses with previous experience and nurses without previous experience) showed no significant difference in perceptions of preparedness between the two groups. This indicates that previous nursing experience did not influence the new nurse graduates' perceptions. However, an effect on this variable, that had not previously been considered, was the manner in which the subjects interpreted the questionnaire. For instance, the subjects may have answered the questionnaire in relation to their course content or they may have answered the questionnaire in relation to the influence of past experience as well as the course content. That is, they may have asked themselves, "How well did the course prepare me?" or they might have asked themselves, "How well am I now prepared as a result of the course and any other experience I might have had?" It was this second example that was the authors intended meaning for the research question, to determine the effects of previous experience on perceptions.

Therefore further research, including these issues, is needed for a more accurate assessment of this variable to be

obtained.

Question 4: Effects of a preceptor on preceptions.

Research Question 4 was: Will nurses who had a preceptor assigned during the 3 month interval perceive that they were better prepared for practice than nurses without a preceptor? Of the group, 56% had a preceptor assigned. A t-test between the nurses who felt their preceptor met their needs and the nurses who did not feel their preceptor met their needs, revealed no significant difference. As it happens the results did approach significance, which suggests a further study on a larger group of subjects may provide information showing preceptor allocation as a positive influence on new graduates' perceptions. A study by Shogan, Prior and Kolski (1985) found preceptor programmes provided new graduates with the opportunity to improve their knowledge base and clinical skills, while making the transition into the workforce less stressful. Therefore further research into this area is needed to validate the effect preceptor allocation has on the new nurse graduates' perceptions.

Question 5: Best and Least prepared areas.

Research Question 5 was: In which areas did new nurse graduates perceive they were best and least prepared for practice as registered nurses? A one-way repeated measures analysis of variance indicated that new nurse graduates perceived that they were least prepared for Carrying out Ward Procedures-Leadership (Category 6). This category involved ward

co-ordination, staff delegation and peer evaluation, skills many of the new nurse graduates said they had little or no experience with, prior to commencing work as a registered nurse. Yet in some cases they were expected to take on these responsibilities shortly after commencing work on the ward.

The remaining categories of the questionnaire fell into two clusters. The first cluster included the areas of Implementing Nursing Care, both General and Specific (Categories 2 and 3) and Planning for Nursing Care (Category 1). The second cluster contained Evaluating Nursing Care (Category 7) and Interpersonal Relationships-Communication, both Patient and Superior related (Categories 5 and 4).

The categories of the first cluster are all associated with providing patient care, for the planning of specific care to its implementation. As was found in the study by Ziv et al.(1990), the new nurse graduates from this present study, felt they needed more time during their educational process, to practise in the clinical setting the procedural skills and problem solving techniques required for the planning and implementation of patient care.

The second cluster contained the categories which centred on communication skills, both verbal and written. It was in these areas that the new graduates felt they were best prepared. The subjects said that being able to communicate well enabled them to develop a good rapport with their peers, patients and other health care workers. It also allowed them to improve their body of knowledge as well as seek assistance when necessary.

QUALITATIVE DATA

Least and Best Prepared Areas

The comments on the least and best areas of preparedness provided by the subjects that were collated into the seven categories of the questionnaire corroborated the statistical results.

It was the area of Carrying out Ward Procedures-Leadership (Category 6) that rated the least well prepared area for the subjects. Many of the comments focused on ward co-ordinating and management skills, which the subjects felt they had little or no experience with. This was followed by the areas of Planning and Implementing Nursing Care, where many of the graduates felt that their preparation, during their educational process, was disjointed or not long enough. They also commented on the difficulty in dealing with full patient loads and emergency situations, neither of which were experienced during their education. Wierda (1989) refers to this phenomena as reality shock, which is what new nurse graduates experience on moving from the relatively protected environment of a student to the real world as a registered nurse, only to find their preparation not meeting their own or their employers' expectations.

Interpersonal Relationships-Communications, and Evaluating Nursing Care were the areas that the subjects felt they were best prepared in. They remarked that their educational process gave them the ability to write concise and accurate documentation. The subjects also indicated that the

communication skills they acquired during their course enabled them to develop good professional relationships with patients and colleagues.

General Comments.

The general comments from the qualitative section (Section 2) of the questionnaire, were focused mainly on the lack of practical experience and patient contact during their course. With many suggestions for change also relating to the length of time allocated to clinical practice. These comments and suggestions are comparable to those made in the studies by McArthur et al. (1981) and Mackay et al. (1981), in which the graduates perceived that their main problems were concerned with the clinical practice areas, in particular, their ability to perform organisational, administrative and technical skills.

Summary

Ongoing evaluation of nursing education programmes is essential to ensure that the education provided is congruent with the professional practice settings in which it will be applied.

The aim of this study was to survey a group of new nurse graduates and ascertain their views about their preparedness to begin practice as registered nurses. Festingers' theory of Cognitive Dissonance was used as the theoretical framework.

It was established that the perceptions of the 34 new nurse graduates surveyed, did not change over time. It was also

revealed that new nurse graduates felt they were least prepared for practice in the area of Carrying out Ward Procedures- Leadership, followed by Planning and Implementing Nursing Care. The new nurse graduates also decided that they were best prepared for practice in the areas of Interpersonal Relationships- Communication and Evaluating Nursing Care. The subjects of this study provided a variety of suggestions for change, aimed at overcoming the perceived problem areas for future nurse graduates.

Implications for Nursing Practice

Implications for nursing practice, based on the conclusions drawn from this study, are in the areas of clinical practice for nursing students and educational programme reviews.

1. Increase or modify the hours allocated to clinical practice. The new nurse graduates involved in this study felt that their clinical practice was often too short or disjointed. It was perceived that to be educationally well prepared for entry into the workforce, as registered nurses, a greater exposure to clinical areas is needed.
2. Include new nurse graduates' evaluations when reviewing educational programmes. It is essential for the ongoing maintenance and development of educational programmes to include up-to-date information from a reliable and informed source. Feedback from the recipients of such an educational process should provide valid and hopefully reliable information.

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APPENDIX A

The following questionnaire contains a series of statements describing elements of nursing care. Read each one, evaluate the extent to which you feel you were prepared by your nursing education programme, to successfully perform in these areas. Circle the number that best reflects your evaluation.

Try to avoid the tendency to mark all columns alike on the basis of a general impression about your education. Try to distinguish strengths and weaknesses as you see them.

Ratings of individuals will be held in strict confidence and will not be seen by anyone other than the researcher.

RATING SCALE

1. I feel I was/am poorly prepared.
2. I feel I was/am less than adequately prepared.
3. I feel I was/am adequately prepared.
4. I feel I was/am more than adequately prepared.
5. I feel I was/am excellently prepared.

PLANNING FOR NURSING CARE

- | | | | | | |
|---|---|---|---|---|---|
| 1. Identify patients' needs, taking into account the significant factors such as, illness, age, general condition, treatment plan, religion, cultural background. | 1 | 2 | 3 | 4 | 5 |
| 2. To recognise the priority of needs for a patient. | 1 | 2 | 3 | 4 | 5 |
| 3. To assess the condition of a patient accurately. | 1 | 2 | 3 | 4 | 5 |
| 4. To initiate and write (if required) a plan of care to meet the needs of the patient. | 1 | 2 | 3 | 4 | 5 |

5. To anticipate the usual pattern of patient progress in a specific condition.	1	2	3	4	5
6. To recognise the life threatening situation.	1	2	3	4	5
7. To use the techniques of problem solving in nursing care planning.	1	2	3	4	5
8. To co-ordinate the plan of nursing with the medical plan of care.	1	2	3	4	5
9. To make appropriate decisions for implementation of nursing care.	1	2	3	4	5

IMPLEMENTING NURSING CARE

General Applications

1. To take appropriate nursing actions to meet priority needs exhibited.	1	2	3	4	5
2. To apply knowledge of anatomy and physiology to patient care.	1	2	3	4	5
3. To take appropriate nursing actions to compensate for altered physiology in disease.	1	2	3	4	5
4. To apply facts and principles of nutrition to patient care.	1	2	3	4	5
5. To make use of comfort or nursing care measures until medical orders can be obtained.	1	2	3	4	5
6. To recognise a patient's response to illness and therapy.	1	2	3	4	5
7. To carry out medical orders or nursing care procedures correctly despite difficulties.	1	2	3	4	5
8. To modify nursing procedures to ensure more effective nursing care.	1	2	3	4	5
9. To carry out nursing care calmly and efficiently under stress.	1	2	3	4	5

- | | | | | | |
|---|---|---|---|---|---|
| 10. To direct patients and families to the appropriate community resources. | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|

IMPLEMENTING NURSING CARE

Specific Application

- | | | | | | |
|---|---|---|---|---|---|
| 1. To prepare patients for their medical and surgical treatments physically and psychologically. | 1 | 2 | 3 | 4 | 5 |
| 2. To explain diagnostic tests and nursing procedures to the patient as indicated. | 1 | 2 | 3 | 4 | 5 |
| 3. To prepare patients physically for diagnostic procedures. | 1 | 2 | 3 | 4 | 5 |
| 4. To administer medications safely to patients. | 1 | 2 | 3 | 4 | 5 |
| 5. To take immediate and appropriate action in an emergency. | 1 | 2 | 3 | 4 | 5 |
| 6. To implement nursing action to support vital functions, e.g. cardio-pulmonary resuscitation. | 1 | 2 | 3 | 4 | 5 |
| 7. To carry out commonly occurring techniques for patient care: oral suction, oxygen administration, tracheostomy care, intravenous therapy, tractions, catheterisation, nasogastric tube, ostomy care. | 1 | 2 | 3 | 4 | 5 |
| 8. To recognise legal limits and their implications for nursing practice. | 1 | 2 | 3 | 4 | 5 |

INTERPERSONAL RELATIONSHIPS AND COMMUNICATION

Patient Relationships

- | | | | | | |
|--|---|---|---|---|---|
| 1. To tactfully handle difficult situations with patients. | 1 | 2 | 3 | 4 | 5 |
|--|---|---|---|---|---|

- | | | | | | |
|---|---|---|---|---|---|
| 2. To keep information about patients confidential despite pressure to divulge it. | 1 | 2 | 3 | 4 | 5 |
| 3. To provide and assist in the religious and spiritual needs of patients and families. | 1 | 2 | 3 | 4 | 5 |
| 4. To adapt explanations to patient's understanding. | 1 | 2 | 3 | 4 | 5 |
| 5. To effectively teach principles of home health care to the patient and to the family of the patient. | 1 | 2 | 3 | 4 | 5 |
| 6. To teach or initiate teaching of patients whose lifestyle will be altered. | 1 | 2 | 3 | 4 | 5 |
| 7. To be reassuring, kind and considerate to the patient. | 1 | 2 | 3 | 4 | 5 |

INTERPERSONAL RELATIONSHIPS AND COMMUNICATION

Relationships with Superiors

- | | | | | | |
|--|---|---|---|---|---|
| 1. To accept suggestions for self improvement. | 1 | 2 | 3 | 4 | 5 |
| 2. To need minimal guidance in adjusting to new situations. | 1 | 2 | 3 | 4 | 5 |
| 3. To consult and co-operate with physicians and others in planning health care programmes. | 1 | 2 | 3 | 4 | 5 |
| 4. To be tactful in handling difficult situations with superiors, e.g. questioning medical orders and/or nursing measures which may appear unsafe. | 1 | 2 | 3 | 4 | 5 |
| 5. To seek assistance when needed. | 1 | 2 | 3 | 4 | 5 |

CARRY OUT WARD PROCEDURES - PROVIDING LEADERSHIP

Acting as Co-ordinator

- | | | | | | |
|--|---|---|---|---|---|
| 1. To efficiently co-ordinate nursing care for a group of patients. | 1 | 2 | 3 | 4 | 5 |
| 2. To be fair and considerate in directing the work of others. | 1 | 2 | 3 | 4 | 5 |
| 3. To organise patient care so as to complete treatment and care on time. | 1 | 2 | 3 | 4 | 5 |
| 4. To delegate tasks to personnel most able to perform them. | 1 | 2 | 3 | 4 | 5 |
| 5. To participate in patient care planning at ward meetings. | 1 | 2 | 3 | 4 | 5 |
| 6. To assume leadership and management responsibilities as needed. | 1 | 2 | 3 | 4 | 5 |
| 7. To devise or suggest new techniques for the welfare of patients or for ward efficiency. | 1 | 2 | 3 | 4 | 5 |
| 8. To promote improvements in nursing practice and nursing education. | 1 | 2 | 3 | 4 | 5 |
| 9. To assist others in recognising their strengths and dealing with their limitations. | 1 | 2 | 3 | 4 | 5 |

EVALUATING NURSING CARE

- | | | | | | |
|--|---|---|---|---|---|
| 1. To interpret vital signs in terms of the different illnesses and health problems for various ages. | 1 | 2 | 3 | 4 | 5 |
| 2. To recognise gross or subtle changes in patient's conditions and select appropriate actions as indicated. | 1 | 2 | 3 | 4 | 5 |
| 3. To report situations accurately despite reflection on self, i.e. accountability. | 1 | 2 | 3 | 4 | 5 |
| 4. To write clear, concise, pertinent and accurate notes on patients. | 1 | 2 | 3 | 4 | 5 |

1. What do you consider to be the area(s) in which you feel you were best prepared. (State one of the previous areas mentioned or any other area that may not be included in this questionnaire.)

2. What do you consider to be the area(s) in which you feel you were least prepared. (State one of the previous areas mentioned or any other area that may not be included in this questionnaire.)

3. Briefly state any other comments you wish to make about your formal educational programme.

DEMOGRAPHIC DATA

Please answer all questions, unless specified otherwise, by circling the number that is most applicable to your situation.

1. Are you working in the same clinical (ward and hospital) as was assigned for your continuous practice?

Yes 1.

No 2.

2. Do you have a preceptor assigned to you?

Yes 1.

(Go to Question 3.)

No 2.

(Go to Question 4.)

3. Does your preceptor meet your needs?

Yes 1.

No 2.

4. Have you had previous nursing experience as:

Enrolled nurse. 1.

Nurse assistant. 2.

Other(please specify) 3.

5. What type of Institution do you work in:

Major Teaching Hospital. 1.

Smaller Suburban Hosp. 2.

Country Hospital. 3.

Other (please specify) 4.

6. Personal Particulars.

a) What year were you born? 19__

b) Your sex is? (M) 1. (F) 2.

APPENDIX B

I(the participant) have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising I may withdraw at any time.

I agree that the research data gathered for this study may be published provided my name is not used.

Participant

Date

Investigator

Date

APPENDIX C

Vicci Lodge
[REDACTED]

Dear

I, like you, have recently completed the Diploma of Health Science (Nursing) at Edith Cowan University. Currently I am undertaking the Bachelor of Health Science (Nursing) in the Honours programme. An element of this programme involves implementing and conducting a research project. For my project I have chosen to survey a group of new graduate nurses to evaluate their perception of their preparedness to commence practice as registered nurses. I am asking for your assistance with this project.

Your participation in this project would require you to answer a questionnaire on two separate occasions. The first, following graduation, but prior to commencing work as a registered nurse, and the second after three months in the workforce.

The questionnaire consists of 55 questions relating to your educational preparation, 52 questions have multichoice answers and 3 are open-ended questions, to allow for further comments. The questionnaire should take approximately 25 minutes to complete.

The information you provide will be treated with the strictest confidence with no connection made between you and the data presented. The questionnaire will be coded to allow for follow-up of non-respondents, distribution of the second questionnaire, and comparison of results.

It is anticipated that the information gained from this study will assist future new graduates to move from the role of student to that of registered nurse, with less concern about their ability to practice.

Your participation would be on a purely voluntary basis and you may withdraw from the study at any time without the need for an explanation or question. However it is a requirement of Edith Cowan University, for the participant of any research project to sign the attached agreement to participate form and return it to the researcher. If you require any further information or have any questions concerning this project, please do not hesitate to contact me on [REDACTED]. Thank you for anticipated participation and best wishes for your future in nursing.

Yours faithfully

Vicci Lodge.

APPENDIX D

Vicci Lodge
[REDACTED]

17.10.91.

Dear

Thank you for your assistance with the first component of my research project and yes it's time to answer my second questionnaire.

As you know the second semester of Edith Cowan University finishes in November, which means my research also needs to be completed and reported on by then, it is because of this time limit that I am asking you to complete and return this questionnaire to me by October 31st.

In addition to the original questionnaire you will find a section asking for information on your workplace and previous experience. This additional information is necessary to determine the influence these variables may have had on your perception.

Once again I'd like to remind you, that the information you provide will be treated with the strictest confidence, with no connection made between you and the data presented. Also remember that your participation is on a purely voluntary basis and you may withdraw from the study at any time without the need for an explanation or question. If you require any further information or have any questions concerning this project, please do not hesitate to contact me on [REDACTED]

The information provided in the first questionnaire was very pleasing, particularly the comments within the open-ended section. I'm looking forward to a similar response to the second questionnaire.

Lastly, if you are interested in the research outcome, let me know and I will provide a report summary, either later this year or early next year. Please tick the box at the bottom of the demographic information page.

Yours faithfully

Vicci Lodge.

APPENDIX E

COMMENTS ON LEAST PREPARED AREAS

Medication administration.

Anatomy and physiology.

Time management.

Taking on full patient loads.

Communications with other health professionals.

Emergency procedures.

Basic nursing care.

Problem solving.

Acting independently.

Recognition of signs and symptoms of disease process.

Dealing with difficult patients.

Discharge planning.

Ward rounds and meetings.

Health teaching.

Health science.

Patient assessment.

I.V. therapy.

APPENDIX F

COMMENTS ON BEST PREPARED AREAS

Sterile procedures.

Planning nursing care.

Basic nursing skills, T.P.R. and B.P., showering patients.

Organizing patient care.

Understanding the needs of patients.

Legal issues.

Anatomy and physiology.

Holistic care.

Pathophysiology.

Scientific principles.

Pharmacology.

Ability to increase knowledge of nursing.

Problem solving.

Researching literature.

Writing assignments.

Physical assessment.

Behavioural science.

Health care teaching.

Self evaluation.

Confidentiality.

Time management.

Ability to cope with an emergency.

Psychiatry.

Professionalism.

Medication administration.

Accountability.

APPENDIX G

GENERAL COMMENTS

Too much behavioural sciences.

Not enough responsibility as students.

Too much emphasis placed on psychiatric and community nursing.

Hospital staff need educating re students ability.

Student presented tutorials need to be checked by lecturer for accuracy.

A lot of worthwhile pharmacology taught but not reinforced.

Overall course was well set-out and informative and prepared us for taking on employment as registered nurses.

Have not applied computing knowledge to the hospital environment.

Increase patient allocation during training would be beneficial.

Last five weeks continuous practice taught me more than all my other training.

Drug calculations need to be emphasized more.

Electives should be nursing orientated to benefit from those units.

Practice should be introduced into training earlier.

Course was very theoretical and was based on "model nursing" not nursing as it is today, ie. a suppressed profession.