

**THE COMPETENCIES OF NEWLY QUALIFIED NURSES AS VIEWED BY  
SENIOR PROFESSIONAL NURSES**

**by**

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**NOVEMBER 1996**

## **DECLARATION**

I declare that "The competencies of newly qualified nurses as viewed by Senior Professional Nurses" is my own work and all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

**LUNIC BASE KHOZA**

## SUMMARY

Descriptive surveys were employed to investigate the competencies of newly qualified nurses (NQNs) as viewed by senior professional nurses (SPNs). The study used questionnaires for collecting data. Questionnaires were delivered by the researcher and also collected by the researcher after completion. SPNs working at thirteen hospitals, that is, six in the former Gazankulu, three in the former Venda, and four in the former Lebowa health services (falling within the Northern Province of the RSA since April 1994) constituted the subjects of this study. Scientific sampling techniques were not employed as the total population of 396 SPNs was studied. This study obtained responses from 259 SPNs.

Findings indicated that specific cognitive, affective and psychomotor competencies were expected of NQNs upon entering the work setting, as perceived by SPNs. NQNs were perceived to be competent in performing numerous, but not all, clinical competencies which were outlined in the four groups' questionnaires.

Application of stages of the nursing process (problem solving and clinical judgement), research, management and administration of a clinical unit, nursing ethics and critical care were perceived by the SPNs to be the central focus of NQNs' incompetency in all four clinical nursing units, namely community, psychiatric, midwifery and general units. Nevertheless, SPNs were aware that they should provide guidance and support to NQNs.

An attempt to elicit SPNs' views on the competencies NQNs should have in the practical

situation, could benefit NQNs at grassroots level. Such information could provide curriculum developers with realistic input which would assist in the delineation and refinement of the professional competencies expected of nurses trained in the comprehensive course leading to registration as a nurse (general, psychiatric, and community) and midwife. The identified competencies could improve the quality of care and the nursing standards if they could be mastered by NQNs in the health services included in this research.

On the basis of these research findings, the expected competencies, which were perceived by the SPNs to be incompetently performed by NQNs, were used to compile an orientation list of competencies to be mastered by NQNs in their first professional position (Annexure D).

## **KEY TERMS**

Ability

Capability

Competency

Competency-based teaching

Efficiency

Essential skills

Perceived cognitive, affective and psychomotor competencies

Proficiency

Quality

Skill performance

## ACKNOWLEDGEMENTS

“Praise the Lord, O my soul, and forget not all His benefits” Psalm 103:2.

I am dedicating this thesis to my husband, whose love and support have made it possible for me to achieve self-actualisation.

My children, you made my dream a reality in many ways.

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**ABBREVIATIONS**

The following abbreviations were used in this study:

ANC	Ante natal care
BA (CUR)	Bachelor of Arts in Nursing Science
BP	Blood pressure
CAE	College of advanced education
HMC	Health matters committee
HSJMs	Highly skilled judgement makers
IV	Intravenous
IVP	Intravenous pyelogram
NQNs	Newly qualified nurses
OPD	Out patient department
PAS	Personnel administrative standards
PHC	Primary health care
RHOSA	Regional health organisation of Southern Africa
RSA	Republic of South Africa
SANA	South African Nursing Association
SANC	South African Nursing Council
SPNs	Senior professional nurses
TPR	Temperature, pulse, respiration
UK	United Kingdom

**USA**      **United States of America**

**GOBIFFF+F**    **This is an abbreviation of the following aspects:**

**G**      **Growth monitoring**

**O**      **Oral rehydration**

**B**      **Breast feeding**

**I**      **Immunisation**

**F**      **Family spacing**

**F**      **Food supplement**

**F**      **Female education**

**F**      **First Aid**

**UNISA**      **University of South Africa**

**THE COMPETENCIES OF NEWLY QUALIFIED NURSES  
AS VIEWED BY SENIOR PROFESSIONAL NURSES**

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**DECLARATION: CHANGE OF RESEARCHER'S NAME**

I, LUNIC BASE KHOZA, confirm that I was formerly registered at the University of South Africa as LUNIC BASE LOWANE. I have subsequently remarried, and have now registered under my new name.

**LUNIC BASE KHOZA**

## CHAPTER 1

### INTRODUCTION AND BACKGROUND OF THE PROBLEM

#### 1.1 INTRODUCTION

Nursing as defined by the South African Nursing Council (SANC 1992:3) is a caring profession which enables and supports the patient, ill or well, so as to achieve and maintain optimum health. Nursing in the Republic of South Africa (RSA) is practised by persons who are registered or enrolled in terms of Section 16 of the Nursing Act, 1978 (Act 50 of 1978) and whose practice has been tested for competency. Thus, all newly qualified nurses (NQNs) are expected to provide competent nursing care to their patients/clients.

Nursing education as a system of equipping nurses with essential competencies "is specifically directed at the development of the nursing student as an adult on a personal and professional level and should lead to cognitive, affective and psychomotor development of the student" (SANC 1992:3). Competency, therefore, is the expected outcome of the system. Nursing programmes worldwide strive to enhance the quality of NQNs with regard to their effective functioning in health care settings. Upon completion of their training, NQNs are expected to have developed analytic styles, critical, evaluative and creative thinking, and the continuing stimulation of the capacity to interpret scientific data for nursing actions, to draw conclusions and to exercise independent judgement (SANC 1992:3).

In the clinical setting, the responsibility for all nursing care rests with the professional nurse. Clinical competency demands the acquisition of higher level behaviours in the cognitive, affective and psychomotor domains of learning. Boggs, Baker & Price (1987:35) in Ohio assert that

competency implies skills, talents, knowledge and understanding that transcend specific tasks and is guided by a commitment to ethical principles. They further indicate that professional competency includes technical competencies. Scheetz (1989:29) in Newburgh, New York, expresses the opinion that clinical competency is "germane" to professional nursing practice. Fitzpatrick, While & Roberts (1992:1210-1211) in England, review literature which reveals a range of the nurse's subroles within the service of nursing. They support the view that competency in psychomotor, cognitive and affective competencies is required for performance within each of these subroles to achieve the delivery of high quality nursing:

- ▶ use of the nursing process;
- ▶ use of research in practice;
- ▶ communication competencies;
- ▶ care management and organisation of workload; and
- ▶ the role of the nurse in health education.

Universally, student nurses are prepared for competency. McGaghie, Miller, Sajid & Telder (1978:18) in Geneva describe a competency-based curriculum organised around three fundamental aspects:

- ▶ required functions (or competencies) for the practice of nursing in a specified setting;
- ▶ the empirically validated principle that students, when given appropriate instruction, can all master the prescribed basic performance objectives;
- ▶ education as an experiment where both the processes of student learning and the techniques used to produce learning are regarded as hypotheses subject to testing.

These statements indicate that the intended output of a competency-based programme is a health professional who can practise nursing at a defined level of proficiency.

*Use the Denver Act*

The programme objectives stipulated in the SANC's Regulations (R425 of February 1985) for the course leading to registration as a nurse (general, community and psychiatric) and midwife, exemplify competency-based education. The curriculum aims at providing for the personal and professional development of the nurse so that, on completion of the course she

- ▶ shows respect for the dignity and uniqueness of man in his socio-cultural and religious context;
- ▶ is skilled in the diagnosing of man's health problems, the planning and implementing of therapeutic action and nursing care for the individual;
- ▶ is able to direct and control interaction with patients;
- ▶ is able to maintain the ethical and moral codes of the nursing profession;
- ▶ is able to collaborate harmoniously within the nursing and multidisciplinary team;
- ▶ is able to delineate her own practice according to personal knowledge and skill;
- ▶ displays an enquiring and scientific approach to the problems of practice;
- ▶ is able to apply the principles of management in a nursing unit;
- ▶ is able to provide clinical teaching within the nursing unit;
- ▶ has the cognitive, psychomotor and affective competencies to serve as a basis for effective practice and for continuing education.

Swendsen Boss (1985:8-9) in Utah, USA, describes competency-based education as having the following characteristics:

- ▶ competencies guide educational planning; each competency describes the desired behavioural outcome;
- ▶ competencies are derived from roles and emphasise performance rather than knowledge;

the competency emphasises how the nurse will use her acquired knowledge in the client care setting; the competency is always stated in such a way as to answer the question, "What will the nurse be doing with the client?";

- ▶ competencies emphasise clinical judgement, not just psychomotor competencies; clinical competency is not simply the performing of competencies.

NQNs in the clinical setting are expected to be competent in problem-solving, administration and management of activities, applying clinical judgement, researching nursing problems, teaching both patients and nurses, promoting good interpersonal relationships/communications, caring, applying ethical principles, and applying both technical and manual competencies (Du Preez 1990:27; Girot 1993:117; Holden & Klingner 1988:23; Matthews 1982:11; Sanford, Genrich & Nowotny 1992:72; Searle 1986:51; Swendsen Boss 1985:8).

*professional responsibility*

Research has indicated that many NQNs are neither competent nor confident in all these areas of their new role. Assertions of the NQNs' low self-concept and lack of commitment in their perceived roles also continue to occupy considerable space in the literature on nursing. Hughes, Wade & Peters (1991:69) in Dallas, USA, and Cantor, Schroeder & Kurth (1981:17) in Iowa, USA, assert that NQNs may frequently come to their first work experience with marked discrepancies between what they feel capable of doing and what is expected of them. Kramer in McCloskey (1985:896) in the USA indicates that NQNs are expected to assume full responsibility almost immediately upon graduation. Vanetzian & Higgins (1990:269) cite Benner & Wrubel's view (1982) that it is essential to know when the NQN is performing nursing activities at a satisfactory level. If the transition from student nurse to professional nurse is a developmental process, then nursing education programmes must determine the part that it will play in the NQN's

preparation for practice.

Brown & Jaros (1990:19) indicate that although there is a clear definition of purpose for clinical nursing practice in the RSA, it is not always correctly interpreted by clinicians, managers and educators, and despite a legislated and well circumscribed scope of practice distinguishing the role of the registered nurse from that of other categories of nurses, ambiguity in role descriptions in the actual practical situation prevails.

This study is therefore undertaken to endeavour to identify the expected competencies of NQNs upon entering the work setting. It will attempt to identify competencies of NQNs in cognitive, affective and psychomotor competencies in the work setting, as viewed by senior professional nurses (SPNs). The teaching guide for the programme leading to registration as a nurse (general, psychiatric and community) and midwife also emphasises that "the school should identify the critical nursing skills in which the student must achieve competence in order to assume responsibility for the nursing regimen" (SANC 1992:7). It is, however, only realistic to assume that NQNs are novices in the real practice situation. They still need mentoring by their seniors. A delineated list of competencies (based on the needs of NQNs as perceived by SPNs), perceived by SPNs to be unsafely, incompetently or inadequately performed by NQNs, should be developed to form the basis of orientation programmes for the general, psychiatric, midwifery and community clinical nursing units. Such lists could be used to evaluate the competencies of NQNs in their first professional positions.

## 1.2 MOTIVATION

### 1.2.1 Introduction

In 1985 the regulation and the directives of the course for the education and training of a nurse (general, community and psychiatric) and midwife, leading to registration with the SANC were published (R425 of February 1985). NQNs referred to in this study have completed this training programme to register as professional nurses. The study done by Troskie (1993:50) to critically evaluate the NQN's competency to practise in the RSA, indicates that the competency of the NQN practitioner in the RSA could be regarded as being questionable.

Discussions were held by the South African Nursing Association (SANA) and South African nurse educators' associations regarding the clinical competency of the NQN who has followed the comprehensive (R425) course (SANA Minutes May 1991). Problems identified with the implementation of the programme include:

- ▶ clinical competencies of NQNs have not been identified;
- ▶ poor student accompaniment;
- ▶ lack of teaching in the wards; and
- ▶ lack of continuous supervision (SANA Minutes May 1991).

This study will attempt to investigate the first of these four problem areas, namely identifying the competencies of NQNs as perceived by SPNs.

The Health Matters Committee (HMC) of the RSA, and Regional Health Organisation of South Africa (RHOSA) drafted a memorandum on certain nursing issues in need of attention (RHOSA Memorandum 4 August 1992), to focus the attention of the HMC sub-committee on nursing on certain concerns expressed by members. The concerns expressed by members during committee

meetings included the following,

- ▶ midwives were poorly prepared to do midwifery after the four-year course in comparison with those who had done the one-year midwifery course;
- ▶ the general nursing training did not produce diplomates who could handle practical procedures adequately in the general nursing clinical units; and
- ▶ the integrated-course nurses were perceived to have inadequate knowledge for rendering community health services (RHOSA Memorandum 4 August 1992).

On the basis of the identified problems, the HMC recommended a re-evaluation of the basic approach, re-introducing a practical-based training with a stronger academic emphasis, but in one specialist area. This implied that at the end of the training period, NQNs would be thoroughly prepared to specialise in one specific area, that is, in general nursing, psychiatric nursing, community nursing or midwifery (RHOSA Memorandum 4 August 1992).

In reply to this memorandum, the sub-committee of the HMC issued a memorandum which stated that "with regard to the four-year integrated training programme a large percentage of graduates are coping well with the realities of nursing practice, be it in general, psychiatric, community health nursing, or midwifery" (Memorandum to the HMC/RHOSA Committee 4 March 1993). Nevertheless, this might also imply that the competency discrepancies affect specific regions or specific health services only.

Interactions between the HMC and the sub-committee on nursing indicated a need for research to ascertain whether NQNs were competent professional nurse practitioners upon completion of the R425 course. This study, similar but not identical to Troskie's study (1990), intends to further

*none is midwifery competent*

investigate SPNs' views of the competencies of NQNs in the general, psychiatric, community and midwifery nursing units, in the former areas of Venda, Gazankulu and Lebowa (falling within the Northern Province since 1994).

### **1.2.2 The importance of maintaining NQNs in the nursing services**

According to the World Health Organisation (WHO) the present health delivery system, namely "Health for all by the year 2000", is based on primary health care, which necessitates comprehensive nursing training to enable a nurse to render preventive, promotive, curative and rehabilitative services which provide for all man's health needs, from before birth till death (Dennill, King, Lock & Swanepoel 1995:80-82). The SANC emphasises that there is a "fundamental need to create an awareness in the registered nurse of the socio-cultural implications in the provision of comprehensive nursing in the South African community" (SANC1985:2). Under the "old" system of nursing education in the RSA (that is, prior to the R425 programme published in 1985), a nurse would require at least six years (three years for general, one for midwifery, one for community health nursing and one for psychiatric nursing), to acquire the same comprehensive education and training that a nurse (general, psychiatric and community) and midwife, following the R425 course, could acquire in four years.

In practice, however, nurses had to obtain study leave and "work back the time to their employers" before they could apply for study leave to do the next course. Many nurses therefore required up to nine years to obtain registration as general, community health, psychiatric nurses and midwives. The "old" system was too time consuming and not cost-effective in producing comprehensively prepared professional nurses.

Due to the shortage of nurses, hiring an NQN to function directly in areas such as midwifery, community and psychiatric nursing units, might become a necessity in the RSA.. Expertise could be the consequence of education, training, guidance, supervision and practice. Troskie (1993:56) in the RSA revealed in her study that NQNs who worked in the psychiatric hospitals received a greater amount of guidance than the nurses working in other areas, with the result that these NQNs were perceived to be more competent in problem solving than others. Searle (1987:210) expresses concern that a shortage of professional nurses in the RSA might necessitate the employment of larger numbers of enrolled nurses and nursing auxiliaries. Supervision of these sub-professional categories could cause difficulties for the professional nurses who have to guide and accompany students and NQNs.

### **1.2.3 Problems interfering with competency development among NQNs**

The NQN in the ward setting may, more often than not, be rewarded for success in carrying out bureaucratic, non-nursing activities such as the keeping of good records or keeping the ward neat and tidy. Benner & Benner (1979:58-63) in the USA assert that if the nurse finds herself having to carry out a managerial role for most of the working day, she is likely to become disillusioned. A study done by Lowane (1990:58) on "Nursing students' perceptions of clinical learning experiences" indicated that qualities such as:

- ▶ ward organisation and management;
- ▶ motivation of other members of the team;
- ▶ problem-solving;
- ▶ preparation for leadership; and
- ▶ development of interpersonalcompetencies

had received very little attention during training in the health services of the former Gazankulu,

falling within the Northern Province of the RSA since 1994 (Lowane 1990:58).

Lathlean & Corner (1991:2) cite Vaughan's exploratory research on factors affecting the transition from student to professional nurse from five schools of nursing in England. The sample comprised of 43 registered nurses. One of the respondents said: "We are trained to pass an exam ..., not to run a ward, how to cope with difficult doctors and relatives and how to cope with and treat consultants" (1991:2). More than a quarter of the nurses in the main sample argued that no area of their training had been helpful in preparing them to cope with different aspects of the NQN's role.

The discrepancy between nursing education and the depth of clinical competencies expected of NQNs seems to exist universally, as reflected in international nursing publications. Primm (1986:135) in the USA states that the nursing service expresses the opinion that graduates are not adequately prepared to function in the "real world" of practice. Nursing education responds that graduates are prepared to practise in both the present and the future, but the service does not use graduates in the roles for which they are prepared. Kramer in McCloskey (1985:902) in the USA supports this view by indicating that there is an accusation that new graduates cannot determine priorities. According to Kramer this implies that they cannot set priorities according to the head nurse's value system.

Nursing service should take cognisance of the fact that a clinical learning experience occurs in a learning situation, created by the person presenting the learning situation and by the person presenting the learning opportunity, that is, the professional nurse. The hours of clinical practice expected of student nurses during training (1000 hours preventive and promotive health; 1500

curative health; 1000 midwifery; 500 rehabilitation and others at the discretion of the school) are apparently adequate provided they are channelled towards providing maximum benefits to a student nurse (SANC 1992:20). Accompaniment is very important in the teaching of the student nurse. NQNs probably still need supervision, encouragement and motivation to acquire new competencies, and to become more competent to remain in the profession.

Usually NQNs find adjusting to a work setting a challenging experience. Their successful adjustment to their work situations could influence their ability to apply the principles and concepts learned in school. There might be clashes of "values" between the NQN and her seniors. SPNs might have unrealistic expectations of the NQN. The SPNs' expectations might include that the NQN should have clinical competency, play a leadership role in a multi-disciplinary team context, and explore and identify a theoretical framework for nursing practice. Van Ess Coeling (1990:26), at a midwestern university in the USA, indicates that large numbers of new graduates leave their first work experience during the first 18 months on the job, in spite of growing corporate attention to orientation and retention activities.

One solution to this problem might be that an NQN be assisted to understand the "unit culture". This could help her to identify which behaviours are expected so that she would fit into the work group. NQNs who know how to assess important cultural elements of the potential work group during an initial interview will be in a better position to select a unit to their satisfaction (Van Ess Coeling 1990:27).

In conclusion, Kieffer (1984:198) in Kentucky, USA, asserts that it might be unrealistic to expect educational programmes to teach all existing technical nursing competencies or to expect new

graduates to be competent in performing all such competencies. Decisions should be made as to which competencies to include and which to eliminate from the basic educational programme. This implies determining which competencies new graduates could be expected to perform competently and which competencies would require further education and practice in the clinical practice setting or during post basic clinical nursing courses.

### **1.3 STATEMENT OF THE PROBLEM**

This study endeavours to provide a realistic picture of the competencies of NQNs as perceived by SPNs. Moreover, competencies which SPNs expect from NQNs in the general, community health, psychiatric and midwifery units, will be identified. This study will attempt to identify differences between the expected and the performed competencies of NQNs, as perceived by the SPNs.

### **1.4 PURPOSE OF THE RESEARCH**

This study will attempt to determine the competencies of NQNs at entry-level position, and to identify the significant and desirable competencies as perceived by SPNs. The identified desirable competencies will form the basis for developing a list of competencies to be mastered by NQNs in their first professional position. If competency is the goal of an educational programme, the first step in programme design should be a clear and precise listing of the competencies to be mastered during the education period. The purpose of this study is to identify the competencies which SPNs expect of NQNs; to identify the psychomotor, affective and cognitive competencies of NQNs as perceived by SPNs, and to ascertain whether there are differences among the perceptions of SPNs concerning the competencies of NQNs in the general, community, psychiatric and midwifery nursing units.

## 1.5 RESEARCH QUESTIONS

The study will attempt to answer the following questions:

- What competencies do SPNs expect NQNs to have upon entering the work setting?
- Which cognitive, psychomotor and affective competencies do NQNs have upon entering the work setting, as perceived by SPNs?
- Are there differences between the expected and the performed competencies of NQNs, as perceived by the SPNs?
- Are there differences among the perceptions of SPNs concerning the competencies of NQNs in the general, community, midwifery and psychiatric clinical nursing units?
- Which competencies of the NQNs need to be improved, as perceived by the SPNs?

## 1.6 ASSUMPTIONS UNDERLYING THE STUDY

Polit & Hungler (1991:18) define assumptions as being "basic principles that are accepted on faith or assumed to be true, without proof or verification. Assumptions are embedded in thinking and behaviour".

The basic assumptions underlying this study are the following:

- ▶ SPNs expect NQNs to be competent in performing specific cognitive, affective and psychomotor competencies, based on the scope of practice of a registered nurse (R2598);
- ▶ the competencies of NQNs might vary, depending upon the type of patients being nursed in the clinical nursing unit (general, psychiatric, community health or midwifery);
- ▶ SPNs might consider orientation programmes essential to facilitate NQNs' mastery of the identified competencies;.
- ▶ SPNs expect NQNs to function as independent practitioners within the scope of practice

of a registered nurse (R2598).

### **1.7 IMPORTANCE OF THE STUDY**

Information regarding the competencies of NQNs, as perceived by SPNs, might render valuable contributions towards improving nursing education programmes in the RSA. Such information could provide curriculum developers with realistic input regarding competencies acquired and competencies showing a deficiency. This should assist in the delineation and refinement of the professional competencies expected of nurses trained in the comprehensive course leading to registration as a nurse (general, psychiatric and community) and midwife.

"Quality assurance" is the outcome of professional competency. There is a need to look at the performance of NQNs because nurse educators want to know whether they are preparing nurses who are able to use their education in carrying out their responsibility for providing high quality care.

This study could be valuable because its findings could provide data influencing the ongoing discussions held by various nursing education and health professional committees in the RSA, concerning the competencies of the NQNs in the RSA who followed the R425 course.

The findings of this study may provide a platform for future studies and may also be used to design a competency-based orientation model for NQNs.

### **1.8 DEFINITIONS**

The following definitions are provided to enable the readers of this study to share the author's

meaning of these specific terms.

### **1.8.1 Competency**

The definitions of competency as depicted in the literature, share common concepts such as ability; quality; performance; efficiency and capability. For the purpose of this study "competency" refers to NQNs' cognitive, affective and psychomotor ability to perform specific tasks satisfactorily as determined by SPNs. The definition of "competency" in this study concurs with that of Searle & Pera (1992:92) in the RSA who define competency as "a demonstrated cognitive, affective and/or psychomotor ability required for the performance of specific activities".

### **1.8.2 Newly qualified nurse (NQN)**

For the purpose of this study an NQN is a professional nurse who has trained under Regulation no. 425 of 22 February 1985 of the SANC, and qualified as a nurse (general, psychiatric and community) and midwife, with less than one year's clinical experience. NQNs have received theoretical education at nursing colleges associated with specific universities, and their clinical learning experiences at hospitals and other health services approved by the SANC.

### **1.8.3 Senior professional nurse (SPN)**

An SPN, according to the Personnel Administration Standard (PAS), is a professional nurse who has a total period of three years' actual service and recognisable experience, and has been promoted to the higher post of SPN; or a professional nurse who has a total period of six years' actual service and recognisable experience, and has been promoted to the higher rank of SPN (RSA 1991:16). For the sake of clarity, this study refers to SPNs as persons who have been promoted to these posts or ranks and who are directly involved in the clinical settings utilised for

conducting this research.

#### **1.8.4 Professional nurse**

According to PAS of the RSA, a professional nurse is a person who has registered with the SANC as a registered professional nurse. Both the NQNs and the SPNs referred to in this study are thus professional nurses.

#### **1.8.5 Clinical setting**

This term refers to any practical situation where NQNs interact with patients/clients under the supervision of SPNs. It includes hospitals, health centres, clinics and specialised institutions rendering general, community health, psychiatric or midwifery nursing services.

#### **1.8.6 R425 course**

The R425 course refers to the training programme followed by NQNs defined in this study, leading to the qualification as nurse (general, psychiatric and community) and midwife. (This regulation [R425] and its directives were published by the SANC in 1985.)

### **1.9 ABBREVIATIONS**

A list of abbreviations used throughout this thesis is provided on page vi in order to facilitate the readers' references to the abbreviations.

### **1.10 SCOPE AND LIMITATIONS OF THIS STUDY**

This study merely tries to ascertain what the general perceptions of the SPNs are, concerning the competencies of NQNs working in the general, psychiatric, community health and midwifery

units. Future studies could request SPNs to evaluate individually the competencies of each respective NQN with whom they are working. Furthermore, future studies could ask the NQNs to evaluate their own competencies. Alternatively, future researchers could directly observe and evaluate NQNs' competencies. In these ways the competencies of NQNs as perceived by themselves, and as evaluated by a researcher, could be established.

### **1.11 ORGANISATION OF THE REPORT**

Chapter 1 presents an introduction to and provides a background for the problem under study. It includes the introduction to and motivation for the study, statement of the problem, assumptions underlying the study, research questions, and importance of the study. It provides definitions of terms used in this study, indicates the scope and limitations of the study, and finally the layout of the rest of the chapters of the report.

Chapter 2 reviews relevant texts, articles and studies undertaken by other researchers pertaining to the competencies of NQNs as viewed by SPNs.

Chapter 3 discusses the methodology adopted in this study.

Chapter 4 provides information about the SPNs' profile (obtained from section one of the questionnaires).

Chapter 5 presents a detailed discussion of data analyses obtained from section two of the four groups' questionnaires namely community, psychiatric, midwifery and general nursing units.

Chapter 6 describes and interprets research findings based on data analyses (obtained from answers to open-ended questions in section three of the questionnaires).

Chapter 7 contains a summary and a conclusion, the recommendations and the implications of the findings for future research.

The bibliography presents a list of references used throughout the thesis, as well as works consulted during the course of this study.

Annexures include the following:

- Questionnaires (community; psychiatric; midwifery and general clinical nursing units).
- Covering letter for questionnaires.
- Letters of permission to conduct the survey.
- Guidelines to develop a competency-based orientation programme for a unit.

## **CHAPTER 2**

### **REVIEW OF LITERATURE ON THE COMPETENCIES OF NQNS**

#### **AS PERCEIVED BY SPNS**

##### **2.1 INTRODUCTION**

This chapter reviews literature relevant to the competencies of NQNs. The literature review is an essential step in the research process as it provides the practical and theoretical background against which the researcher's findings could be evaluated.

##### **2.2 PURPOSE OF THE LITERATURE STUDY**

The primary focus of the literature review is to search for similar problems studied by other researchers. The purpose is to identify the diversity and universality of views; what is already known about the competencies of NQNs in the work setting; determinants suggested to remedy methodological shortcomings; earlier works relevant to the assumptions of this study; and, to establish effective ways of conducting the present study (Polit & Hungler 1991:127-133).

The review of the literature also provides a perspective on the problem in terms of interpreting the results obtained in this research. Finally, the comparison of the results of this study with earlier findings may suggest new research and the development of competency-based models which could either contribute towards resolving conflicts or extending the base of knowledge in this respect.

### **2.3 EXPLORATION OF THE MEANING OF THE TERM "COMPETENCY"**

Competencies are many and multifaceted in the clinical practice setting. Butler (1978:7), in Boston, USA, outlines different views concerning the meaning of the word "competency" itself, including:

- ▶ competency is seen as the application of knowledge;
- ▶ it is knowledge and skill combined;
- ▶ knowledge and skills constitute separate competencies;
- ▶ competency is equated with behavioural objectives;
- ▶ only directly measurable performance comprises competencies; and
- ▶ unexpected and unmeasurable learning outcomes are included in the concept of competency.

McGaghie et al (1978:19), in Geneva, assert that it would be pointless to suggest that there is a single definition of competency. This concept includes a broad range of knowledge, attitudes, and observable patterns of behaviour which together account for the ability to deliver a specified professional service. Competencies may also be ambiguous and tied to local customs and constraints of time, finance and human resources.

Swendsen Boss (1985:8), in Utah, USA, indicates that competency is more than knowledge and skill. Values, critical thinking, formulation of attitudes and integration of theory from the humanities and sciences into the nursing role are also competencies. This author defines competency as the "... ability to meet or surpass prevailing standards of adequacy for a particular activity" (1985:8). This includes not only job-related competencies but also a well-rounded education that teaches a nurse to apply integrated theories in a critical, scientific manner.

The NQN can correctly perform numerous clinical tasks, provided that, amongst other provisions, the many roles and functions involved in her work are defined and clearly expressed. The competencies identified in this study do not claim to be the only elements of competency. However, those elements of competency which can be defined, could represent the critical point of departure in the socialisation process of NQNs.

#### **2.4 THE SCOPE OF PRACTICE OF A REGISTERED NURSE**

In the RSA, the scope of practice of a registered nurse is the legislated and circumscribed role of registered nurses in the RSA. It also embraces the level of knowledge and competency of the practitioners, and the ethics and accountability of the practitioners in the RSA (Searle & Pera 1992:141). NQNs, as defined in this study, are nurses registered with the SANC. Their acts and procedures are determined by the scope of practice of a registered nurse (R2598) as amended. The study, therefore, uses the scope of practice as a conceptual frame of reference. Searle & Pera (1992:133), in the RSA, assert that the registered nurse must see any act as a whole range of activities. It does not mean one single act, but all acts related to keeping the particular bodily function active in any and every situation throughout the lifespan of the patient. They further state that all actions must have preventive, promotive, curative and rehabilitative components.

These acts and procedures, which should be performed by scientifically based physical, chemical, psychological, social, educational and technological means applicable to health care practices, have been outlined as follows, in Regulation no. R2598 of 30 November 1984 of the scope of practice of a registered nurse:

- ▶ the diagnosing of a health need and the prescribing, provision and execution of a nursing regimen to meet the need of a patient or group of patients or, where necessary, by referral

- to a registered nurse;
- ▶ the execution of a programme of treatment or medication prescribed for a patient by a registered person;
  - ▶ the treatment and care of, and the administration of medicine to a patient, including the monitoring of the patient's vital signs and of his reaction to disease conditions, trauma, stress, anxiety, medication and treatment;
  - ▶ the prevention of disease and promotion of health and family planning by teaching to and counselling with individuals and groups of persons;
  - ▶ the prescribing, promotion or maintenance of hygiene and physical comfort, and rehabilitation of the patient;
  - ▶ the promotion of exercise, rest and sleep with a view to the healing and rehabilitation of a patient;
  - ▶ the facilitation of body mechanics and the prevention of bodily deformities in a patient in the execution of the nursing regimen;
  - ▶ supervision over and maintenance of a supply of oxygen to the patient;
  - ▶ supervision over and maintenance of the fluid, electrolyte and acid base balance of the patient;
  - ▶ facilitation of the maintenance of bodily regulatory mechanisms and functions in a patient;
  - ▶ facilitation of the healing of wounds and fractures, protection of the skin and the maintenance of sensory functions in the patient;
  - ▶ facilitation of the maintenance of the nutrition of the patient;
  - ▶ supervision over and maintenance of elimination by the patient;
  - ▶ facilitation of communication by and with the patient in the execution of the nursing regimen;

- ▶ facilitation of the attainment of optimum health for the individual, the family, groups and the community in the execution of the nursing regimen;
- ▶ the establishment and maintenance, in the execution of the nursing regimen, of an environment in which the physical and mental health of a patient is promoted;
- ▶ preparation for and assistance with operative diagnostic and therapeutic acts for the patient;
- ▶ the co-ordination of the health care regimens provided for the patient by other categories of health personnel;
- ▶ the provision of effective patient advocacy to enable the patient to obtain the health care he/she needs; and
- ▶ care of the dying patient, and care of a recently deceased patient within the execution of the nursing regimen.

The acts and procedures outlined in the scope of practice provide the nature of the professional role a registered nurse must play, but lacks clarity regarding the competencies which she must perform to accomplish the prescribed role. McGaghie et al (1978:19) in Geneva, indicate that the primary consideration in delineating the role and functions involved in the registered nurse's work is to define and clearly express the competencies. This implies that careful identification of these competencies of nursing practice is the first and most critical step in designing a competency-based curriculum. For example: "The assessing and diagnosing of a health need and the prescribing of nursing regimen" should specify what it is that the registered nurse should do. Specific health problems should be identified by observing, monitoring, communicating, interpreting, measuring and discriminating, and thereafter specific nursing action should be identified, planned and implemented to meet the specific health need.

Searle & Pera (1992:133), in the RSA, emphasise that if this approach is followed in nursing practice, it will be seen that each element of the scope of practice constitutes a very wide range of nursing activities. The primary consideration is that each element embraces cognitive, affective and psychomotor competencies.

## 2.5 THE SCOPE OF THE REVIEW OF RELATED LITERATURE

A search for relevant literature was undertaken with the assistance of the University of South Africa (Unisa) reference librarians. The researcher requested a bibliography on the competencies of NQNs. Other cues such as role performance of NQNs; nursing competencies; role of a professional nurse; competency-based learning; caring in nursing; and problem-solving in nursing were provided. A copy of the bibliography was sent to the researcher after three months, listing relevant literature delineating essential competencies expected of NQNs in the clinical setting.

Literature pertaining to cognitive and affective competencies was limited, but that pertaining to psychomotor competencies was relatively abundant. A similar study, though not identical to this study, was conducted by Troskie (1990) in the RSA. Troskie did a critical evaluation of the NQN's competency to practise. Although the methodology of this study differs from that of Troskie, her study forms the basis of the data analysis to further increase understanding of the competencies of NQNs. The present study merely intends studying the competencies of NQNs as viewed by SPNs, whereas Troskie critically evaluated the competency of the NQN as viewed by herself as well as by her supervisor.

Other topics which proved relevant to this study were:

- ▶ teaching for clinical competency;

- ▶ assessment of competency in clinical practice;
- ▶ comparison of expected and evidenced baccalaureate degree competencies;
- ▶ the new nurse's work entry; and
- ▶ becoming a staff nurse (a guide to the role of the newly registered nurse).

All references in the bibliography of each article were further explored and significant additional articles were retrieved. A few articles with relevant titles were also retrieved by the researcher in the Unisa library. A considerable number of articles were obtained from the library. Few books pertaining to the competencies of NQNs were obtained. The books that were perused, provided background information which was supported by the studies published in the journal articles.

Throughout the literature the clinical competencies are based on the nurse's ability to perform cognitive, affective and psychomotor competencies. Figure 2.1 indicates the competencies required in the clinical setting, as depicted in the literature. This study will attempt to identify whether these competencies fall within the scope of practice of a registered nurse (R2598) in the RSA.

#### COMPETENCIES

COGNITIVE	AFFECTIVE	PSYCHOMOTOR
Problem-solving Research Administrative/management Clinical judgement Critical thinking and decision making Teaching	Adaptive/adjustive Interpersonal relationships/ Communication Caring Ethical viewpoint of man	Manual Technical

FIGURE 2.1: The cognitive, affective and psychomotor competencies expected of NQNs.

## **2.6 COGNITIVE COMPETENCIES**

### **2.6.1 Problem-solving competencies**

The clinical role of an NQN should be based on a sound theoretical knowledge of problem-solving competencies. She is expected to adopt a sensitive, individualised approach to the care of the patient or client, and to undertake a wide range of activities which require, among others, competency in collecting information; assessing patients' needs; defining a problem; analysing and making judgements about this information; planning, and evaluating the care given.

The scope of practice of a registered nurse as outlined in item 2.4 mandates every professional nurse, whether newly qualified or not, to be competent in the diagnosing of a health need and the prescription, provision and execution of a nursing regimen to meet the need of a patient. This implies applying problem-solving competencies. Makhathini (1992:23), in the Natal region of the RSA, cites authors who believe that problem-solving, like any other competency, can be taught. However, NQNs are expected to be competent in problem-solving due to the fact that they have been engaged in active learning and in coping with real problems in the clinical setting. It could also be expected that they have been exposed to learning through case study, ward conference, patient-centred learning, clinical assignments and ward rounds.

The nursing process, a scientific approach to nursing practice, is often described as a problem-solving process. Fitzpatrick et al (1992:1212), in England, reviewed various literature sources concerning the nursing process, and identified the following key elements:

- ▶ nursing process embodies four main stages, namely assessment, planning, intervention and evaluation;
- ▶ it involves a problem-solving approach;

- ▶ it promotes individualised care, i.e. patient-centred care;
- ▶ it involves the competency of decision making;
- ▶ it promotes a holistic approach to patient care;
- ▶ it involves a scientific approach; and
- ▶ it involves the process of critical thinking.

These key elements suggest the variety of competencies which are required by a nurse to implement the nursing process competently. For instance, in the assessment stage, the competencies of communication, observation and critical judgement are necessary. Furthermore, the nurse must discriminate among and synthesise information, select and prescribe nursing care. Technical, interpersonal and teaching competencies are utilised in the intervention stage and in the evaluation stage (Hurst, Dean & Trickey, 1991:1444-1447).

A number of studies investigating the problem-solving abilities of senior students, NQNs and experienced nurses have been done. The findings of these studies appear to concur with Benner's analysis of clinical nursing in the USA. She argues that the progression from novice to expert consists of a series of steps of competency acquisition. Increased competency in problem-solving involves a change from a reliance on abstract principles to the use of past, concrete experiences (Benner 1984:13). In Benner's study, a variety of settings pertaining to patients' problems were presented: one patient needed colostomy teaching; someone's intravenous (IV) had stopped; someone was feeling nauseated; and all of a sudden the morning had gone and no one had been given a bedbath. According to Benner, the competent nurse lacks the speed and flexibility of the proficient nurse but does have a feeling of mastery and the ability to cope with and manage the many contingencies of clinical nursing. Various authors reveal that nurse practitioners who have

had considerably more experience than another group of nurses, are more proficient at problem solving on simulated patient care problems (Benner 1984:26; Holden & Klingner 1988:24).

The studies conducted by Makhatini (1992:66-68); Chang & Gaskill (1991:813-817) and Holden & Klingner (1988:23-29) support the view that a nurse's problem-solving competencies improve with experience. Makhatini (1992:66-68) in the Natal region of the RSA, found that the levels of the problem-solving competencies of the comprehensive nursing programme diplomates participating in her research were not satisfactory. However, findings reveal that the fourth-year students might be better problem solvers than the first years. In their study in Australia, Chang & Gaskill (1991:813-817) reveal that there is no overall improvement in perceptions of problem-solving ability six months before and at the completion of all courses. There is, however, a significant mean difference ( $P < 0.01$ ) in the study participants' problem-solving confidence. Registered nurses with 5 - 10 years' experience have a significantly different ( $P < 0.01$ ) approach to problem solving. Holden & Klingner (1988:23-29) in Chicago, reveal two versions, one supporting the afore-mentioned view and the second one showing no significant differences among student nurses' problem-solving abilities.

Holden & Klingner (1988:27) set hypotheses which guided their investigation:

1. It was expected that experienced paediatric nurses would be better able to diagnose why an infant was crying than non-experienced nurses.
2. It was expected that more advanced students would perform better than less advanced students on problem-solving ability.

The two student groups were enrolled in the first semester and the final semester respectively, but

did not differ from each other on the types of information selected.

Similar findings were revealed by Lowane (1990:77-78) in the former area of Gazankulu (forming part of the Northern Province in the RSA since 1994). She revealed that student nurses following the comprehensive course in Gazankulu were not fully capable of solving patients' problems. The mean scores fell below 50 percent on the item "how to solve patients' problems" which was contrary to what they said on the item "they always listen to patients' problems" (87 percent). These findings seem to indicate that although nurses listen to patients' problems they cannot solve these problems.

Chang & Gaskill (1991:818), in Australia, identify a need to facilitate acquisition of teaching approaches which may aid the achievement of problem-solving abilities. Methods such as deductive and inductive reasoning could be considered powerful approaches to be applied in the clinical setting.

Henderson (1982:176-181) and Makhatini (1992:69-71) also recorded findings which indicated the relationship between the nature of nursing education programmes and the problem-solving ability of nursing graduates. Henderson cites a study conducted with Sturt College of Advanced Education (Sturt CAE) graduates and graduates from hospital-based schools in Melbourne, Australia, on the clinical performance in problem solving. The hospital-based graduates formed the comparative group for the study. The findings of the study presented a dilemma for both Sturt CAE graduates and their supervisors. Graduates rated themselves below hospital graduates on "trying different solutions" and "deciding to call in others", whereas their supervisors rated their performance above that of hospital graduates. On "deciding when nursing intervention is necessary" there was agreement that Sturt CAE graduates' performance was above that of hospital

graduates. On "asking questions when unsure", Sturt CAE graduates were rated below the hospital graduates.

The study done in the Natal region of the RSA by Makhatini (1992:69-71), revealed that the fourth-year comprehensive student nurses (college-based students) performed better than the third-year students (hospital-based students) of the basic nursing programme. She indicated the best performance by the basic third-year students on the issue "identification and interim problem formulation" and the worst performance in the area of providing a detailed description of nursing interventions for one problem identified as a priority. Therefore, the assumption that hospital-based graduates are better problem solvers than college or university-based graduates could be questioned.

Studies revealing the inability of NQNs to apply the nursing process have also been identified. Joyce-Nagata, Reeb & Burch (1989:314-320) conducted a research with 142 nurse administrators in health care settings in the Mississippi area in the USA. The findings revealed that administrators agreed that 16 competencies out of 67 were not performed competently by the graduates. The unevicenced competencies included the nursing process competencies such as:

- ▶ identifying the needs of a patient;
- ▶ recording nursing diagnoses derived from data analyses;
- ▶ ranking goals based on nurse/client priorities; and
- ▶ identifying multiple resources available to implement the plan of care and selecting those most likely to facilitate goal achievement.

All these items relate to stage one of the nursing process. This implies that graduates were not efficiently prepared in the stage of assessment. However, it was evidenced that graduates were

competent in formulating a plan of care with the client; monitoring progress toward achievement of goals; and recording of data (Joyce-Nagata et al 1989:320).

In the study done in Baltimore, USA, by Ignatavicius (1983:20), NQNs also perceived several areas of the nursing process as weaknesses: "documenting care plans on cardexes"; "teaching patients"; "setting priorities"; and "making independent nursing judgements". Each of these weaknesses could be expected from inexperienced nurses, except the documentation of care plans. Nursing care plans could be the source of clinical learning experiences in basic nursing programmes. Therefore one would expect documentation of care plans to be a strength of the NQN.

The study done by Hurst et al (1991:1444-1455) showed few differences from the findings of the two studies discussed on the nursing process. They conducted interviews to explore nursing problem-solving abilities, using the five steps of the nursing process namely problem identification, assessment, planning, intervention and evaluation. The sample consisted of 90 experienced nurses and 30 learners and NQNs from 20 Health Districts and Boards in the United Kingdom. The findings revealed that 71 percent of the informants perceived the implementation of assessment not to be a problem. This finding appeared to be contrary to the findings of the two studies previously discussed. A large proportion of informants (87 percent) commented on implementation. The findings indicated that NQNs could implement the plan of care regardless of their being poor planners. Vignettes in problem identification, planning and evaluation received relatively low percentages. The researchers concluded that nurses seemed to concentrate on the "doing" aspects of nursing (implementation) at the expense of the analytical process associated with problem identification, planning and evaluation.

Lathlean & Corner (1991:5), in England, provided similar evidence in their research findings. They observed that few NQNs were able to articulate clearly the concepts of the nursing process. Often no reference was made to individualising patient care or to systematising assessment, planning, implementation and evaluation. Nurse managers identified gaps in the NQNs' practice of individual patient care management, such as long-term planning of a patient's care.

The study done by Troskie (1993:56), in the RSA, compared the competencies of NQNs' ability in problem-solving in the psychiatric, community and midwifery areas. Results indicated that the NQN in the psychiatric hospital was better in problem solving than the community health nurse. This nurse, working in a psychiatric hospital, might have received a greater amount of guidance than the nurse working in the community. The history-taking procedure may also have been intensified and based on the nursing process, with the result that NQNs may have quickly developed competency in problem solving. The discrepancy was observed with the community nurse, who often had to work in isolation and had to seek her own solutions to her problems and did not always have access to other personnel for support.

#### Summary.

There were a number of findings regarding problem solving in the studies discussed. Application of stages of the nursing process was found to be the central focus of NQNs' incompetency. NQNs referred to in this study also appeared to have deficiencies in problem solving. The clinical curriculum appeared to be procedure-orientated clinical teaching; there may have been a lack of identification of critical learning opportunities in the clinical programme. Student nurses in the clinical setting seemed to have spent more time in completing workbooks and checklists which were purely psychomotor competency performance (Lowane 1990:77; SANA minutes 1991).

Although the nursing process is a popular approach to individualised patient care, it may be only one approach to problem solving in nursing. Clinical teachers and supervisors may need to be more flexible in their approaches to enable them to introduce more adaptable and diversified methods of problem solving without affecting the totality of man.

In identifying and creating learning opportunities for student nurses, cognisance should be taken of "the importance of the nurse's own observations and the need to develop problem-solving skills so as to be able to act on these observations" (SANC 1992:8).

### **2.6.2 Research competencies**

Research appears to receive very little attention in the basic nursing educational programme. It appears not to be emphasised, either, in the scope of practice of a registered nurse (R2598). Nevertheless, research could form an essential base to increase nursing knowledge in practice. Research may also hasten the development of other competencies such as problem solving, critical thinking and clinical judgement.

Fitzpatrick et al (1992:1212) cite Akinsanya's argument which indicates that student nurses must be enthused into becoming research-minded, through research-orientated teaching. Students should be able to read and critically analyse research and determine the applicability of the results to the clinical setting. Other authors such as Fawcett cited in Ehrenfeld & Eckerling (1991:231), in Israel, and Du Preez (1990:27), in the RSA, indicate that registered nurses should simply be expected to understand, interpret and use research data, share findings with others and apply them in their practice. Fawcett asserts that nurses with masters or higher degrees are the ones expected to conduct investigations and studies (in Ehrenfeld & Eckerling, 1991:231).

Numerous studies investigating the importance of research into nursing practice have been identified, but only a few studies are relevant to the topic of the thesis. All the studies perused have indicated that research and its application to clinical nursing appear to be lacking. Buckwalter (in McCloskey & Grace 1985:112) cites findings of nationwide Delphi technique surveys, conducted by the Western Interstate Commission for Higher Education in the USA. The top three responses which were valued as the most important areas of research were:

- ▶ determining means for greater use of research in practice;
- ▶ identifying effective means of communicating, evaluating and implementing change in practice; and
- ▶ establishing the relationship between clinical nursing research and quality care.

Joyce-Nagata et al (1989:314-320) in Mississippi, USA, also revealed non-evidenced practices by new graduates in the following research items:

- ▶ analysis of existing studies in nursing;
- ▶ conducting action-orientated, time-limited, minimally complex studies; and
- ▶ applying findings of own and of others' research for the improvement of client care.

Registered nurses' perceptions of research in the study done in Israel by Ehrenfeld & Eckerling (1991:224-231) indicated that they perceived research activities as part of the nurse's role, especially:

- ▶ reading research ( $\bar{x}=4.25$ ); and
- ▶ applying research findings ( $\bar{x}=4.39$ ).

"Reading research" also scored highest on

- ▶ perception of ability ( $\bar{x}=4.25$ ); and

- ▶ perception of intent to do so in the future ( $\bar{x}=4.31$ ).

Ability to "initiate research" scored lowest of all ( $\bar{x}=3.31$ ).

The study done by Troskie (1993:58) in the RSA also revealed that most respondents (both NQNs and their supervisors) agreed that the nurses did not seem to have the necessary theoretical background to do research.

Lathlean & Corner (1991:6) in England, revealed that observations by ward sisters and tutors showed that even where the newly registered nurse was deemed clinically competent, there were still some inadequacies especially in the awareness and application of research-based knowledge.

Summary.

The literature reviewed appears to indicate that registered nurses might still lack a research-orientated mind. The findings might consequently imply that teaching of the research process to diplomates could be insufficient or non-existent. Incorporation of research projects in the clinical learning objectives might be essential. This could be done in the form of a clinical requirement. By so doing a student nurse would have received a concrete background for professional development and continuing education. However, this could only be a successful endeavour if the students received competent guidance throughout the research process.

### **2.6.3 Administrative/management competencies**

"On registration they (newly qualified registered nurses) are supposed to be competent, clinically knowledgeable and skilled, able to manage the planning and implementation of the care of a group

of patients, well organised and capable of taking charge of the ward, adept at answering telephone calls, even in difficult circumstances such as breaking bad news to relatives, confident in their dealings with doctors, and good teachers of, and role models for students, the ranks of whom they have only just left" (Lathlean & Corner 1991:1), in England. As a professional nurse, the NQN is expected to have management knowledge and competencies and be competent in the function of planning, organising, leading and controlling. She must know and be committed to the global mission, policies and procedures of the organisation and responsible for setting the standard of nursing care in her ward (Du Preez 1990:27; Kelly in Kershaw 1990:61; Searle 1980:5). NQNs are fully fledged managers, therefore they are not exempted from care management or from the organisation of the workload. Fitzpatrick et al (1992:1213), in England, indicate that the ward sister's role has been identified as crucial to the provision of "good" care through "good" management. Three key areas of responsibility for the ward sister have been identified as:

- ▶ maintaining a high standard of patient care;
- ▶ the day-to-day management of the ward; and
- ▶ the supervision and teaching of other nursing staff.

Few studies related to the NQN's ability to perform management roles have been identified. Lewis (1990:808-818), in the United Kingdom, conducted a study exploring the perceptions of ward sisters concerning their responsibilities. Although the title sounds irrelevant to the thesis title, ward sisters identified two major strategies as ways of managing. These were monitoring and assessing, and facilitating/supporting. They regarded monitoring and assessing competencies as a major way of controlling and organising what happened on the ward. To show that they were suspicious of the competencies of NQNs, one ward sister expressed herself as follows:

"During the first three weeks she [the newly arrived trained nurse] works in very close contact

with me. During that time I can make a valid assessment about her care decisions. I want to make sure that they are safe, and I want to make sure she can make appropriate clinical decisions" (Lewis 1990:811).

Lathlean & Corner (1991:2) cite an exploratory study done in England by Vaughan (1980), who indicated that NQNs felt inadequately prepared on aspects of managing the clinical units. Vaughan also asked for suggestions of subjects which could be included in the general training in order to prepare the student better for her new role upon registration. The highest proportion of comments referred to "management", including management principles and competencies.

Humphries (1987), as cited by Lathlean & Corner (1991:2), pursued the study done by Vaughan (1980) by asking a group of NQNs the same set of questions as Vaughan. The findings revealed that inadequate preparation was still highlighted as one of the most important reasons why difficulties were experienced in the transition from student to staff nurse. Management practice again featured high on the list of requests for inclusion in basic training followed by a deeper knowledge base; interpersonal competencies; and personal supervision and support.

Studies which contradicted the findings of Humphries and Vaughan's studies were not identified. However, a study supporting the findings was done by Lowane (1990:58-59) on "Nursing students' perceptions of clinical learning experiences". The findings of this study indicated that administrative competencies were minimally learnt as perceived by the third-year and fourth-year student nurses in the former area of Gazankulu (forming part of the Northern Province of the RSA since 1994). The following areas were not identified in their learning: supervising others;

assuming leadership; making decisions; and management of time and equipment. However, student nurses commented on the following as being factors contributing to their incompetency: poor delegation; being delegated the same task every day; poor supervision; and matrons' criticising rather than teaching. The study done by Girot (1993:116) in England, supports Lowane's findings. One sister interviewed stated that NQNs knew nothing: "... they actually want to be fed one way of doing something" (Girot 1993:116). A synopsis of Vaughan's research studies cited by Lathlean & Corner (1991:19), in England, also identified the following factors affecting NQNs' competency:

- ▶ staff attitudes (42 percent);
- ▶ inadequate preparation (40 percent);
- ▶ insecurity (21 percent); and
- ▶ delegation and co-ordination of work (55 percent).

NQNs in England seem to be aware of their shortcomings in the clinical setting. The findings of the study done by Lathlean & Corner (1991:6), in England, revealed that problems encountered included:

- ▶ writing up doctors' rounds and passing on the appropriate information;
- ▶ drawing up the duty roster;
- ▶ knowing how to get help from outside the ward; and
- ▶ knowledge of district policies and procedures.

Some of the shortcomings mentioned could be prevented by providing orientation on policies and working procedures such as how to co-ordinate with other members of the health team, and how to refer. However, Troskie's study (1993:50), in the RSA, indicated that there was no significant relationship between the competency of the NQNs and orientation provided to them in their new

positions.

Being in charge of a ward appears to be a common experience for many NQNs, necessitated by the shortage of SPNs. The study conducted by Lathlean, Smith & Bradley (1986) in England, cited in Lathlean & Corner (1991:43), found that half of the newly registered nurses studied had taken total charge of their wards within the first month following registration. NQNs often became frustrated and left the profession. Both Vaughan (1980) and Humphries (1987), cited in Lathlean & Corner (1991:43), explored NQNs' feelings about being left in charge of the ward. Vaughan found that the highest number of incidents causing worry were about being in charge, and ward management (Heslop & Lathlean in Lathlean & Corner 1991:43-44).

Conversely, being in charge and managing were found by some nurses to be satisfying: "I found it satisfying, the first shift when I was in charge and coped well with several dramas. I knew what to do and people appeared to have confidence in me" (Lathlean & Corner 1991:44). Similar findings were revealed in the study done by Lowane (1990:97) in the former area of Gazankulu, (forming part of the Northern Province of the RSA since 1994). "Being left in charge of a ward for a short time" was not necessarily perceived as being stressful by all groups of student nurses who participated in Lowane's research.

#### Summary.

The studies discussed indicate that managerial competencies may be lacking among the majority of NQNs. This could pose a great transitional problem. During studenthood the nurse works under the guidance of a registered nurse. She is not an independent practitioner. Even if by chance she is allocated some management duties, she is likely to make mistakes without the necessary

guidance. Becoming a professional nurse cannot be an overnight thing, but development of competencies is a gradual process which does not allow any interruptions. This implies that management competencies could be taught and practised at all levels of student nurses' education. For example, a first-year student nurse should be able to control and maintain equipment; manage her time effectively; utilise policy manuals; and supervise general assistants on the use of disinfectants. Managerial competencies may be identified and categorised according to the level of student nurses' training. This may facilitate the process of transition at the end of the course, from being a student nurse to being a registered professional nurse.

#### **2.6.4 Clinical judgement competencies**

A number of investigators have attempted to describe the cognitive processes involved in making judgements by comparing the methods and solutions of novices and experts in a given problem domain. Literature suggests that expert knowledge is stored in the form of chunks or patterns of familiar stimuli which function as one unit of information. Consequently experts have more information available in working memory than novices (Benner 1984:13-38; Itano 1989:120; Jones 1988:185-192; Kyriacos 1992:48-50; Le Breck 1989:41; Sanford et al 1992:70).

Le Breck (1989:40), in the USA, identified the information processing theory as the account of clinical judgement most grounded in basic psychological concepts of memory and cognitive processing. He cited a study done by Elstein, Shulman & Sprafka (1978) that traced the diagnostic reasoning of a group of experienced internists on a number of simulated cases with varying degrees of fidelity to real clinical situations. They identified four steps in producing diagnoses: cue acquisition; hypotheses generation; cue interpretation and hypotheses evaluation. It has been identified (under the problem-solving item) that NQNs appear not to be equipped with

the intellectual competencies necessary for integrating the vast amount of factual content and are therefore not able to manipulate it in such a way as to arrive at a definition of the patient's problem. The findings of the research done by Hurst et al (1991:1444-1455) in England, indicated that NQNs could not make clinical judgements enabling them to identify the problem, plan and evaluate properly.

Itano (1989:120-125) analysed the clinical judgement process used by registered nurses. This research identified highly skilled judgement-makers (HSJMs) and student nurses in their final semester at a particular university of nursing in Hawaii, USA. Criteria used to identify these HSJMs required high ratings in the following categories:

- ▶ collects appropriate data within a realistic time frame;
- ▶ able to prioritise patient problems;
- ▶ makes accurate assessments of patients' states of health in a realistic time frame;
- ▶ able to clearly state one's assessment; and
- ▶ consciously plans and organises one's work-day.

Findings revealed that registered nurses (HSJMs) collected more cues than student nurses with a difference of 517 and 368 cues respectively.

A study with similar findings was conducted by Sanford et al (1992:70-74) in Dallas, USA. Using ex post facto design, the difference in clinical judgement abilities of recent baccalaureate nurses seeking employment in a large metropolitan hospital and of nurses without a baccalaureate degree was determined. Clinical judgement was operationally defined as the ability to:

- ▶ identify specific patient problems;

- ▶ specify the nursing interventions in order of priority;
- ▶ identify the rationale for each stated intervention; and
- ▶ identify preventive actions that could eliminate or minimise patient risk.

The results indicated NQNs' incompetency in clinical judgement. Eighty-three nurses (72.8 percent of the respondents) had less than one year of experience. The clinical judgement scores ranged from three percent to 93 percent. The mode was 68.7 percent and the mean was 63.7 percent. Eighty percent of the subjects did not achieve the acceptable level of eighty percent on the clinical judgement scale.

#### Summary.

The two studies discussed indicate that clinical judgement competency as expected of an NQN runs parallel to exposure and experience in a given situation (Itano 1989:120-125; Sanford et al 1992:70-74). The findings also support Le Breck's (1989:40) view that clinical judgement is grounded in the basic psychological concepts of memory and intelligence. This may as well imply that NQNs referred to in this study might not as yet be "skilful clinical judges". The scope of practice (R2598) obliges a registered nurse in the RSA to apply skilful clinical judgement to enable her to identify reactions to disease conditions; stress; anxiety; reaction to medication; to assess poor oxygenation in a patient; fluid and electrolyte and acid base imbalance in a patient; nutritional status; and to interpret accurately the vital signs findings. However, it has been indicated that NQNs are novices. Benner (1984:16), in the USA, emphasises that novice nurses are unable to draw on past experiences in order to make decisions. They have learnt a set of principles but do not yet have the judgement required to move away from them.

### 2.6.5 Teaching competencies

The scope of practice regulation (R2598) indicates that patient/client teaching is an important responsibility of the practising nurse in the RSA. A number of literature sources recommend that all professionals engaged in health teaching should be better prepared for this role. Others have cited the need for client/family education programmes as one of the national priorities in nursing research (Ackerman, Partridge & Kalmer 1981:37; Gleit & Graham 1984:25; Murdaugh 1980:1073). Over and above patient/client teaching, a ward sister has a duty to teach student nurses or other categories of learners within her ward. She must ensure that neophytes in the profession are adequately prepared for professional practice. She needs to develop competency in her professional knowledge and judgement so that she is able to provide meticulous teaching and guidance to all subordinates.

Kershaw (1990:70), in England, argues that it is advisable for all nurses to develop some teaching competencies. In order to teach, nurses need to be able to communicate effectively at all levels. Explaining something to a patient, client or family in "simple terms" seems to be totally inappropriate. The move appears to be towards preparing nurses to teach nurses rather than to prepare nurses to teach patients. However, a number of literature sources support the view that patient/client teaching is of more importance than teaching other nurses. Feeley & Gerez-Lirette (1992:801), in Canada, also support patient/client teaching by stating that "the fundamental task of nursing is to assist families in developing their potential for health by engaging them in an active learning process".

Patients/clients have a basic human right to health knowledge, and therefore NQNs must be competent to convey this knowledge. To achieve this they require a variety of competencies and

knowledge. For instance the process of health education may be considered comparable to the nursing process. It requires careful planning, goal and objective setting, implementing and evaluation (Fitzpatrick et al 1992:1213). The authors express consensus regarding the characteristics of "good teachers" as competency in forming and managing interpersonal relationships; communication competencies; sensitivity to learners' needs; competency; the ability to care; and team leadership. The identified characteristics will be discussed in detail under the affective competencies.

Although the nurse has extensive patient contact, teaching efforts may often fail. Murdaugh (1980:1073), in Tucson, Arizona, expresses the view that one major cause of the failure is the fact that teaching is not based on an adequate understanding of the teaching-learning process, whether the goal of the nurse is to add to a patient's knowledge, improve a competency or change an attitude. She is in a teaching-learning situation and therefore needs teaching competencies. The study done by Lowane (1990:109-115) in the former area of Gazankulu (falling within the Northern Province of the RSA since 1994), revealed significant areas which may confirm NQNs' failure to teach effectively. Lowane observed that student nurses, the NQNs-to-be, performed poorly on the following items:

- ▶ teaching other students in the ward;
- ▶ giving informal, individualised teaching;
- ▶ planning ward teaching programmes; and
- ▶ having clearly defined learning objectives in the wards.

In order to overcome the identified shortfall, Lowane (1990:115) recommends that peer group teaching be actively incorporated in students' learning of clinical competencies. This would enable SPNs' to become equipped to teach. She further recommends that in order to improve the

acquisition of teaching competencies, student nurses should have workbooks comprising teaching aspects, forming part of their examination on completion of the second, third and fourth years of study.

Some of the literature supports the views discussed above that many nurses lack the communication competencies necessary for patient/client teaching. Gleit & Graham (1984:25), in Virginia, cite Brennan, a professor of health education, who notes that although "nurses are required to fill the communication gap between patients and physicians, nurses' professional training ill equips them to fulfil this need".

Research relevant to these views was done by Milde & Heim (1991:397-402). The study was conducted to examine perceptions about health education competencies from faculty and students in the final nursing semester in midwestern institutions in Iowa, USA. The survey instrument for data collection included a teaching competencies inventory in the following areas: use of the teaching process; content areas of health education; use of teaching strategies; activities of the health educator; and locations in which a nurse might teach. The findings revealed that all the subjects believed that the items on the teaching competencies inventory were considered to form part of the nurse's role. These items included:

- ▶ assessment of individual group learning needs;
- ▶ identifying nursing diagnosis;
- ▶ developing learning objectives;
- ▶ implementing a teaching plan;
- ▶ evaluating learning; and
- ▶ documentation.

The greatest difference in performance expectation occurred in the categories of the use of teaching approaches and activities of the health educator. The students consistently had a higher expectation of their desired performance than faculty. Students believed that their ability should be at the competent level. Students' beliefs in this regard appear to be correct, as they may be expected to use different teaching approaches to suit the persons being taught.

This study's assumption that "the competencies of NQNs might vary, depending upon the type of patients being nursed in the clinical nursing unit (general, psychiatric, community health or midwifery)", has apparently been supported by a survey done by the Health Education Curriculum Development Project, which was initiated at the Johns Hopkins University, USA. Findings revealed that nurses employed in hospitals were considerably less active in health education than those in public health. Both professional nurses in practice and their supervisors valued health education as a high priority in nursing practice (Ackerman et al 1981:37-43). It could, therefore, be expected that NQNs who are community-based, display a higher level of competency in a patient/client teaching process than hospital based NQNs. Primary health care is the envisaged comprehensive service for "Health for all by the year 2000" (Dennill et al 1995:80). It appears to be essential for NQNs to be competent health educators.

The study by Murdaugh (1980:1073-1078) in Tucson, Arizona, USA, was not directed to investigate NQNs' competencies as such, but focused on investigating the teaching efficiency of all registered nurses. The pretest results indicated that the nurses did not have adequate knowledge of basic learning principles: they could not effectively assess learning readiness; they did not have an understanding of learning objectives or how to evaluate whether or not learning had taken place. The study by Vanetzian & Higgins (1990:269-275) in the USA substantiated

those findings by revealing that new graduates themselves perceived teaching/collaboration to be the most difficult area to implement, followed by interpersonal relationship communication. These two areas appeared to be inseparable.

The study done by Troskie (1993:58) in the RSA supported findings regarding the incompetency of NQNs in their teaching role. The item on the nurses' ability to provide personnel development according to the potential of the individual was rated by the NQNs at only 31.8 percent being completely competent and 16.8 percent by their supervisors. The SANC (1992:11) teaching guide for the programme leading to registration as a nurse (general, psychiatric and community) and midwife, emphasises that clinical learning opportunities are needed right from the outset, which will enable the student finally to "apply teaching principles in clinical teaching, patient teaching and health education".

Another research was conducted by Gleit & Graham (1984:25-28) in Virginia to shed some light on the preparation of nurses for the teaching role. The study contributed towards delineating the key content in preparing students for the teaching role. Findings indicated that the following aspects should be included:

- ▶ the teaching role of the nurse;
- ▶ principles of teaching;
- ▶ responsibility of the client in meeting learning needs;
- ▶ relationship of values to teaching; and
- ▶ learning theories.

The teaching role of the nurse received a frequency of 86 out of n=88 and the principles of teaching received a frequency of 82. This emphasises the fact that the nursing education

curriculum should place greater emphasis on the content and the process of teaching. This should not be an end in itself. Greater emphasis should be placed on the applicability of these facts and principles. It could be beneficial if the nursing education curriculum introduced educational aspects such as didactics, educational psychology and teaching methods at the elementary course level.

#### Summary.

The studies discussed under teaching competencies indicate the importance of teaching student nurses "how to teach". It is essential that NQNs be competent health educators. Only one study done in the USA by Ackerman et al (1981:37-43) distinguished between the health education competency levels of hospital-based nurses and community nurses. Community nurses were perceived to be considerably more active in providing health education. Findings from this study might indicate that community-based NQNs may provide better health education more effectively than NQNs allocated to the psychiatric, midwifery and general nursing units.

NQNs should also take cognisance of the fact that they will pass through different phases of reaction to their first position after graduation, and that they will experience both positive and negative feelings. Figure 2.2 summarises the expected cognitive competencies of NQNs as depicted in the literature.

<p><b>PROBLEM-SOLVING Competencies</b></p>	<ul style="list-style-type: none"> <li>- Competency in collecting information</li> <li>- Providing individualised approach to patient care</li> <li>- Planning and evaluating patient care</li> <li>- Defining a patient's problem</li> <li>- Defining nursing diagnosis</li> <li>- Selecting information for the solution of a problem</li> <li>- Prescribing nursing regimen</li> <li>- Taking decision of care to be given</li> <li>- Recording nursing diagnosis</li> <li>- Prioritising goals of care</li> <li>- Identifying multiple resources to implement care</li> <li>- Selecting and organising relevant data</li> <li>- Formulating a care plan</li> <li>- Counselling patients</li> </ul>
<p><b>RESEARCH Competencies</b></p>	<ul style="list-style-type: none"> <li>- Understanding research</li> <li>- Identifying areas for research in nursing</li> <li>- Interpreting the research process</li> <li>- Encouraging research in nursing</li> <li>- Using research data</li> <li>- Reading and critically analysing research</li> <li>- Determining applicability of the results in clinical settings</li> <li>- Sharing findings with others</li> </ul>
<p><b>MANAGEMENT Competencies</b></p>	<ul style="list-style-type: none"> <li>- Using time efficiently</li> <li>- Producing clear and accurate reports</li> <li>- Working with constraints e.g. staff shortage</li> <li>- Delegating aspects of care to peers</li> <li>- Leading team conferences</li> <li>- Receiving and giving reports</li> <li>- Assuming leadership role</li> <li>- Making out on and off duty list</li> <li>- Applying policy and procedure as needed</li> <li>- Preparing for doctors' rounds and accompanying doctors during rounds</li> <li>- Ordering ward stock</li> </ul>

<b>CLINICAL JUDGEMENT Competencies</b>	<ul style="list-style-type: none"> <li>- Prioritising patient problems</li> <li>- Cue acquisition</li> <li>- Cue interpretation</li> <li>- Making accurate assessment of a patient</li> <li>- Able to clearly state one's assessment</li> <li>- Planning and organising one's work-day</li> <li>- Specifying nursing intervention in order of priority</li> <li>- Discriminating and synthesising information</li> <li>- Assessing patients/clients' health needs</li> <li>- Identifying rationale for each stated intervention</li> <li>- Identifying preventive actions to minimise patient risk</li> </ul>
<b>TEACHING Competencies</b>	<ul style="list-style-type: none"> <li>- Acquiring communication competencies</li> <li>- Able to explain in simple terms</li> <li>- Setting goals and learning objectives</li> <li>- Identifying learning needs</li> <li>- Managing interpersonal relationships during teaching</li> <li>- Describing principles of teaching</li> <li>- Use of teaching strategies</li> <li>- Implementing teaching plan</li> <li>- Organising learning opportunities for learners</li> <li>- Interpreting learning objectives</li> <li>- Identifying relationship of values to teaching</li> <li>- Applying learning theories to the teaching of students</li> </ul>

FIGURE 2.2 Summary of expected cognitive competencies of NQNs as depicted in the literature (Ackerman et al 1981:37-43; Gleit & Graham 1984:25-28; Joyce-Nagata et al 1989:314-320; Sanford et al 1992:70-74).

## 2.7 AFFECTIVE COMPETENCIES

### 2.7.1 Adaptive /adjustive competencies

Appreciation of new graduates' experiences in a clinical setting could facilitate their adaptation

competencies. One educator describes the problem: "The most difficult adjustment to make is caused by the lack of correlation between what is taught and what they see. We, of course, teach the optimal, knowing they're not going to find it in the clinical setting. Then they get a shock - the shock of realising that, for the most part, they are unable to put into effect the principles they would like to" (Benner & Benner 1979:64) in the USA. Shortage of facilities in the clinical setting could be another major problem. Nurse educators might improvise to enable students to cope with reality. However, NQNs may be dismayed, upon entering the work setting, to find themselves unable to perform their nursing tasks due to lack of equipment.

Louis (1980:226) indicates that voluntary turnover during the first eighteen months on the job is increasing among college graduates in their first career jobs in the USA. She proposes that an appreciation of what newcomers typically experience during the transition period, and how they cope with their experiences, is fundamental to designing entry practices that facilitate newcomers' adaptation to the environment. Louis' proposal corresponds with the intent of this study. This study is aimed at identifying the expected competencies of NQNs, as perceived by the SPNs, so that an orientation model, a list of competencies based on the identified needs, may be developed, and this could enhance the NQNs' successful adjustment to their work situation.

Louis (1980:236) describes some key features of a NQNs' experience and outlines a model for understanding the processes of their coping or making sense out of their new environment. It is proposed that change, contrast and surprise constitute major features of the entry experience. Regarding change, there should be recordable evidence of a difference that includes new location, title, salary, job description, prerequisites and many other things. The NQN may experience a change in role and in professional identity. Other changes could involve altered status and major

differences in basic working conditions. This type of experience may be considered realistic. The consequences underlying change were identified in the study done in England by Lathlean & Corner (1991:19). NQNs experienced difficulties with the role in the four main aspects:

- ▶ delegation and co-ordination of work (55 percent);
- ▶ staff relations (32 percent);
- ▶ talking to relatives (18 percent); and
- ▶ the management system in the hospital (8 percent).

Louis (1980:236) describes contrast as features against a general background. Particular features may emerge when individuals experience new settings. The newcomer may evaluate aspects of the new role using old role experiences. Surprise, as the third feature, represents a difference between an individual's anticipated and actual experiences in the new setting. Several forms of surprise often arise during the encounter stage and require adaptation on the part of the NQN. Although there is evidence in the literature to suggest that socialisation experiences affect personal and role outcomes, few empirical studies of the socialisation process have explicitly addressed the question of how specific socialisation tactics affect NQNs' adjustment to an organisation. A study to this effect was conducted by Jones (1986:262) in the USA, addressing newcomers' subsequent adjustment to an organisation and their role behaviours. Findings revealed a pattern of relationships between tactics and outcomes, supporting the proposition that different socialisation tactics may lead to different outcomes of socialisation. The social dimensions of socialisation appeared to be particularly significant in influencing role orientations and subsequent adjustment to organisations.

The study cited by Henderson (1982:181) augmented the findings of Jones' study. Henderson

further compared adjustment competencies of Sturt CAE graduates with those of hospital-based nursing graduates in Australia. Sturt CAE graduates perceived themselves to be below the hospital graduates in performance in all seven items, namely:

- ▶ being accepted in the ward;
- ▶ being accepted by other first-year registered nurses;
- ▶ accepting criticism from staff;
- ▶ confidence in one's nursing ability;
- ▶ enthusiasm and interest in nursing;
- ▶ working under pressure; and
- ▶ adjusting to the work environment.

The findings of Henderson's study appear to imply that hospital-based nursing graduates adjust to their clinical practices within a shorter time than college or university-based nursing graduates. This may be attributed to the fact that hospital-based student nurses become clinically grounded upon entering the course, which facilitates their socialisation process. On the other hand, college or university-based nursing graduates have to become socialised to the clinical situation after graduation.

Van Ess Coeling (1990:28) did a research follow-up with 40 senior student nurses at a midwestern university in the USA. "Using work group culture knowledge to adjust to working life" was her theme. The new graduates were quick to identify whether the priority of their work group was giving physical or psychological care. One nurse shared how a strong focus on organisational efficiency motivated her to change her behaviour so that she would fit in with the group. She explained, "I was told I had to be organised when I started here. This changed me. I'm

not an organised person, so I've become more organised. I'm willing to become more organised because I enjoy working here." This was contrary to several nurses who planned to leave their units, indicating that a major reason was nurses' on their present unit not helping each other enough. What emerged most strongly was that most units used an indirect manner of criticism. Nurses said that they could hear people talking behind their back, or just sensing that people were disapproving. The findings of the study done by Lowane (1990:73) in the area of Gazankulu (forming part of the Northern Province in the RSA since 1994), concurred with the finding that "negative attitude of sisters" had been perceived as a factor hindering student learning in the clinical setting by an average of 80 percent of third and fourth-year student nurses .

The study by Lathlean & Corner (1991:8), in England, revealed that there was a tendency for NQNs to uncritically accept the work culture without questioning the prevailing methods and attitudes, even when these were contrary to the nurse's own beliefs and views. NQNs tend to get into a routine, and to become less aware of deficiencies. However, some NQNs in another study revealed that following established guidelines was very important to their unit, and that was another indication of avoidance (Van Ess Coeling 1990:29). It needs to be realised, however, that following guidelines and uncritically accepting the unit routine without questioning could be associated with lack of confidence in oneself, that is, "a feeling of inadequacy". Lathlean & Corner (1991:8-9) in England, identified that there were NQNs with insufficient sensitivity to their own shortcomings while, at the other extreme, there were nurses who were "too aware" of their weaknesses and unable (or unwilling) to identify their own strengths, leading to a diminution of self-confidence. Lowane (1990:73), in the former area of Gazankulu (forming part of the Northern Province in the RSA since 1994), also identified fourth-year student nurses' poor perception of themselves in the item "feeling of inadequacy in practising clinical skills" while first

years enjoyed complete confidence.

### Summary

In most cases, adjustment seems not to be considered a practical competency which can be evaluated. However, adjustment of an NQN in the clinical setting may facilitate the development of confidence. The studies discussed in this regard indicate that there is a relationship between adjustment of NQNs and placement. Troskie's findings (1993:56) augment this by revealing that nurses working in their area of interest are more positively inclined towards senior personnel. Therefore, the "principle of choice", if applied upon hiring NQNs, could improve attitudes among NQNs.

In conclusion, it may be expected that an NQN, who throughout her training showed a sense of commitment to learning (by identifying herself as a member of a unit team; participating actively in rendering nursing care; identifying herself with other senior members and emulating good role models), will easily pass the surprise stage (Louis 1980:236), upon entering the work setting, and start to demonstrate efficiency in her role performance.

### **2.7.2 Competencies relevant to maintaining interpersonal relationships and communications**

Nurses usually become competent in communication as a result of professional preparation as well as life experiences. In order to provide effective psychological care and support for patients' needs, NQNs require professional communication competencies. Shuldham (in Lathlean & Corner, 1991:73) asserts that communication can present difficulties for the NQN. She has to make decisions about many things, divide attention fairly among individual patients, and may feel

guilty if seen talking to patients and relatives. Furthermore, she has to communicate with a wide range of people and may have limited experience of doing so. The NQN may fear losing face. As the nurse in charge she may have to continue to manage the ward, delegate work to others and act as mentor to student nurses. She may also have to discuss with patients and their relatives many issues concerning diagnosis, progress and prognosis, and cope with the ensuing emotions.

Shuldham (in Lathlean & Corner, 1991:73-74) cites a review of one hundred complaints from patients regarding their care. Findings reveal that 25 percent of the complaints were due to a primary breakdown in communication. Fifty percent had reported a communication problem. Although these findings are not directly applicable to the NQN, they indicate that nurses in general have a communication deficiency. Shuldham also cites Walton (1986), who examined the Health Service Ombudsman's report, in England, which revealed the failures in communication concerning nurses, namely failure:

- ▶ to give relatives adequate or timely information;
- ▶ to summon medical attention or facilitate meetings between relatives and medical staff;
- ▶ to offer waiting patients or relatives reassurance or explanations for delays;
- ▶ in communication between hospital and community care staff;
- ▶ to maintain sympathetic staff attitudes; and
- ▶ to keep proper records.

Similar findings may be expected from the results of this study. The training and education of student nurses might not prepare them adequately to maintain interpersonal relationships and communications in multicultural health care settings in the RSA.

The South African health-care delivery system has to cater for widely varied cultural groups and there is therefore a need to address this diversity. Failure to understand the specific needs of individuals, families and groups of particular cultures, could contribute to causing the nurse's low self-concept and low self-confidence and consequently to incompetence in the communication-interaction process (Felder 1990:276; Leininger in McCloskey & Grace 1990:536). Brink (1990:42) also supports this view by indicating that in a multicultural country like the RSA, knowledge of transcultural specific and universal care is greatly needed to guide nursing decisions in caring for individuals, families and communities.

The scope of practice (R2598) prescribes that an NQN in the RSA should be competent in "the facilitation of communication by and with a patient in the execution of the nursing regimen". The use of appropriate communication competencies facilitates the development of caring and therapeutic relationships with patients and families. Adequacy of communication enables the nurse to comply with the professional duty of being accountable. For example, during the implementation of the nursing process, unless nurses can communicate competently, they cannot assess patients' needs for care, plan care effectively, implement it, or evaluate it. Fitzpatrick et al (1992:1212), in England, reports several studies which indicate that poor communication may be linked to inadequacies in the teaching of communication competencies in nursing education programmes. Other possible explanations for ineffective communication may include:

- ▶ nurses' inability to cope with stress;
- ▶ insufficient time;
- ▶ fear of patient involvement;
- ▶ the inhibiting effect of senior staff; and
- ▶ nurses' awareness of the limitations of their knowledge.

The teaching guide for the programme leading to registration as a nurse (general, psychiatric and community) and midwife, endorses that the student should be able to "apply interpersonal skills in all social interactions, in demonstrating empathy, providing reassurance, in crisis management and in exercising assertiveness" (SANC 1992:11). The guide further emphasises that the student should have appropriate orientation regarding the following competencies before being allocated to a psychiatric unit:

- ▶ communication competencies in diagnosis and therapy;
- ▶ group competencies;
- ▶ counselling competencies;
- ▶ crisis-intervention competencies; and
- ▶ competencies in management of stress.

Therefore, this study expects the NQN allocated to the psychiatric unit to have developed mastery of interpersonal communications competencies.

Searle and Pera (1992:136) in the RSA, also support the opinion that competency in communication is essential to all nurses. This implies interpersonal relationships such as:

- ▶ careful listening;
- ▶ meticulous explanation to a patient;
- ▶ consultation with a patient;
- ▶ meaningful touch;
- ▶ consideration;
- ▶ courtesy;
- ▶ oral, written and mechanical means of communication;
- ▶ assisting a patient to communicate his/her needs to others; and

- ▶ communication with his/her relatives and friends.

Kramer (1974:23) in the USA also asserts that new graduates may not be expected to know everything, but it is realistic that they should come to the work scene schooled and practised in basic interpersonal, organisational, manual and communication competencies. Kramer further indicates that the appellation "lack of self-confidence" among NQNs, may well be masking an underlying issue. They might be suffering from a lack of interpersonal communication competency.

Few studies supporting the conceptual views discussed on the interpersonal communication competencies of NQNs were identified. Girot (1993:114-119) conducted a study in England to examine experienced ward/departmental sisters' understanding of the term "competency in learner nurses and how they measure it". On analysis, the attributes of both competent and non-competent students were found to cluster naturally into four common themes: trust; caring; communication competencies and knowledge/adaptability. The notion of non-verbal communication seemed to dominate the sisters' expectations, especially from third-year level to finalists. This was a signal for "incompetency": "they give the most amazing body language that is quite fascinating to watch ... They'll have their shoulders close to their heads and they'll have their hands behind their backs ... and that sort of thing ...". With senior students and new graduates, sisters interviewed expected them to be much more independent as practitioners and more effective communicators. The ward sisters' viewpoint of competency in communication supports the assumption of this study. NQNs are expected to be independent practitioners upon entering the work setting. This may not be the case. Candlin (1992:445-451), in Australia, argues that a sophisticated communication process at which individuals must be competent, is not automatic. It must be worked at and developed if the nurse is to be truly committed to the healing

process. It is the responsibility of nurse educators to facilitate the growth and development of this competency in the students of today, if they are to be the nurses of tomorrow, meeting new challenges.

The findings of the study done by Henderson (1982:181) in Australia revealed that Sturt CAE graduates' performance on interpersonal communications was above that of hospital graduates on the following items: treating the patient as an individual; talking with patients; talking with relatives of patients. The item, caring for a patient who is displaying anxiousness, was evidently not met by Sturt CAE graduates, whereas the supervisors rated them above their hospital colleagues. Diverse findings were revealed by Troskie (1993:57) in the RSA. A significant difference was found on all the items under "communication". Supervisors evaluated the NQN at a lower level. Troskie's table indicated below shows that NQNs consistently regarded themselves to be better communicators than their supervisors did (Troskie 1993:57).

TABLE 2.1 Troskie's table indicating communication procedures as perceived by an NQN and her supervisor.

COMMUNICATION PROCEDURES	PERCENTAGE			
	COMMUNICATION WITH PATIENT		COMMUNICATION WITH PATIENTS' FAMILY	
	NEWLY QUALIFIED NURSE N = 253	SUPERVISOR N = 238	NEWLY QUALIFIED NURSE N = 253	SUPERVISOR N = 238
Explain Procedures	59.0	35.0	56.7	34.1
Admission Orientation	80.0	50.0	75.8	47.1
Support	67.2	33.9	60.6	36.4
Health Education	52.2	27.4	52.6	30.6
Inclusion in Planning	48.0	29.3	44.0	25.7

On the other hand, the persistently low ratings of communication procedures by the supervisors could be questioned. The findings may reflect NQNs' negative attitudes towards patients and their families. This study, however, recommended that the area of interpersonal communications

be explored in depth in order to establish the cause of the reported incompetency. Contradictory findings were revealed by the study done by Vanetzian & Higgins (1990:269-275) in the USA. The study compared new graduates' self-appraisal on nursing performance with those of their evaluators. Performance on interpersonal relations/communications was rated second to professional development. The items included:

- ▶ promoting the inclusion of patients' decisions and desires concerning his care;
- ▶ seeking assistance when necessary;
- ▶ helping a patient communicate with others;
- ▶ promoting the patient's right to privacy;
- ▶ explaining nursing procedures to a patient prior to performing them; and
- ▶ helping a patient meet his emotional needs.

The contradiction in findings might be due to the fact that the NQNs referred to in Troskie's study were diplomates, whereas new graduates referred to in the study of Vanetzian & Higgins were basic degree graduates.

#### Summary.

With the exception of Vanetzian & Higgins' (1990:269-275) study in the USA, other studies and conceptual views concur that NQNs are not adequately prepared as far as interpersonal relations/communications are concerned. Interpersonal communications competencies could also be learnt through emulating seniors. If SPNs maintain good relations with students while mentoring them, NQNs are expected to be efficient in this regard. The study done by Lowane (1990:82), in the area of Gazankulu (forming part of the Northern Province of the RSA since 1994), revealed aspects which could be extremely important if they were prevalent in the clinical

setting. Student nurses said that they needed superiors who encouraged them to feel free to ask questions; they needed free communication with all the ward staff; they needed to learn through positive examples from their superiors. However, this type of milieu may be insufficient or lacking in some clinical settings where student nurses and NQNs may be working..

Contrary to student nurses' positive perceptions in the study done by Lowane (1990:89-90), student nurses' responses resulted in high frequencies on the following items related to factors causing stress in the clinical setting:

- ▶ oppression by ward sisters;
- ▶ being shouted at in front of the public;
- ▶ harmful remarks made in front of patients; and
- ▶ questions not answered by superiors.

Nevertheless, a high percentage of students indicated that they would like to learn more about the following aspects: listening to patients' problems (87,7 percent); good communication (78,1 percent); how to comfort patients in severe pain (74,2 percent) and interpersonal relationships (73,4 percent) (Lowane 1990:89-90).

### **2.7.3 Caring competencies and ethical viewpoints of man**

Caring is the core of nursing practice, and the core of nursing competencies. Caring permits the nurse to focus on priority needs, allowing her to notice subtle signs of improvement or deterioration in a patient's condition. The function of the nurse practitioner is to utilise her scientific and technological knowledge to provide a caring service (Giot 1993:116).

Caring embodies all other aspects of clinical competencies. Nursing treats individuals, families,

groups and communities, while nurses observe, listen, test, assess, diagnose, monitor, manage, treat and cure. But above all, nursing is "caring" (Diers 1986:27). Brink (1990:38-43), in the RSA, argues that despite the fact that caring is the heart of nursing, there is growing evidence that nurses are not as effective as they ought to be in their caring role. This signifies that more attention needs to be given to the teaching of caring.

"Caring is more than kindness." Valentine (1989:28), in the USA, indicates that in today's competitive health care environment, the term "caring" is used to promote positive consumer response to services, but little attention is paid to its substantive nature. Nurses tend to regard simple things such as talking to patients, listening to patients and reassuring patients as most important "caring behaviour". However, this type of caring needs to be complemented by demonstrations of clinical expertise in performing therapeutic actions.

Research studies based on measuring nurses' competencies on "caring" appear to be limited, but studies on patients' and nurses' perceptions of caring behaviour seem to be voluminous. This study therefore utilised the identified elements of caring behaviour as a point of reference to identify NQNs' competencies in "caring" as perceived by SPNs. A number of studies revealed that nurses tended to perceive expressive affective behaviours as most important. Kelly (1992:121-124) conducted a study in the USA to explore "How do senior nursing graduates describe their professional self-concept?" Findings revealed that caring was identified as the core variable. The majority used caring qualifiers such as being cheerful, friendly, a good listener, empathic, compassionate, patient and good humoured. The following self-descriptions for caring were made by the informants: "I am a very caring person, patients tell me they know I care about them"; "I encourage self-care"; "I try to treat them as persons, not as patients"; "I am not a very skilful

nurse as far as technical competencies are concerned; I have the knowledge in my head but it doesn't always come out" (Kelly 1992:123). Self-descriptions of competency were exemplified by the following statements: "I try to treat everyone the same and not discriminate; efficient, pleasant". The findings of the study revealed that these graduates-to-be lacked self-confidence and they were not competent to describe what they physically did to denote "good caring" (Kelly 1992:123). However, this study would have benefitted subsequent research if the graduates had explicitly identified the caring competencies for which they felt adequately prepared, and in which they were competent, as well as those competencies in which they regarded themselves as being incompetent or inefficient.

The research done by Girot (1993:116), in England, revealed that the notion of caring competency was expected of senior student nurses and NQNs. One sister in a general ward recognised that a finalist student lacked patience with demanding patients. She preferred up and about patients. The lack of concern by this particular student appeared to have prevented her from caring and she was thus perceived as being incompetent. Lack of trust was also identified in those students identified as being incompetent.

Demanding patients might help a nurse to develop observational competencies. The findings of the study done by Lowane (1990:69) in the former area of Gazankulu, in the RSA, indicated that "observation of patients" was minimally learnt by fourth-year students (29 percent) as compared with 84 percent of first and second-year students. This might have implied that finalists no longer interacted directly with patients. They had possibly bypassed the stage; or this discrepancy could be attributed to the emphasis placed on management functions during the final year of training at the expense of other clinical functions. Development of the observation competencies is

indispensable to the determination of appropriate nursing actions in providing expert patient care (Lowane 1990:69). A different perception was described by senior student nurses in the study done by Windsor (1987:151) in the USA. These respondents perceived their clinical experiences to be very valuable. They learnt assessment, caring, therapeutic communication and other psychomotor competencies.

"Good nursing practice as perceived by clients" was a study done in Finland by Astedt-Kurki & Häggman-Laitila (1992:1195-1199). Though not directly related to the SPNs' views of NQNs' competencies, the study provided clear indications that today clients generally know more about health care and that they have greater expectations. The expectations identified served as "indicators" for competencies. The findings revealed that the clients expected to be treated as individual people. Discussion with the nurse, being listened to and being provided with individualised relevant information were regarded as signs of good and safe nursing care. Caregivers were expected to show interest in their feelings and experiences; patients' need for help should not be belittled; and patients' freedom of choice and right to make decisions should be respected.

Patients wanted to be informed of their own illness, its causes, care possibilities, as well as the length of care and the prognosis of their illness. They also expected to be informed and prepared for caring for themselves at home and for assessing their own state of health. Consequently, in general the hospital environment was regarded as being unhomely and uncomfortable. Having an opportunity for "peace and quiet for oneself" was felt to be lacking in hospital. Rest and sleep were affected by an uncomfortable bed, noise, pain, worries and anxiety about illness (Astedt-Kurki & Häggman-Laitila 1992:1195-1199). Nurses might not be adequately prepared to relieve

pain and alleviate worries and anxiety. Another aspect could be lack of peace and quiet for oneself. The nursing trend appears to be to provide individualised patient care according to his/her needs. "Routine nursing care" does not, however, seem to have been eradicated. Patients may be woken up at awkward times for temperatures, bathing, tea and many other non-essential activities. The concepts "assess patients' needs" and "respect of patients' rights" may still be lacking. The dominating clinical practice appears to be "assess nurses' needs" to complete the day's routine in the clinical setting. Although it is essential to "assess nurses' needs", it is also important to "assess patients' needs" in order to render effective nursing care to patients/clients.

Credibility was given to the health centres, however, as the nurses were viewed as taking the clients' health problems seriously, concentrating on them and making sure that the action proceeded flexibly from the clients' point of view (Astedt-Kurki & Häggman-Laitila 1992:1198).

Studies exploring both nurses' and patients' views of caring behaviours indicated diverse perceptions of most and least important behaviours. Nurses perceived behaviours such as comforting, touching, attentiveness, listening and sensitivity as effective caring behaviour. In contrast, the patients were more concerned with the nurses' demonstrating a high degree of competency with hands-on competencies, physical assessment and monitoring as well as accessibility at the university college of allied health sciences and professional nurses in the USA (Mangold 1991:134-139). Trust and comfort were the major attributes of caring as perceived by professional nurses and senior students. Both groups agreed that the most important behaviour was "listens to the patient". This is contrary to the findings of the study done by Lowane (1990:72). The item "listening to patient's problems" was not mastered by the fourth-year students, and "comforting patients in severe pain" was also minimally learnt in the former area of

Gazankulu, in the RSA. NQNs may also suffer incompetency in this regard.

Von Essen & Sjoden (1991:1363-1374), in Sweden, also revealed that patients ranked items concerned with giving honest and clear information and competent clinical expertise as most important, while nursing staff ranked affective behaviours as important. Chipman (1991:171-175), in the USA, also identified three categories of nurses' affective caring behaviours as giving of self; meeting patients' needs in a timely fashion; and providing comfort measures for patients and their families. Komorita, Doehring & Hirschert (1991:23-29), in the USA, also obtained a clear difference between the perceptions of nurses and patients. The data supported the results of previous studies. Nurses tended to consider comfort and trust relationship items as most important while patients perceived behaviours associated with physical care as most important.

Philosophical and ethical points of view regarding man, health and nursing may be the key elements of "caring". Studies relevant to exploring ethical competency of NQNs were not found. However, the study done by Joyce-Nagata et al (1989:316) in Mississippi, USA, indicated that graduates provided evidence of unexpected behaviours on the following ethical points:

- ▶ knowing a variety of value systems;
- ▶ recognising the dignity and worth of the individual; and
- ▶ providing conditions in the environment that support human dignity.

Similar findings were revealed by Sweeney, Regan, O'Malley & Hedstrom (1980:39) in Boston. Patients also expected nurses to maintain professional decorum and demonstrate ethical behaviour.

"To recognise the dignity and worth of the individual in such a way that sympathetic and empathic

interaction take place and to be able to maintain the ethical and moral codes of the profession" is the expected outcome of the programme objectives for the training of NQNs in the RSA (SANC:R425 of 1985). Brink (1990:41), in the RSA, also indicated that research in this area had revealed that a number of aspects related to caring were included in the curriculum for the course leading to registration as a nurse and midwife. Such caring aspects included interpersonal competencies, therapeutic use of self, empathy and stress alleviation.

#### Summary.

The studies discussed on "caring" revealed diverse perceptions of caring behaviours. Nurses were inclined to perceive affective behaviours as being most important, while patients perceived both affective behaviours and the demonstration of physical care as being most important. This study intended to utilise both nurses' and patients' perceived caring behaviours to identify NQNs' competencies.

The acts and procedures entailed in the scope of practice (R2598) exemplify "caring behaviour" expected of professional nurses in the RSA . Caring means physical contact and interaction with the client. Searle & Pera (1992:139), in the RSA, express concern regarding the role of technology. They indicate that human beings have not changed. Man will always need the comfort and support of another human being. They further indicate that the caring role will become increasingly difficult as technological advances are incorporated into modern medical science. Without the competent and concerned nurse, technology cannot meet man's total health needs.

SPNs should take cognisance of the fact that they are the role models for teaching caring in the clinical setting. Brink (1990:41), in the RSA, cites literature which reviews ways of promoting

the teaching of caring. Literature supports the view that the nursing teacher, by being an example of care, can effect a caring attitude in the student nurses. Superiors must first exhibit and practise caring to enable students to acquire "caring" competencies and behaviours.

ADJUSTIVE/ADAPTIVE COMPETENCIES	INTERPERSONAL COMPETENCIES	CARING AND ETHICAL COMPETENCIES
<ul style="list-style-type: none"> <li>- Accepting criticism from seniors</li> <li>- Confidence in one's nursing ability</li> <li>- Working under pressure</li> <li>- Adjusting to work environment</li> <li>- Enthusiasm and interest in nursing</li> <li>- Coping with demands of work load</li> <li>- Being sensitive to people's feelings</li> <li>- Committing herself to unit objectives</li> </ul>	<ul style="list-style-type: none"> <li>- Careful listening to patients</li> <li>- Applying a meaningful touch</li> <li>- Showing consideration</li> <li>- Assisting a patient to communicate his/her needs to others</li> <li>- Treating patient as individual</li> <li>- Talking with patients</li> <li>- Talking with relatives of patients</li> <li>- Caring for a patient who is displaying anxiousness</li> <li>- Promoting the inclusion of patients' decisions and desires concerning his/her care</li> <li>- Seeking assistance when necessary</li> <li>- Helping a patient communicate with others</li> <li>- Promoting the patient's right to privacy</li> <li>- Explaining nursing procedures to a patient prior to performing them</li> <li>- Helping patient to meet his/her emotional needs</li> </ul>	<ul style="list-style-type: none"> <li>- Discussing with the client</li> <li>- Providing individualised relevant information</li> <li>- Respecting a patient's freedom of choice and right to make a decision</li> <li>- Preparing patients for self-care</li> <li>- Relief of pain</li> <li>- Alleviating worries and anxiety</li> <li>- Recognising the dignity and worth of the individual</li> <li>- Providing conditions in the environment that support human dignity</li> <li>- Demonstrating ethical behaviours</li> </ul>

FIGURE 2.3 Summary of the expected affective competencies of NQNs as depicted in the literature (Komorita et al 1991: 23-29; Lowane 1990:72; Mangold 1991:134-139; Von Essen & Sjoden 1991:1363-1374).

## **2.8 PSYCHOMOTOR COMPETENCIES**

The manual competencies that were considered to be a very important part of nursing care seem to have been overlooked somehow in the evolution of the educational process. It appears as though nursing education of today places primary emphasis on psychosocial behaviour and the acquisition of cognitive knowledge at the expense of psychomotor competencies. Scheetz (1989:29), in New York, USA, supports this view by indicating that though NQNs have an adequate theoretical base, they lack competency in the clinical practice setting. This lack of competency is manifested by awkwardness when performing psychomotor competencies. Sweeney et al (1980:37) in Boston, USA, also indicate that, historically, when nursing education was hospital controlled, it stressed the practice element as much as, if not more than, theoretical content. Manual techniques were the mainstay of nursing performance. However, Peck & Jennings (1989:406-414) in New York, USA, substantiate their viewpoint of nursing education changes by indicating that technical and manual competencies are less useful unless they are applied within the context of an understanding of the whole person and the whole society.

### **2.8.1 The dichotomy of liberal arts and professional preparation**

Though this study is not aimed at researching the dichotomy of liberal arts and professional preparation of a nurse, it is essential to have a broader perspective of the two aspects, as they are perceived by various authors as the primary source of nursing education conflict.

Morse, Bottoms & Wastlick (1992:282-288) in the USA, highlight the important issues surrounding the liberal arts and professional preparation components of the baccalaureate curriculum, and make suggestions concerning the integration of the two. They express the view that within the context of professional preparation, a liberal education is necessary for a graduate

to be versatile and to be able to deal with diversity and change, and it is necessary to develop students who are capable of dealing with ambiguity. However, the authors cite Green and Salem (1988) who express the opinion that any education that emphasises knowledge for its own sake, without also attending to the practical implications of that knowledge is irrelevant, if not sterile.

Elman & Lynton (1985) as cited by Morse et al (1992:283) in the USA, suggest a major revision in curriculum structure to help achieve integration. They state that the curriculum should be revised so that the experiential components become the primary learning experiences. Learning would be derived from doing, with emphasis placed on inductive reasoning, problem definition and the ability to generalise. The HMC of the RSA appears to concur with Elman and Lyntons' views. The HMC also recommends re-evaluation of the basic approach of the comprehensive four-year programme of nurse training in the RSA. Reeds (1987) cited by Morse et al (1992:283) in the USA, also substantiates the suggested views by proposing a curricular model that integrates rather than separates professional and liberal arts courses.

Bevis & Watson (1989:39-40) in the USA, argue that the mandate is to shift from a focus of training to education, from technique to understanding, from strict content to critical clinical decision making, from product line thinking to value-based human caring education. Various other studies reviewed do not, however, agree with their argument. Sweeney et al (1980:39) in the USA cite research findings published by Shields, who surveyed the kind of competencies a nurse should be able to perform after graduating from a basic nursing programme. Respondents placed manual competencies as the first ability that the graduate should have. Other requirements, such as legal knowledge, interpersonal competencies and teaching competencies, followed manual competencies in priority. Bailey (1989) cited by Sweeney et al (1980:39) in the USA also revealed

similar findings. Head nurses and clinical instructors chose the demonstration of manipulative competencies and technical competencies as the most effective type of behaviour. Physicians also chose efficient performance in an emergency or stress situation as the most important behaviour. This could imply that nurses should be taught technological competencies. Patients selected the provision of emotional support as nurses' key behaviour.

It is, however, generally agreed that new graduate nurses are deficient in technical competencies, and that educational institutions must again emphasise clinical competencies to enable new graduates to provide basic nursing care. A slightly different view has been expressed by Sweeney et al (1980:39) in the USA, who assert that despite the relative importance placed on developing competency in performing manual competencies, nurses in various settings show little agreement about this subject. The diversity emanates from philosophical differences between the educational system and the service agency. The educational system prepares a person for a life of learning with emphasis on cognitive and affective processes, rather than on content and techniques, while the service agency is primarily concerned with technical and organisational competencies which include safety, organisation, direct and rapid problem solving during emergencies, care for all types of patients and immediate intervention behaviour.

Studies exploring the psychomotor competencies required in the clinical setting revealed that most, if not all the basic manual competencies should be taught for competency. Only a few selected technical competencies were identified to be taught for competency. The study by Clayton cited by Chaska (1983:124-127), presented a survey to determine a defensible list of professional competencies in Georgia, USA. The competency statements were divided into 11 categories which included safety, hygienic care, rest, nutrition, elimination, respiration, medication

and specific therapeutic assessment, communication, organisation and self-development. Findings revealed that with the exception of two, all items received an approval rate of at least 80 percent from registered nurses. "Assesses nutritional status" and "Utilises oxygen analyser to correctly determine oxygen concentration" failed to make the defensible list. In respect of the second of the two technological competencies previously mentioned, the result might have been expected, as it demands technological operations which may need some kind of specialisation.

According to the scope of practice (R2598) "the facilitation of the maintenance of nutrition of a patient" is an expected competency of the professional nurse in the RSA. A nurse can only maintain the nutritional status of a patient after she has done a proper assessment. "Maintenance of nutrition" embraces such things as oral and intravenous methods of feeding, nutritional education, the design of nutritional programmes for a patient, assistance with feeding infants, the helpless, the unconscious, the mentally disturbed and the aged (Searle & Pera 1992:136) in the RSA. Assessment forms the basic step of all nursing actions.

The study done by Kieffer (1984:198-202) in Kentucky, USA, also supported the significance of teaching manual competencies. Such competencies as assessment of vital signs, assisting with mobility, elimination, hygiene and asepsis, medication administration, and the use of sterile techniques were ranked among the top 25 percent of most frequent/most important in the practice setting where new graduates were employed. The technologically complex competencies occupied the mid-range of frequency/importance on the list of competencies. The least frequent/least important competencies were only significant to a particular clinical group when viewed separately. They included caring for casts, maintaining various types of traction, and maintaining a croupette.

One assumption of this study states that the competencies of NQNs might vary, depending upon the type of patients being nursed in the clinical nursing unit (general, psychiatric, community health or midwifery). NQNs in the USA indicated poor performance in critical care (Vanetzian & Higgins 1990:273). Such findings could be considered normal. Critical care is a significant area which needs specialisation such as intensive care. It may, however, be observed that SPNs did not comment much on this aspect, as the majority of hospitals in the geographic area of this study are without intensive care units. Schwirian (1978:350) also indicated in her study in the USA that critical care received a lower alpha coefficient of  $< .859$  compared to  $< .978$  for the professional development subscale, as perceived by new graduates and their employers. The critical care aspects identified by Schwirian included:

- ▶ performing technical procedures;
- ▶ suctioning tracheostomy care;
- ▶ catheter care;
- ▶ use of cardiac monitor respirators; and
- ▶ meeting the emotional needs of a dying patient.

NQNs might be discredited for not being able to perform clinical care. Several factors can be identified which could contribute to such a situation. NQNs may be overwhelmed with administrative and organisational tasks which can consume a disproportionate part of their working day. Vaughan (in Lathlean & Corner 1991:24) indicates that in England priority setting, delegation of work, negotiation and organisation become the order of the day with little time to pay much attention to the continuing development of practice. In New York, Benner & Benner (1979:57-58) conducted focused interviews with the nursing service respondents. The respondents completely condemned the newly registered nurse: "Some of them haven't done

catheterisations, and medications seem strange to them. It's surprising how little experience they have had" (Benner & Benner 1979:57).

Diverse views regarding the psychomotor competencies new graduates should be able to perform when they arrive on the doorstep of the practice setting were identified in a few studies. Sweeney & Regan (1982:37-39) in Boston, in the USA, compared the attitudes of faculty and nursing service personnel in rating the importance of a number of psychomotor competencies. The competencies which were perceived to be essential by faculty and non-essential by nursing service, were technical in nature. They included competencies such as:

- ▶ using electronic thermometer for taking temperature;
- ▶ performing tracheal aspirations;
- ▶ obtaining accurate central venous pressure reading; and
- ▶ performing vision test.

Graduates in the study done by Sweeney et al (1980:40-41) in Boston, USA, also regarded those competencies as a bonus, meaning that "it would be nice if every student had the opportunity to perform this procedure, but it is not essential". The findings once more support the notion of the philosophical difference between the education system and the nursing service system.

Summary.

The studies cited on the psychomotor competencies of NQNs reveal that competent performance is essential in all basic nursing care competencies. However, NQNs are not trained to become technicians. NQNs could probably be skilled in the use of machines applied during emergencies such as:

- ▶ operating a respirator;

- ▶ incubating a patient;
- ▶ delivering oxygen; or
- ▶ using a vacuum extractor to aid delivery of a distressed baby.

Although the literature reviewed indicates that all the basic competencies are considered essential, the NQNs do not necessarily perform them at a competent level.

An attempt to summarise the psychomotor competencies depicted in the literature was found not to be feasible as the competencies identified were too numerous. Identifying psychomotor competencies in this study shall be based on the scope of practice of registered nurses (R2598), that is, description of competencies required to meet the prescribed actions and procedures outlined in this regulation shall be attempted.

## **2.9 THE MEANING OF "AN NQN" AS PRESENTED IN THE LITERATURE REVIEWED**

Throughout the literature reviewed, NQNs appeared to be lacking competencies to perform important cognitive, affective and psychomotor competencies. This perception is supported by Benner (1984:14-35) who undertook a research study in California, USA, of beginning and expert nurses to determine differences in their clinical performance. In her findings, Benner describes the NQN as a novice, one who is only just beginning to develop the expertise needed to give clinical care. Benner asserts that the stages of competency acquisition fall into five broad categories, namely: the novice, the advanced beginner, the competent practitioner, the proficient practitioner and the expert practitioner. Recognition of these phases could, to some extent, overcome the feelings of inadequacy which are often experienced in the early days after qualifying. It is unrealistic to think that expert practice will be achieved immediately.

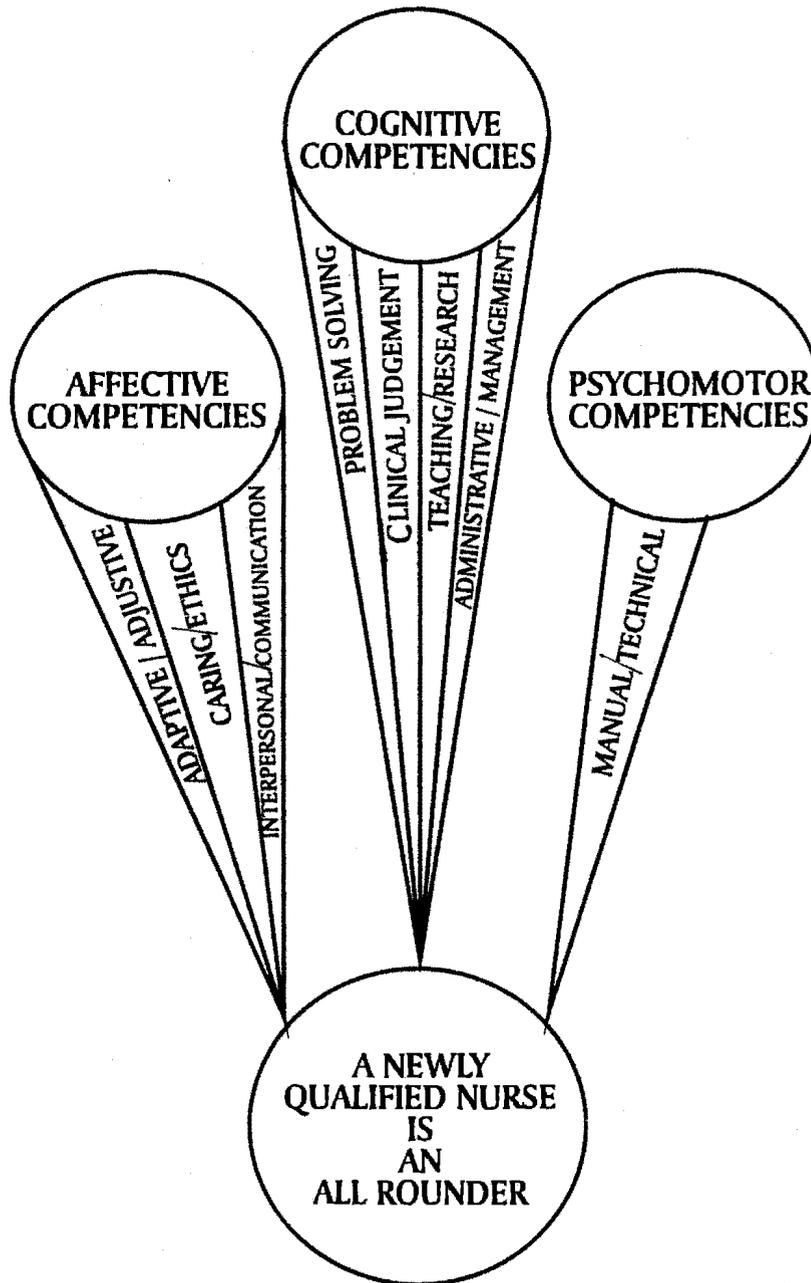
Benner (1984:38) describes the five phases as follows:

1. The novice. One who is new to a situation, has no experience of the situation and is therefore unable to draw on past experience in order to make decisions. She wants to respond to everything but cannot work out priorities.
2. The advanced beginner. One who starts to recognise "aspects" which may influence decision making in a particular situation. She can demonstrate marginally acceptable performance, although she still lacks experience.
3. The competent practitioner. One who begins to see her actions in terms of long-range goals or plans. She is able to plan her work effectively for a longer period of time. She takes time at the beginning of the day to assess all those for whom she will be caring, attending to immediate needs and prioritising work. She has a feeling of mastery.
4. The proficient practitioner. One who has attained a bank of past experience. She is able to view the situation as a whole rather than in terms of aspects; she is fast and efficient, yet retains her humanity.
5. The expert practitioner. She has an enormous background of experience. She can recognise that there is a problem brewing before it becomes apparent to others.

Benner does not clearly indicate the time frame for transiting from one stage to another. She suggests that it could take two to three years to reach the stage of proficiency.

Ideally, the NQNs have achieved competency in all aspects of cognitive, affective and psychomotor competencies upon entering the work setting. Apparently, however, the NQN could be an all rounder without sufficient competency in any specific area. Figure 2.4 summarises the ideal image of an NQN as depicted in the literature reviewed. Figure 2.5 presents a model of the

reality of an NQN's stages of competency acquisition (based on Dreyfus' model of competency acquisition).



**Figure 2.4:** The “ideal” image of an NQN as depicted in the literature discussed in Chapter 2 (Ackerman et al 1981:37-43; Komorita et al 1991:23-29; Joyce-Nagata et al 1989:314-320; Sweeney et al 1980:37-44).

Figure 2.5.: Model of the reality of a NQN's stages of competency acquisition (derived from Dreyfus' Model of Skill Acquisition) (Benner, 1984:38)

NOVICE	ADVANCED BEGINNER	COMPETENT	PROFICIENT	EXPERT
				* By virtue of NQN's comprehensive training, this particular nurse can specialise and become an expert in the following nursing fields:
			* Now an all-rounder	
* Enriched with theoretical background, vivid clinical experience	* Practises discrimination	* Slight change of situation reverses the progress	* Can demonstrate efficiency in cognitive, affective and psychomotor competencies.	<input type="checkbox"/> Midwifery
* Clinical situation seems new and strange	* Starts to identify herself with the competent nurse	* Able to set priorities	* Can solve complex problems simultaneously.	<input type="checkbox"/> Psychiatric nursing
* Organisational culture unfamiliar	* Does have a feeling of mastery, but is not a competent nurse, lacks flexibility	* Develops holistic understanding of events	* Can assume first level positions	<input type="checkbox"/> Community health.
* Scope of practice lacks clarity, needs sustained guidance and support	* Support and guidance still needed	* Able to interpret the guidelines/rules	* Promotable to the rank of senior professional nurse	<input type="checkbox"/> General specialisation in different areas such as:
* The goals of patient care seem to be impossible to achieve		* Can assume "second level" position		- paediatric nursing
* Needs detailed instructions		* Periodically needs exposure to first level position.		- theatre
* Ideally the stage may not exceed six months of exposure.		* Able to deal with the most important problems first.		- intensive care
* Transcending the period most likely to become disillusioned.				- surgical courses
				- medical courses

## **2.10 FACTORS INFLUENCING THE DEVELOPMENT OF NQNS' COMPETENCIES**

The development of competencies in nursing practice is grounded on the professional socialisation of student nurses (NQNs-to-be). Factors contributing towards the development of student nurses' competencies are many and varied, including the following:

- Competency develops from effective application of principles and facts. During the professional preparation of student nurses, learners should be enabled to integrate theory with practice. Student nurses should know why they learn certain principles, how they apply the principles in nursing practice, and when and where the principles are applied (Bevis & Watson 1989:39-40; Morse et al 1992:282-288; Troskie 1993:59-60).
- Competency develops from curiosity. Nursing tutors, concerned with the mentoring of student nurses, should continuously challenge the students. Student nurses should show curiosity to acquire new knowledge and competencies. It is widely accepted that curious persons excel in their performance.
- Competency develops from effective practice. Effective practice is grounded in effective learning principles, facts and curiosity, and also requires the following aspects:
  - \* A conducive clinical milieu. A supportive milieu encourages students to learn clinical competencies. Reilly and Oermann (1985:77) assert that such a milieu is characterised by valuing learning, exhibiting a caring relationship with all concerned, providing for students' freedom to explore, question and to try out different approaches.
  - \* An ideal unit supervisor. Unit supervisors' inherently different personalities contribute to different settings or psychosocial climates for learning by student nurses. Effective practice requires a helping unit supervisor, enabling students to understand and interpret the unit "values", set positive examples, and assume

responsibility for providing support to students. On the other hand, students need to provide feedback by showing commitment to learning, participating actively, asking questions when unsure, and also showing acceptance of their own shortcomings. Team co-operation and open communication should be enhanced.

- \* Competency develops from good clinical facilities. Effective practice requires adequate clinical facilities such as “competent” supervisors, adequate equipment for use, adequate time and “adequate” patients (Lowane 1990:80-92).
- \* Competency develops from preparedness to take up the registered professional nurses’ role by student nurses. Supervisors should play a vital role to make the student realise her roles as a registered nurse. An advanced student nurse should ask herself the following question: “Now that I am a professionally registered nurse-to-be, what is expected of me?” The following aspects could provide answers to this question:

Commitment

Devotion

Responsibility

Accountability

Competency.

This study will investigate the last aspect, namely competencies of NQNs in the clinical situation, as perceived by SPNs.

## **2.11 CONCLUSION**

This study is undertaken to identify the expected competencies of NQNs, as perceived by SPNs, upon entering the work setting, and the competencies which SPNs expect from NQNs in the

general, community health, psychiatric and midwifery nursing units. The purpose of the literature review has been to increase understanding of the research problem, namely “The competencies of NQNs, as perceived by SPNs”. The literature review has revealed that specific cognitive, affective and psychomotor competencies are expected of NQNs. However, NQNs have been reported to be lacking competencies in performing various nursing actions.

Since the implementation of the four-year course (R425) in the RSA, there has been a need for research to explore the NQNs' cognitive, affective and psychomotor competencies. Troskie's thesis (1990:290) critically evaluated the competencies of the NQN in the RSA. This research indicated that further studies should be done to determine the extent to which the comprehensive training of the student nurse to prepare her to practise competently in each of the four specialities of general, community health, psychiatric nursing, as well as midwifery. This study intends to identify the competencies expected of NQNs in the general, psychiatric, community health and midwifery nursing fields respectively in the former areas of Venda, Gazankulu and Lebowa, (forming part of the Northern Province of the RSA since 1994).

The research approach of this study is different from that of Troskie (1990). Troskie evaluated the influence of placement on the competency of the NQN; whether orientation contributed towards the competency of NQNs and the type of guidance given by the supervisor/preceptor, whereas this study intends to answer the following research questions:

- What competencies do SPNs expect NQNs to have upon entering the work setting?
- Which cognitive, psychomotor and affective competencies do NQNs have upon entering the work setting, as perceived by the SPNs?
- Are there differences between the expected and the performed competencies of NQNs as

perceived by the SPNs?

- Are there differences among the perceptions of SPNs concerning the competencies of NQNs in the general, community, psychiatric and midwifery clinical nursing units?
- Which competencies of the NQNs need to be improved, as perceived by the SPNs?

The research methodology adopted to research these questions will be discussed in the next chapter.

## CHAPTER 3

### THE METHODOLOGY ADOPTED TO STUDY THE COMPETENCIES OF NQNS AS VIEWED BY SPNS

#### 3.1 INTRODUCTION

This chapter describes the research methods, population, instruments and also decisions regarding the strategies to be used to collect and analyse the data to address the research questions.

#### 3.2 RESEARCH APPROACH

This research is based on identifying the competencies of NQNs as viewed by SPNs. A descriptive survey was employed to provide insight into the problem. Seaman (1987:182) describes a descriptive study as a "factor-searching study" which can be used in the clinical area. Seaman considers descriptive studies to be basic but also both sophisticated and difficult. The descriptive studies may lead to new ways of thinking about important clinical problems, may possibly lead to changes in nursing practice, and the researcher may be able to focus the stages of research moving from description of data to an empirical generalisation.

In a study similar to this one done by Troskie (1990) in the RSA, a survey was used to evaluate the competencies of NQNs as viewed by themselves and their supervisors. In this regard Vanetzian & Higgins (1990:9) compared the new graduates and evaluators' appraisal of nursing performance in the USA. Clayton in Chaska (1983:124-127) also used a descriptive survey in Georgia (USA) to determine a defensible list of professional competencies. The majority of the studies discussed, used either interviews or questionnaires or both as methods for collecting data.

However, Sanford et al (1992:71) used an ex post facto design to determine the clinical judgement abilities of new graduates in Dallas (USA). The findings of these studies were derived from quantitative descriptive statistics and the use of inferential statistics to measure variances. This study is also intended to use the quantitative descriptive approach to describe the SPNs' views of the competencies of NQNs in the clinical setting.

### **3.3 HYPOTHESIS**

Since this study is descriptive in nature, no hypothesis has been formulated. The researcher is not interested in establishing cause-effect relationships. It is stated by Polit & Hungler (1991:19) that descriptive studies can be of considerable value in nursing practice. The phenomena that nursing researchers have been interested in describing, are varied but the aim is to provide an opportunity for the human experience to be revealed without preconceived restrictions.

### **3.4 THE RESEARCH POPULATION**

The target population of this study consisted of SPNs employed in the health services of the former areas of Venda, Gazankulu and Lebowa (forming part of the Northern Province of the RSA since April 1994). Tables 3.1, 3.2 and 3.3 provide the detailed information concerning the target population.

This study was conducted during the transitional period in the RSA. The three health departments, namely Venda, Gazankulu and Lebowa, the Department of Health of the RSA and the Transvaal provincial administration's health services during 1994, were in the process of amalgamation to become the Northern Province's Department of Health. This study describes the departments separately because the functions and administrative work were still done by the respective

departments concerned.

[See Annexure C for letters of permission.]

### 3.4.1 "Venda" health services

Venda used to be an independent state, situated in the northern part of the RSA. The state had no independent nursing council and the education and training of nurses as well as the standards of nursing practice were determined by the SANC.

According to the hospital and nursing yearbook (Engelhardt 1993:207), Venda health services consisted of four hospitals and multiple community clinics and health centres. Table 3.1 provides more details about the hospitals, clinics and health centres, and the total population of SPNs per hospital.

TABLE 3.1 Venda health services, and the total population of SPNs participating in the study

HOSPITAL	CLINICS AND HEALTH CENTRES	NUMBER OF BEDS	TOTAL NUMBER OF SPNS
DONALD FRASER	21	438	14
SILOAM	13	547	22
TSHILIDZINI	22	500	34
	56	1485	70

Table 3.1 reveals discrepancies in the total number of SPNs among Venda hospitals. However, this study could not justify such discrepancies, as the information concerning the total number of

SPNs employed in a particular hospital was obtained from the nursing management concerned.

One hospital, namely Hayane, was not utilised in this study because there were no NQNs employed during the time of data collection.

A large number of clinics and health centres are attached to each hospital where NQNs might be working. However, the specific numbers of NQNs appointed to the respective health services could not be ascertained.

#### **3.4.2 "Gazankulu" health services**

Gazankulu, though widely spread, is situated adjacent to Venda in the north-eastern part of the RSA. It was a self-governing homeland in which eight hospitals and a significant number of clinics and health centres were operating at the time of the research. Table 3.2 provides details of Gazankulu health services, and the total population of SPNs (Engelhardt 1993:207-208).

TABLE 3.2 Gazankulu health services and the total population of SPNs participating in the study

HOSPITAL	CLINICS AND HEALTH CENTRES	NUMBER OF BEDS	TOTAL NUMBER OF SPNS
ELIM	7	667	83
LETABA	10	384	49
MALAMULELE	11	124	16
NKHENSANI	10	320	51
SHILUBANA	3	170	14
TINTSWALO	16	315	43
	57	1980	256

Two hospitals were not utilised in this study because they had been privatised, and permission was not obtained to conduct research in these private hospitals.

### 3.4.3 "Lebowa" health services

At the time of the study Lebowa was a self-governing homeland occupying a large part of the northern area of the RSA. Lebowa health services were widely scattered, some with distances of up to 400 kilometres away from the offices of the Department of Health. The services had 18 hospitals, multiple clinics and very few health centres. The following difficulties were encountered after permission was given to visit all the Lebowa hospitals for collection of data:

- ▶ three hospitals were greatly affected by service instability and it was therefore not feasible to conduct research at these hospitals.;
- ▶ some of the hospitals could not provide assistance for this study as there were no NQNs employed in their services; and

- ▶ staffing was a major problem; it was established that these hospitals offered clinical learning experiences for student nurses training in the four-year comprehensive course; upon completion of the course they could regrettably not be employed due to lack of posts.

This study therefore utilised only four hospitals, employing NQNs in “Lebowa”, as detailed in table 3.3 (Engelhardt 1993:211-212).

TABLE 3.3 Lebowa health services and the total population of SPNs participating in the study

HOSPITAL	CLINICS AND HEALTH CENTRES	NUMBER OF BEDS	TOTAL NUMBER OF SPNS
KGAPANE	20	262	16
SEKORORO	2	208	11
MAPHUTHA L. MALATJI	2	204	15
MOKOPANE	5	208	28
TOTAL	29	882	70

The discrepancies among the Lebowa hospitals concerning the total number of SPNs employed could not be justified in this study. The information reflected was obtained from the nursing managers concerned.

The three tables, 3.1, 3.2 and 3.3, reveal that this study utilised 13 hospitals with a total of 396 SPNs. A summary of the total population is provided in table 3.5.

The researcher utilised the total population of SPNs, for the following reasons:

- ▶ the total population was relatively small;
- ▶ SPNs working in specific clinical nursing areas such as midwifery, community and psychiatric units were relatively few, therefore it might have happened that they would not be included in the sample if a random sampling method was employed;
- ▶ nurses do not all work at the same time; some take study leave, others maternity leave, sick leave, vacation leave, and others resign, and the remaining population could therefore not be guaranteed;
- ▶ it proved to be completely impractical to obtain the names and addresses of SPNs, according to nursing authorities, because of the services' instability. It was recommended that the researcher should deliver the instruments herself during a specific period found to be convenient in order to maximise the response rate.

In order to overcome the previously outlined problems, the researcher scheduled two visits per hospital. A period of four weeks was allowed between the first and the second visit. Data were collected between May 1994 and July 1994.

### **3.5 THE RESEARCH INSTRUMENT**

The researcher used questionnaires for collecting data. A questionnaire is the instrument most commonly used for obtaining survey data (Polit & Hungler 1993:202-206). The questionnaires were not mailed, but delivered for completion on the appointment dates. The advantages of self-delivery of the questionnaires were the following:

- ▶ it was observed that professional nurses expressed feelings of aggression rather than being co-operative and it was therefore essential that the researcher conduct personal interviews

with the SPNs to obtain co-operation;

- ▶ the questionnaires were completed at the same time and collected by the researcher; this method was found to be beneficial as the researcher could assist the SPNs by briefing them about the problem of the study, its purpose, and also instruct them on how to go about completing the instrument;
- ▶ it was relatively cost effective as there was no postage involved; working on estimates, the researcher spent approximately R5.00 per questionnaire on travelling expenses;
- ▶ SPNs might not return mailed questionnaires and it was therefore anticipated that self-delivery and conducting completion of questionnaires would maximise the response rate.

The following disadvantages of using questionnaires as a method of data collection were largely overcome by the method employed:

- ▶ omission of items by SPNs due to misunderstanding, or poor or ambiguous directions; and
- ▶ reluctance of SPNs to complete a lengthy questionnaire.

Although formal face-to-face interviewing could be regarded as a powerful method of collecting data in surveys, the method was not employed in the study for the following reasons:

- ▶ there was a gross shortage of SPNs in the health services; the few available SPNs were utilised to complete questionnaires; and
- ▶ in most hospitals the situation was not conducive to allow the researcher to spend more than three hours interacting with SPNs.

Informal interviews were, however, held with SPNs after completion of the questionnaires. A few SPNs voluntarily approached the researcher to express their concern about the clinical teaching

of student nurses training in the four-year comprehensive course. These comments will be included in the relevant chapters discussing the results of the study.

### **3.5.1 Development of the questionnaires**

The questionnaires were developed after perusal of books on research, as well as other authors' studies. This study more or less followed Troskie's format (1990) for developing questionnaires. Troskie's study also based questions on the scope of practice of a registered nurse in the RSA (R2598) and the key concepts to identify the competencies of NQNs were similar. The following journal articles were also used to select relevant items and the final questionnaire was developed specifically for this research:

- "Selecting technical skills to teach for competency" (Kieffer 1984:200-201).
- "Evaluating the performance of nurses" (Schwirian 1978:349).
- "Identification of professional competencies" (Clayton in Chaska 1983:128-132).
- "Essential competencies for baccalaureate graduates" (Sweeney & Regan 1982:37-41).

Literature focusing on the competencies of NQNs from the different clinical nursing units, namely general, midwifery, community and psychiatric, was not found. However, to maximise the extent of the difference of views among SPNs supervising in these respective units, the researcher decided to develop four separate questionnaires, each to suit a particular clinical nursing unit. This was done for the following reasons:

- ▶ questions were not generalised, and were intended to identify competency in specific competencies for a particular clinical nursing unit;
- ▶ the scope of practice of a registered nurse (R2598) formed the basis of questions measuring psychomotor competency and care was taken to ensure the applicability of the

competencies to respective clinical nursing units;

- ▶ questions directed at a specific clinical nursing unit might carry more weight for the SPNs, than generalised questions; and
- ▶ the findings would reveal how essential or non-essential the competency was perceived to be in each of the four clinical nursing units; this would facilitate the identification of relevant competencies to be taught for ensuring competency during the professional preparation of NQNs.

The layout of the questionnaires was identical for all four nursing units.

SECTION ONE requested the SPNs to complete general information which included their profile in the work setting. The questions requested SPNs to indicate their age, years of experience as SPNs, their engagement in studies, the presence of NQNs in the units in which they were working, and their professional qualifications. Aspects such as placement and the position in the hierarchy might influence SPNs' ability to judge the competencies of NQNs. The SPNs used in this study were expected to have relevant professional qualifications and also to reveal their commitment to continuing education in order to evaluate NQNs objectively.

SECTION 2 comprised of part A and part B. Part A intended to identify "What competencies do SPNs expect NQNs to have upon entering the work setting?" The expected competencies were outlined under the three areas, namely cognitive, affective and psychomotor. Furthermore, each area of competency was categorised as follows:

Cognitive: (Problem-solving; research; clinical judgement; teaching; and administrative/management competencies).

**Affective:** (Adaptive; interpersonal relationships/communications; caring; and ethics competencies).

**Psychomotor:** (Competencies were intended to identify assessment; maintenance of safety for individual and family; maintenance of nutrition of a patient; administration of treatment and care; carrying out aseptic technique procedures; critical care; and maintenance of elimination by a patient.)

Using a four (4) point scale obtained from McGaghie et al (1978:36), SPNs were required to indicate essential competencies expected of NQNs upon entering the work-setting. To facilitate comprehension, clarification of the key concepts was done by the researcher. The following key was used:

1. **ESSENTIAL:** This is an expected competency of NQNs upon entering the work setting.

2. **DESIRABLE BUT NOT ESSENTIAL:**

It would be beneficial to nursing practice if every NQN could perform this competency, but it is not essential.

3. **USEFUL BUT SHOULD NOT BE REQUIRED:**

Not expected at that level of experience.

4. **NON-NURSING:** This competency should not be considered part of the nurse's role.

Part B of Section two also used a four (4) point scale requiring the SPNs to identify the NQNs' cognitive, affective and psychomotor competencies. The questions were developed in such a way that the SPNs simultaneously answered part A and part B. This was done for the following reasons:

- ▶ there was no duplication of items; and

- ▶ it would be easier for the SPNs to relate their views concerning the essential competencies and the NQNs' perceived competencies simultaneously.

The following key concepts, obtained from Benner & Benner (1979:127) were used for part B:

1. MASTERY: Able to perform competently and efficiently without supervision.
2. COMPETENT: Able to perform without supervision and with reasonable efficiency.
3. NOT SAFE, PRACTICE & SUPERVISION NEEDED: Perform unsafely/inadequately/incompetently; practice and supervision are needed.
4. NON-NURSING: Do not think this competency should be considered part of the nurse's role.

To evaluate whether the items were successfully completed, each item was supposed to have two (2) ticks, as shown in item O of section two of the questionnaires.

The literature discussed in chapter two was focused on identifying the competencies required of NQNs. Very few studies could be traced which concentrated on evaluating both the NQNs' essential competencies and the extent to which NQNs performed these competencies. This research attempts to identify competencies which the SPNs expect NQNs to have mastered. Furthermore, the SPNs will be requested to indicate their general perceptions concerning the NQN's cognitive, affective and psychomotor competencies in the respective clinical nursing units, namely general, psychiatric, community and midwifery units.

SECTION THREE was identical in all four clinical nursing units' questionnaires. It consisted of both closed and open-ended statements with different key concepts. This section was intended to loosen the restrictions of closed-ended type of questions, and also to strengthen the findings

obtained from section two. The section requested the global views of the SPNs concerning competency deficiencies, difficult competencies, causes which could contribute to incompetency of NQNs, and lastly, the SPNs' suggestions to improve the competency of NQNs.

### **3.5.2 Pretesting the instruments**

Pretesting of the instruments of the four clinical nursing units was done in the following manner:

Initially, the questionnaires were given to four qualified clinical tutors serving in different hospitals, but specialising in a particular nursing unit, to complete. This was done in order to identify major problems such as ambiguity, vague or difficult language, confusing statements and relevance of items when judged in the light of the clinical learning experience of a particular nursing unit, namely general, community, psychiatric and midwifery.

Subsequently, the revised questionnaires and the cover letter were submitted to a sample of twelve SPNs of a particular hospital to complete. No sampling technique was employed to draw the pretest sample. However, the following criterion was used: six SPNs were selected from the sub-sections of the general unit, that is, one each from medical, surgical, paediatrics, operating theatre, outpatient department and casualty, and one preceptor; two SPNs working in the midwifery unit, two working in the psychiatric unit and two working in the community health services. The completed questionnaires were taken to computer analysis for an opinion regarding the feasibility of the questions asked in relation to what the study intended to evaluate. The promoter of the study accompanied the researcher during the computer analysis. The distribution of perceptions were revealed in all four groups, but it was observed that analysis to obtain frequencies and percentages should be done separately according to the four units' questionnaires

as section two was different from one group to another.

### **3.5.3 Validity and reliability**

"An appraisal instrument that measures what it claims to measure is valid" (Van Dalen 1979:135).

Van Dalen further indicates that a researcher must present some evidence which provides confidence that a test measures the precise characteristics for which it was designed. Seaman (1987:436) defines reliability as "the extent to which data are consistent, accurate and precise; the extent to which procedures, such as measurement, yield consistent data; stability, equivalence and internal homogeneity of instruments". Although validity and reliability were not measured through repeated testing of the instruments, the following issues were observed in this study:

- ▶ content validity was ensured by developing questionnaires relevant to a specific nursing unit (general, psychiatric, community and midwifery);
- ▶ the SPNs were thoroughly guided on how to complete the questionnaires. This reduced the possibility of ambiguity and lack of drive to complete the questionnaire. Sufficient time for completing the questionnaires was also given by the hospital authorities;
- ▶ evaluation of the questionnaires by qualified clinical tutors relevant to a particular nursing unit justified the objectivity of the questionnaires; and
- ▶ lastly, the pretest questionnaires were analysed by computer to determine the feasibility of subjecting the data to computerised statistical analyses.

## **3.6 COLLECTING THE DATA**

### **3.6.1 Permission to collect data**

In observance of the ethical constraints underlying the undertaking of a research project, the following aspects were considered:

- A letter requesting permission to conduct the study was addressed to the Directors General of the Departments of Health and Social Welfare of the former Gazankulu, Venda and Lebowa. Although the three departments were in the process of being amalgamated by the present government in the RSA, the administration procedures were still being implemented separately during the period of collecting data.
- A covering letter to complement the researcher's introductory explanations was issued together with the questionnaires requesting co-operation of SPNs. In the letter the purpose and the importance of the study were clarified. Anonymity and confidentiality of the individuals and the health services were guaranteed. Names were not requested from the SPNs.
- Co-operation was requested from the nurse administrators of the hospitals concerning time, conducive environment and release of SPNs from their unit activities in order to come and participate in the completion of questionnaires. Co-operation was also obtained with community supervisors by inviting SPNs working in the community services to take part in completing questionnaires.
- The researcher also noted that participation in research remained voluntary and depended on the willingness of each participant. The following issues were considered "threats" to participation by the SPNs:
  - the questionnaire was relatively long; however, most SPNs were sufficiently interested in the research to complete the questionnaire;
  - shortage of nursing personnel in all the hospitals caused SPNs to panic because of the time factor; nevertheless, it was observed that they were able to finish completing the questionnaires within 45 to 60 minutes;
  - SPNs needed sustained motivation to get them to participate.

### **3.6.2 Distribution of the questionnaires**

The questionnaires were not mailed. As indicated previously, appointments were made with nurse administrators of the hospitals concerned. SPNs also welcomed the procedure of going about and assisting them with the completion of the questionnaires. The first collecting of data took place from 20 May to 20 June 1994 and the second round was completed by 22 July 1994. The response resulted in both usable and unusable questionnaires, which will be discussed in item 3.6.4.

### **3.6.3 Limitations**

This study was conducted under difficult conditions during a period of political change. Since 1990 a great deal of activity on the part of various political groups and professional groups in line with the socio-political transformation of the country has taken place in the RSA. The whole process had direct implications for nurses and nursing and this resulted in nurses nationwide embarking on strikes. The reasons for these strikes were varied, and were addressed differently. The geographic area of this study was also adversely affected by nurses' strikes at the time of data collecting. This was expected to have an effect on the response rate, but a lower response rate was anticipated if the questionnaires were to be mailed.

Delegation of responsibility to nurse administrators and nurse educators to assist SPNs with the completion of questionnaires proved a failure. A few questionnaires which were left with those who volunteered to perform the task on behalf of the researcher, were found to be uncompleted during the second round. This might have happened because of administrative nursing practice problems encountered during the collection of data.

Coding of the hospitals for data analysis was not done. The researcher found it not to be feasible to compare 13 hospitals. Some nursing units such as psychiatric and community were also not represented in all the hospitals utilised in this study. The population sizes in other hospitals were too small to warrant comparison. In addition, NQNs employed in a specific hospital were not necessarily educated at a college of nursing associated with the hospital concerned. Lastly, the study itself was not intended to compare hospitals, and therefore the interpretation of the findings had equal implications for each of the 13 hospitals utilised in this study.

The total population might seem to be somewhat distorted due to the fact that nursing authorities experienced a problem of identifying who had been promoted to the rank of SPN after the mass promotions during the period November 1993 to May 1994. The promotions were effected after nurses' strikes. Tables 3.1, 3.2 and 3.3 reflect the total population in this study, according to information provided by the three health authorities concerned.

#### **3.6.4 Response to the questionnaires**

Because questionnaires were not delivered and left to be controlled by another person, it was anticipated that 350 or more of the SPNs would participate in this study. Therefore 370 questionnaires were printed as follows:

General	-	200
Midwifery	-	50
Community	-	70
Psychiatric	-	50

Table 3.4 provides the detailed information regarding the questionnaires completed, questionnaires not usable and questionnaires left uncompleted and usable questionnaires.

TABLE 3.4 Response to questionnaires indicated according to clinical nursing units

CLINICAL NURSING UNITS	QUESTIONNAIRES PRINTED	QUESTIONNAIRES COMPLETED UNUSABLE	QUESTIONNAIRES UNCOMPLETED	QUESTIONNAIRES USABLE
GENERAL	200	11	34	136
MIDWIFERY	50	6	6	38
COMMUNITY	70	3	4	56
PSYCHIATRIC	50	6	13	29
TOTAL	370	26	57	259

Table 3.4 reveals that some questionnaires were missing, unusable or uncompleted. This could be attributed to the following reasons:

- ▶ completed unusable questionnaires: the majority of these were found to be incomplete because some ticked Part A only and some Part B only. Four general questionnaires were found with column one ticked at both "essential" and "mastery", and they were therefore also discarded;
- ▶ it was expected that psychiatric institutions would maximise the response rate to provide a point of view of psychiatric SPNs on the competencies of NQNs. However, none of the psychiatric institutions involved in this study had employed any NQNs. The institutions were therefore not utilised. Only hospitals having psychiatric units (wards) provided data utilised in this study;
- ▶ it was impossible to reach some of the community SPNs because of distance. Nevertheless, 80 percent of the printed questionnaires were completed satisfactorily.

Table 3.5 provides information concerning the total population and the number of questionnaires completed per hospital.

TABLE 3.5 Response of total population in relation to questionnaires completed

HOSPITAL	TOTAL POPULATION SPNS	QUESTION- NAIRES COMPLETED	PERCENTAGE
DONALD FRAZER	14	9	64.3
SILOAM	22	16	72.7
TSHILIDZINI	34	23	71.9
ELIM	83	52	63.4
NKHENSANI	51	23	45.0
LETABA	49	39	75.6
SHILUBANA	14	8	57.1
TINTSWALO	43	39	90.7
MALAMULELE	16	9	56.3
KGAPANE	16	5	31.3
SEKORORO	11	8	72.7
MAPHUTHA L. MALATJI	15	9	60.0
MOKOPANE	28	19	67.8
TOTAL	396	259	65.4

The table reveals that the response rate was above 60 percent. The percentage can be regarded as satisfactory when taking into consideration the difficulties encountered during the period of

data collection. A similar response was observed in Troskie's study (1993:53) in which 59 percent of supervisors responded to the mailed questionnaires. The data analysis chapter is therefore based on the response of 259 SPNs of the 13 hospitals indicated in table 3.5.

### **3.6.5 Planned analysis of the data**

The questionnaires of the four clinical nursing units, namely community, psychiatric, midwifery and general units, intended to identify the SPNs' views concerning the competencies of NQNs. Data obtained were entered into coding sheets. Two research assistants were orientated by the researcher to assist in entering the data. The intended analysis of computerised data was to note the percentage distributions of items and frequency distributions.

These computer analyses of the data, provided the information needed to discuss the research findings, draw conclusions, suggest guidelines to improve the orientation of NQNs in the clinical nursing unit, and to make recommendations for further research.

Chapter four will attempt to analyse, interpret and describe the profile of the population of SPNs participating in the study.

## **CHAPTER 4**

### **ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS: A PROFILE OF THE SPNS**

#### **4.1 INTRODUCTION**

This chapter attempts to analyse, present and describe the profile of the SPNs who operate in four clinical nursing units, namely community (56), psychiatric (29), midwifery (38) and general (136) SPNs. These descriptions are based on the computerised analysis of the data derived from responses in section one of the questionnaires given to 259 SPNs employed in the former areas of Venda, Gazankulu and Lebowa health services (falling within the Northern Province of the RSA since 1994). Chapter three "methodology" section 3.4 provides detailed information about the population. The descriptions of findings are based on frequencies and percentages.

#### **4.2 AGE OF SPNS**

Question one requested the SPNs to indicate their ages. Table 4.1 presents the detailed information of the SPNs in all four clinical nursing units, namely community (n=56), psychiatric (n=29), midwifery (n=38) and general (n=136).

**Table 4.1: Age distribution of SPNs**

AGE DISTRIBUTION	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	1	1.8	3	10.3	3	7.9	3	2.2
30 years and younger	7	12.5	1	3.5	4	10.5	17	12.5
31 - 40 years	29	51.8	17	58.6	21	55.3	73	53.7
41 - 50 years	15	26.8	7	24.1	9	23.7	37	27.2
51 years and older	4	7.1	1	3.5	1	2.6	6	4.4
<b>TOTAL:</b>	<b>56</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>136</b>	<b>100.0</b>

Table 4.1 reveals that the largest number of SPNs fell within the age group of 31-40 years in all four nursing units. Few SPNs were aged 30 years and younger. Further analysis of the SPNs who fell within the age group of 31-40 years revealed that the majority of the SPNs were 36 years and above as follows: community (29.1 percent), psychiatric (38.4 percent), midwifery (48.5 percent) and general (30.3 percent). This could imply that the nursing services concerned were rendered by experienced professional nurses. SPNs of 51 years and older were found in all four nursing units: community four (7.1 percent) psychiatric one (3.5 percent), midwifery one (2.6 percent) and general six (4.4 percent). Further analysis revealed that the oldest SPN was 58 years old and working in the midwifery unit. All the questionnaires could be utilised, even those where the SPNs failed to indicate their age, since age discrepancy was not a critical variable which influenced subsequent responses.

### 4.3. YEARS OF EXPERIENCE

**TABLE 4.2: Distribution of years of experience as SPNs (according to four nursing units)**

YEARS OF EXPERIENCE	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	4	7.1	2	6.9	2	5.3	8	5.9
Less than one year	13	23.2	4	13.8	6	15.8	30	22.0
1 - 5 years	27	48.2	16	55.2	21	55.3	61	44.9
6 - 10 years	7	12.5	7	24.1	8	21.0	23	16.9
11 - 15 years	5	9.0	0	0.0	1	2.6	9	6.6
16 and more	0	0.0	0	0.0	0	0.0	5	3.7
<b>TOTAL</b>	<b>56</b>	<b>100,0</b>	<b>29</b>	<b>100,0</b>	<b>38</b>	<b>100,0</b>	<b>136</b>	<b>100,0</b>

The largest number (125) of SPNs had 1-5 years of experience as SPNs. Fewer SPNs (53) had less than one year's experience. Professional experience could play an important role in improving competency in nursing. Moreover, experienced SPNs could be expected to be able to evaluate NQNs' competencies for the purpose of this research.

### 4.4 PROFESSIONAL QUALIFICATIONS OF SPNS

SPNs were requested to indicate their professional qualifications in order to ascertain whether patient care was rendered by professional nurses with expertise in the particular clinical setting. In table 4.3 each SPN could provide two or more answers, therefore summation of the totals was not feasible.

**Table 4.3: Professional qualifications held by SPNs**

PROFESSIONAL QUALIFICATIONS	n = 259	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
		F	%	F	%	F	%	F	%
General Nursing	253	55	98,2	29	100,0	34	89,5	135	99,3
Midwifery	254	55	98,2	28	96,6	38	100,0	133	97,8
Psychiatric Nursing	63	9	16,1	29	100,0	5	13,2	20	14,7
Community Nursing	100	28	50,0	6	20,7	12	31,6	54	39,7
Nursing Education	37	2	3,6	1	3,4	6	15,8	28	20,6
Nursing Administration	36	8	14,3	2	6,9	6	15,8	20	14,7
Clinical Specialisation	69	24	42,9	1	3,4	12	31,6	32	23,5
• Intensive Care	7	2	3,6	-	-	1	2,6	4	2,9
• Paediatric Nursing	12	1	1,8	-	-	1	2,6	10	7,4
• Clinical Assessment, Treatment and Care	25	19	33,9	-	-	-	-	6	4,4
• Ophthalmology	7	3	5,4	-	-	1	2,6	3	2,2
• Advanced Midwifery	18	4	7,1	-	-	9	23,7	5	3,7
• Operating Theatre	6	-	-	1	3,4	1	2,6	4	2,9
• Oncology	2	-	-	-	-	-	-	2	1,5
• Orthopaedic Nursing	3	-	-	-	-	-	-	3	2,2

Table 4.3 reveals that one SPN in each of the community and general nursing units failed to indicate their professional qualifications. The findings revealed that 50 percent of the SPNs in the community nursing unit held qualifications in community health nursing science, and 33.9 percent in clinical assessment, treatment and care. Only four out of 56 SPNs held qualifications in advanced midwifery. This could imply that there is a need for professional nurses to be enabled to do this course. The majority of community health services involved in this study were in rural areas, away from hospitals. All the community health services rendered midwifery services. Priority could however be given to SPNs who wish to follow a community health nursing science course in the light of the findings mentioned previously, that only 50 percent of SPNs working in the community health services were qualified community health nurses.

Another qualification which could be of importance in the community health services is oncology. None of the SPNs in the community health services seemed to have oncology nursing qualifications. Increasing cancer awareness among the community and counselling of cancer patients by expert professional nurses could be essential. However, a situational analysis should be done to establish the prevalence of cancer in the geographic area of this study in order to support the need to enable professional nurses to follow the course in oncology nursing.

Regarding professional qualifications held by SPNs allocated to the psychiatric nursing units, the findings revealed a 100 percent relevance in placement of psychiatric nurses. SPNs who were qualified psychiatric nurses were all qualified general nurses, and only one was not registered as a midwife. However, no SPN seemed to have completed a course in advanced psychiatric nursing. The need for SPNs working in psychiatric nursing units to be qualified in advanced psychiatric nursing could be essential for effective clinical teaching and for more effective patient care. Nurses

who have successfully completed the course in advanced psychiatric nursing, could contribute towards rendering improved nursing care to psychiatric patients. This would seem to be particularly important in the geographic area where this study was conducted, due to the shortage of psychiatrists in this area.

The findings in the midwifery unit revealed that all 38 SPNs were qualified midwives. Only nine of them possessed qualifications in advanced midwifery. Table 4.3 indicates that 135 SPNs in the general nursing units had done general nursing as a basic course, and 133 of them were also qualified midwives. Table 4.4 indicates clinical specialisation courses held by SPNs in the general nursing units.

**Table 4.4: Clinical specialisation courses held by SPNs in the general nursing units**

<b>PROFESSIONAL QUALIFICATIONS</b>	<b>GENERAL CLINICAL UNITS (n = 136)</b>					
	<b>MEDICAL</b>	<b>SURGICAL</b>	<b>CLINICAL TEACHING DEPARTMENT</b>	<b>OUT-PATIENT DEPARTMENT</b>	<b>OPERATING THEATRE</b>	<b>PAEDIATRICS</b>
	<b>% n = 32</b>	<b>% n = 32</b>	<b>% n = 7</b>	<b>% n = 27</b>	<b>% n = 6</b>	<b>% n = 28</b>
Clinical Specialisations	6,23	21,88	3,57	44,44	83,33	57,40
• Paediatric Nursing	3,13	9,33	0,00	0,00	16,67	57,14
• Operating Theatre	3,13	0,00	3,70	3,70	33,33	0,00
• Clinical Assessment, Treatment and Care	3,13	0,00	0,00	18,52	0,00	0,00

Table 4.4 reveals a shortage of clinical nursing specialists among SPNs working in the general units. The findings revealed that medical units were supervised by general nurses without other post basic courses. Infection control, intensive care and psychiatric nursing could be of value in the medical units. Medical patients might need intensive care, especially unconscious patients and cardiac cases. They might need mental assessment to exclude the cause of derangement which might be due to an electrolyte imbalance in the body or other physical causes.

SPNs working in surgical units did not have qualifications such as orthopaedics, trauma care and oncology. There might be patients having fractures or suffering from cancer, needing qualified nurse specialists. Only 9.33 percent of the SPNs were qualified paediatric nurses. It was evident that SPNs allocated to the clinical teaching department were not qualified in clinical specialisation courses. It would be beneficial to introduce such courses to enable them to provide clinical teaching with expertise in the different work settings. Of the SPNs working in paediatric units (n=28), 57.14 percent were qualified paediatric nurses. Only 33.33 percent (n=6) of the SPNs working in the operating theatre were qualified theatre nurses. Expertise in a particular field could put one in a better position to judge another person's performance.

#### **4.5 CLINICAL AREAS TO WHICH SPNS WERE ALLOCATED**

Question four of the questionnaires requested the SPNs to indicate the clinical area in which they were working when completing the questionnaires. The findings revealed that community SPNs were allocated to the three clinical areas illustrated in table 4.5.

TABLE 4.5 Community clinical areas to which SPNs were allocated

CLINICAL AREA	FREQUENCY	PERCENTAGE
CLINIC	12	21.4
HEALTH CENTRE	42	75.0
MOBILE CLINIC	1	1.8
NO RESPONSE	1	1.8
	56	100.0

Clinics referred to in this study were relatively small day facilities rendering services such as treating minor ailments, rendering mother and child care, providing geriatric care and attending to chronic diseases. However, nurses had to take calls at night for attending to emergencies. Health centres operated more or less like hospitals, admitting patients suffering from any kind of disease. Seriously ill patients were transferred to hospitals. The staff establishments of health centres were relatively large because they rendered day and night services. A mobile clinic operated at the visiting points within the communities where there were neither clinics nor health centres. Mobile clinics rendered all the services rendered by the clinics. Deliveries were done at both the community health clinics and at community health centres.

Pertaining to the psychiatric nursing units, the question was intended to establish whether psychiatric services included community psychiatric services, psychiatric units in hospitals and independent psychiatric institutions. Only 31 percent of the SPNs indicated that they were allocated to the psychiatric units, 17 percent to the community psychiatric services and 52 percent of the SPNs did not respond. Psychiatric institutions were not utilised in the study due to the reason indicated in chapter three, that no NQNs were employed at the time of data collection.

This questionnaire required the SPNs working in the midwifery unit to indicate clinical areas in which they were working such as labour wards, antenatal care wards, post natal wards and neonatal/prematurity care units.

Table 4.6 illustrates responses from the general SPNs where the clinical nursing units, including sub-units, for instance, a surgical clinical unit could consist of a gynaecology unit, a trauma care unit and orthopaedic units for males and females respectively.

TABLE 4.6 General clinical area of work of SPNs

CLINICAL AREA	FREQUENCY	PERCENTAGE
NO RESPONSE	4	2.9
MEDICAL	32	23.5
SURGICAL	32	23.5
CLINICAL TEACHING DEPARTMENT	7	5.2
OUT-PATIENT DEPARTMENT	27	19.9
OPERATING THEATRE	6	4.4
PAEDIATRIC	28	20.6
	136	100.0

#### 4.6 PERIOD OF EXPERIENCE BY SPNS IN THE ASSIGNED UNITS

**Table 4.7: Period of experience of SPNs in the present unit**

PERIOD OF EXPERIENCE	CLINICAL NURSING UNIT							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	1	1.8	2	6.9	0	0.0	10	7.4
1 - 11 months	5	8.9	4	13.8	5	13.2	40	29.4
1 - 5 years	29	51.8	16	55.2	21	55.2	53	38.9
6 - 10 years	13	23.2	7	24.1	8	21.1	28	20.6
11 years or longer	8	14.3	0	0.0	4	10.5	5	3.7
<b>TOTAL:</b>	<b>56</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>136</b>	<b>100.0</b>

The largest number of SPNs had 1-5 years' experience in all four nursing units.

Only the general nursing unit reveals 40 SPNs (29.4 percent) having less than a year's experience.

However, further computerised analysis of the data indicated that the least experience amounted to four months in the present unit. SPNs with 11 years or more experience were not evidenced in the psychiatric nursing unit. Table 4.7 could be interpreted to imply that the majority of SPNs were permanently allocated to their respective units. Permanent allocation of SPNs could be essential in improving clinical teaching, and developing expertise in a particular field. A particular SPN could play a vital role in orientating NQNs allocated to her clinical unit. Because of her expertise in the unit she might be in a better position to exercise judgement regarding the

competencies of NQNs. Itano (1989:122) considered registered nurses working in the medical-surgical setting in Hawaii to be highly competent judgement makers. The number of years of experience of the sample ranged from one to 16 years. The mode was four years and the median 7.3 years.

#### 4.7 SUPERVISORY POSITION OF SPNS

The position which SPNs occupied in the unit hierarchy could influence their ability to judge NQNs' competencies. SPNs who have recently been appointed in their first position of authority, according to table 4.8, may lack experience in evaluating the NQNs' performance.

TABLE 4.8 Supervisory position of SPNs

SUPERVISORY POSITION	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	1	1.8	0	0.0	1	2.6	4	2.9
First in charge	18	32.1	11	37.9	11	29.0	43	31.6
Second in charge	15	26.8	10	34.5	17	44.7	50	36.8
Third or lower	22	39.3	8	27.6	9	23.7	39	28.7
<b>TOTAL:</b>	<b>56</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>136</b>	<b>100.0</b>

The findings revealed that a relatively small number of SPNs occupied "first in charge" positions. The majority of SPNs in the midwifery 17 (44.7 percent) and general units 50 (36.8 percent) occupied second in charge positions. Community SPNs (39.3 percent) who responded to this

study occupied mainly third or lower positions. However, according to table 4.8, it could be argued that the majority of the SPNs in general (68.4 percent), psychiatric (72.4 percent) and midwifery clinical units (73.7 percent) had a chance to take charge of the units as they were occupying first and second positions in the unit hierarchy. This implies that NQNs allocated to those areas would probably occupy fourth or lower positions in the hierarchy. NQNs could therefore receive proper guidance and support from SPNs and would probably not need to assume "in charge" roles upon entering the work situation. A similar study done by Troskie (1993:56) in the RSA revealed that NQNs working in a midwifery unit worked with a number of other registered nurses. NQNs in the psychiatric nursing units also received a greater amount of guidance than NQNs who worked in the community nursing units.

#### **4.8 PRESENCE AND HIERARCHICAL POSITION OF NQNS IN THE CLINICAL UNITS**

SPNs in all four nursing units namely general, community, psychiatric and midwifery, were requested to indicate whether they had NQNs allocated to their units at the time of the investigation. The responses to indicate that SPNs were working with NQNs at the time of data collection can be summarised as follows:

- ▶ community 42 (75 percent);
- ▶ psychiatric 18 (62 percent);
- ▶ midwifery 29 (76.3 percent); and
- ▶ general 80 (65.6 percent).

These SPNs were further requested to indicate the number of NQNs who were present in the respective units at the time of data collection. Eighty-one percent of the community SPNs indicated that they were working with one or two NQNs. Two SPNs indicated that each one was

working with 20 NQNs. This might be the case when a particular SPN is supervising several clinics or health centres within a specific geographic area.

In the psychiatric nursing unit SPNs (83 percent) indicated that they were working with one to four NQNs in the unit. The findings appeared to be acceptable in the psychiatric nursing units where nurses specialising in other clinical categories would be less likely to be allocated than in the general or community health units. SPNs (72 percent) in the midwifery unit also indicated that they were working with one to four NQNs. Eighty-five percent of SPNs in the general nursing unit indicated that they were working with one to three NQNs. Fourteen SPNs from the general nursing unit failed to indicate whether NQNs were presently working in their units. These findings seem to indicate that the majority of the SPNs participating in the research had sufficient contact with NQNs to be able to evaluate the NQNs' competencies.

**Table 4.9: Presence of NQNs in the clinical units**

RESPONSE	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	0	0.0	0	0.0	0	0.0	14	10.3
Yes	42	75.0	18	62.0	29	76.3	80	58.8
No	14	25.0	11	38.0	9	23.7	42	30.9
<b>TOTAL:</b>	<b>56</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>136</b>	<b>100.0</b>

The SPNs who ticked "no" as illustrated in table 4.9 revealed that no NQNs were allocated to their units during collection of data. These SPNs indicated that they had worked with NQNs within the previous year, implying a period between June 1993 and June 1994.

Table 4.10 illustrates the position of NQNs in the unit hierarchy. The highest percentage of SPNs (41.1 percent) in the community nursing unit perceived NQNs to be occupying second or third in charge positions. This could necessitate their assuming first in charge positions when the SPNs were off duty. The study done by Troskie (1993:56) in the RSA revealed similar findings. NQNs working in the community units indicated that they were working in isolation without proper guidance and support. Troskie identified only four registered nurses who worked with the NQNs in the community, indicating a shortage of community registered nurses in the areas concerned, and especially a shortage of SPNs working in the community area.

This perceived shortage of SPNs and professional nurses in the community health areas should be further investigated and, if possible, remedied. This would seem to be essential for the RSA to realise the ideal of improved primary health care for all its citizens.

Similar findings were revealed with NQNs in the psychiatric nursing unit. Table 4.10 reveals that SPNs (34.5 percent) perceived NQNs to be occupying second or third in charge positions. This implies that NQNs might often be left in charge of the psychiatric nursing unit.

**Table 4.10: Position occupied by NQNs in the unit**

POSITION	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	1	1.8	3	10.3	3	7.9	19	14.0
2nd or 3rd in charge	23	41.1	10	34.5	6	15.8	38	27.9
4th or 5th in charge	22	39.2	8	27.6	18	47.4	52	38.2
6th or lower	10	17.9	8	27.6	11	28.9	27	19.9
<b>TOTAL:</b>	<b>56</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>136</b>	<b>100.0</b>

Table 4.10 reveals that the majority of SPNs in the midwifery (47.4 percent) and general (38.2 percent) units perceived NQNs to be occupying 4th or 5th in charge positions. SPNs (28.9 percent) in the midwifery and 19.9 percent in the general nursing units perceived NQNs to be occupying sixth or lower positions as revealed in table 4.8.

The majority of SPNs in the midwifery (73.7 percent) and in the general nursing units (68.4 percent) indicated that they were occupying first or second positions in the unit hierarchy. These supervisory positions of the SPNs probably enabled them to evaluate the competencies of NQNs for the purposes of this study.

#### 4.9 THE INFLUENCE OF POSITION ON NQNS IN THE UNITS

SPNs were requested to evaluate how the NQN's position in the unit's hierarchy influenced her

ability to practise as a competent practitioner. The responses to this question were first analysed by the researcher before they were coded onto the computer sheets. The findings from all four the nursing units revealed diverse views which were sorted out and categorised into positive influences; negative influences; and both positive and negative influences. A large number of SPNs indicated positive influences. Table 4.11 provides detailed information.

TABLE 4.11 Responses indicating how NQNs' position influenced their ability to practise as competent practitioners

INFLUENCE	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	12	21.4	11	38.0	9	23.6	44	32.4
Positive	18	32.2	8	27.6	19	50.0	48	35.3
Negative	14	25.0	7	24.1	5	13.2	20	14.7
Both Positive and Negative	12	21.4	3	10.3	5	13.2	24	17.6
<b>TOTAL</b>	<b>56</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>136</b>	<b>100.0</b>

Opinions expressed by the SPNs were similar in all four nursing units illustrated in table 4.11. The following statements were regarded as implying positive opinions concerning the NQNs' performance in the four nursing units namely community, psychiatric, midwifery and general.

- NQNs were not perfect nurses, they needed supervision and guidance in the wards (77.7 percent; 75 percent; 72.3 percent; 54.2 percent respectively).
- NQNs tried their best to improve their practice by asking many questions (55.5 percent;

62.5 percent; 78.9 percent; 43.8 percent respectively).

- NQNs strove to be exemplary to junior nurses (63.5 percent; 37.5 percent; 47.4 percent; 37.5 percent respectively).
- NQNs were reliable to share experience (55.5 percent; 62.5 percent; 52.6 percent; 45.8 percent respectively).
- They needed to be given a chance, they would grow (72.2 percent; 87.5 percent; 57.9 percent; 62.5 percent respectively).
- NQNs now realised that they should be responsible, and SPNs indicated that they gave support to the NQNs (72.2 percent; 100 percent; 78.9 percent; 75 percent respectively).

The following responses by SPNs to this question were directed to specific nursing units:

- NQNs rapidly gained independence at the clinics as they were quite often left in charge during the weekend (community unit - 66.7 percent).
- Psychiatric nursing units, unlike general nursing units, could be difficult to adjust to; they would cope in due course (psychiatric - 50 percent).
- NQNs needed to work under supervision especially in the labour ward (midwifery - 75 percent).

The findings revealed that SPNs were aware of the reality of NQNs as novices in the work setting, and that SPNs were to provide support and further guidance. These findings seemed to differ from the assumption indicated in chapter one section 1.6 which stated that SPNs expected NQNs to function as independent practitioners within the scope of practice of a registered professional nurse (R2598).

SPNs in all four nursing units, namely community, psychiatric, midwifery and general, revealed negative perceptions of NQNs such as:

- NQNs thought they knew much or knew everything (42.9 percent; 28.6 percent; 100 percent; 65 percent respectively).
  - They expected to occupy senior posts (35.7 percent; 14.3 percent; 80 percent; 80 percent respectively).
  - They made blunders every day (78.6 percent; 85.7 percent; 80 percent; 55 percent respectively).
  - They were influenced by many bars on their shoulders, meaning distinguishing devices (35.7 percent; 14.3 percent; 80 percent; 65 percent respectively).
  - Always under the umbrella of their seniors they would not grow (71.4 percent; 71.4 percent; 74.3 percent; 75 percent respectively).
  - Patients were not safe (78.6 percent; 85.7 percent; 80 percent; 85 percent respectively).
- Community health SPNs (68 percent) indicated that midwives without general nursing performed better in practice than the NQNs, having four qualifications namely general, midwifery, community and psychiatric nursing.
- NQNs should be careful or they would receive hidings from patients, they did not have tact (psychiatric unit - 53.6 percent).
  - They were dodging a lot during training (midwifery - 80 percent and general - 88.6 percent) which prevented the NQNs from becoming competent nursing practitioners.

These perceptions might be subjective, but the testing of these statements fell beyond the scope of the current research.

#### 4.10 COURSES OF STUDY FOLLOWED BY SPNS

SPNs were requested to indicate whether they were engaged in any studies, and also to indicate the course of study followed.

TABLE 4.12 Courses of study followed by SPNs

COURSE	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	23	41.1	19	65.5	19	50.0	50	36.8
B A Cur	28	50.0	10	34.5	17	44.8	68	50.0
Technikon courses	5	8.9	0	0.0	1	2.6	13	9.6
Standard 10	0	0.0	0	0.0	1	2.6	5	3.6
<b>TOTAL:</b>	<b>56</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>136</b>	<b>100.0</b>

Refer to table 4.3 which indicates that 50 percent of SPNs working in the community nursing units were not registered community health workers. Although table 4.12 indicates that 50 percent of all SPNs working in the community nursing units were indeed busy improving their professional qualifications, it could not be ascertained whether this 50 percent of SPNs were studying to obtain the community health nursing qualification as part of their BA Cur course. The number of community professional nurses studying at technikons could be expected to increase with the establishment of a distance education two-year course in community health science introduced in 1994 by the Transvaal Technical College in the Gauteng Province of the RSA.

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TABLE 4.12 Courses of study followed by SPNs

COURSE	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	23	41.1	19	65.5	19	50.0	50	36.8
B A Cur	28	50.0	10	34.5	17	44.8	68	50.0
Technikon courses	5	8.9	0	0.0	1	2.6	13	9.6
Standard 10	0	0.0	0	0.0	1	2.6	5	3.6
<b>TOTAL:</b>	<b>56</b>	<b>100.0</b>	<b>29</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>136</b>	<b>100.0</b>

Refer to table 4.3 which indicates that 50 percent of SPNs working in the community nursing units were not registered community health workers. Although table 4.12 indicates that 50 percent of all SPNs working in the community nursing units were indeed busy improving their professional qualifications, it could not be ascertained whether this 50 percent of SPNs were studying to obtain the community health nursing qualification as part of their BA Cur course. The number of community professional nurses studying at technikons could be expected to increase with the establishment of a distance education two-year course in community health science introduced in 1994 by the Transvaal Technical College in the Gauteng Province of the RSA.

In the psychiatric nursing unit, findings revealed that 35 percent of the SPNs were studying for the BA Cur qualification. These findings seem to support findings revealed in table 4.3 indicating that more psychiatric SPNs should probably be motivated to improve their professional qualifications.

#### **4.11 EDUCATIONAL PROGRAMME COMPLETED BY SPNS**

Although registered professional nurses qualify under various educational programmes in the RSA, their nursing practices are determined by the scope of practice of a registered nurse (R2598) as amended. Table 4.13 reveals that the majority of the SPNs qualified in the basic general three-year diploma course (R879) of 1975 as amended, which was replaced by the four-year diploma course (R425) of 1985 which enabled a nurse to register as a nurse, (general, community and psychiatric) and midwife. Upon the completion of a three-year general diploma course, training in midwifery required the completion of a one-year course. Thereafter courses in community health nursing science (one year) and in psychiatric nursing (one year) would be required in order to obtain qualifications similar to those held by NQNs. Refer to section 1.2.2 of chapter one. It took a professional nurse, qualified in the basic general three-year diploma course (R879), up to ten years to obtain the same qualifications as those acquired by NQNs referred to in this study.

**TABLE 4.13: Educational programme completed by SPNs**

PROGRAMME	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	F	%	F	%	F	%	F	%
No response	0	0,0	0	0,0	0	0,0	3	2,2
Basic general 3 year diploma course	39	69,6	18	62,1	32	84,2	109	80,1
Integrated basic general 3½ year course	7	12,5	4	13,8	3	7,9	14	10,3
Four year comprehensive diploma course	2	3,6	1	3,4	1	2,6	2	1,5
Four year comprehensive degree course	6	10,7	6	20,7	0	0,0	6	4,4
Midwifery only/Psychiatric nursing only	2	3,6	0	0,0	2	5,3	2	1,5
<b>TOTAL: .....</b>	<b>56</b>	<b>100,0</b>	<b>29</b>	<b>100,0</b>	<b>38</b>	<b>100,0</b>	<b>136</b>	<b>100,0</b>

#### **4.12 CONCLUSION**

An analysis and discussion of the profile of the population (259) indicated that the population consisted of SPNs in four nursing units namely community (n=56); psychiatric (n=29); midwifery (n=38) and general units (n=136).

The findings revealed that the majority of the SPNs (73.4 percent) had experience of more than one year in the relevant field. A variety of professional qualifications were held by the SPNs. However, the number of SPNs who had completed clinical specialisation courses such as paediatric nursing, intensive care, operating theatre, orthopaedics, oncology, clinical assessment, treatment and care, ophthalmology and others, seemed to be inadequate. The majority of the SPNs (67.6 percent) were occupying first and second in charge positions during the time of data collection. The SPNs in all four nursing units indicated that they were aware of the position of NQNs and that SPNs needed to provide guidance and support to the NQNs.

Chapter five will present the analysis, interpretation and description of competencies of NQNs in the work setting as perceived by SPNs.

**CHAPTER 5****ANALYSIS, PRESENTATION, INTERPRETATION AND DESCRIPTION OF  
COMPETENCIES OF NQNS IN THE  
WORK SETTING, AS PERCEIVED BY SPNS****5.1 INTRODUCTION**

This chapter presents the analysis, interpretation and description of findings obtained from section two of the four nursing units' questionnaires completed by SPNs in the community (56), psychiatric (29), midwifery (38) and general (136) units. Each questionnaire consisted of competencies relevant to a specific nursing unit. Competencies which were only applicable to specific clinical settings were omitted in other questionnaires; for example, "management of a woman in labour" was only applicable to midwifery and community nursing units. Many competencies were, however, identical in the questionnaires of all nursing units.

The descriptions of competencies of NQNs as perceived by SPNs were based on percentages and frequencies of the SPNs' responses in all four the nursing units. Establishing the significance of differences among the four nursing units was found not to be statistically feasible as the numbering of competencies in the various questionnaires did not correspond for the reasons previously indicated. However, differences were expected among SPNs within each of the nursing units namely community, psychiatric, midwifery and general.

SPNs in the four nursing units followed the keys described in chapter three section 3.5.1. The key concepts in Part A were interpreted differently, therefore analysis of each column was observed in each competency. All competencies perceived to be essential by at least 50 percent of the

SPNs in part A were accepted as being essential (expected competencies of NQNs upon entering the work setting) in this study.

Part B of the questionnaires requested SPNs of the respective units to indicate their perceptions regarding the competencies of NQNs. To facilitate understanding of the findings obtained in part B, column one "mastery" and column two "competent" were merged to denote "safe performance", meaning that SPNs perceived NQNs to be competent, or performing the action competently. Columns three and four were separate parts. A specific competency was therefore considered "safe performance" when the two columns, namely one and two, combined, yielded 50 percent and above (implying that at least 50 percent of the SPNs regarded a specific competency to be performed safely by NQNs).

## **5.2 PERCEPTIONS OF SPNS ON COGNITIVE COMPETENCIES**

Table 5.1 presents the cognitive competencies that were perceived to be essential, by 80 percent of SPNs in all four the nursing units, namely community, psychiatric, midwifery and general nursing units, and the competencies of NQNs.

**Table 5.1: Competencies perceived to be essential by SPNs in all four Nursing Units (Part A), and the competencies of NQNs (Part B) as perceived by the SPNs.**

ITEM	COMPETENCIES	CLINICAL NURSING UNITS											
		COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 38			GENERAL n = 136		
		F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
			%	%		%	%		%	%		%	%
	<b>PROBLEM-SOLVING</b>												
1	Obtain adequate information from a patient	56	87,5	72,7	29	100,0	62,0	38	89,5	65,8	135	88,9	60,8
2	Assess patient's needs	56	89,3	67,9	29	93,1	44,8	38	94,7	57,9	135	86,7	55,2
3	Define a patient's problem	56	89,3	50,0	29	89,7	41,3	38	92,1	54,0	135	82,2	52,5
4	Formulate a nursing care plan	55	92,7	45,5	29	96,4	96,4	38	89,5	43,2	134	85,8	48,2
	<b>CLINICAL JUDGEMENT</b>												
5	Record accurately nursing diagnosis	56	91,1	39,2	29	100,0	71,5	38	86,8	57,9	135	86,7	49,7
6	Specify nursing intervention in order of priority	56	87,5	35,7	29	100,0	31,0	38	86,8	45,9	136	82,4	44,4
7	Identify preventive actions to minimise patient risk	56	94,6	50,0	29	100,0	44,8	38	84,2	51,0	136	83,8	40,0
	<b>TEACHING</b>												
8	Teach a patient's family members about the patient's/client's needs	56	94,6	69,6	28	89,3	82,1	38	81,6	65,8	136	81,6	59,6
9	Produce clear and accurate reports	56	91,1	44,6	29	89,7	58,6	38	81,6	47,4	136	83,8	40,0

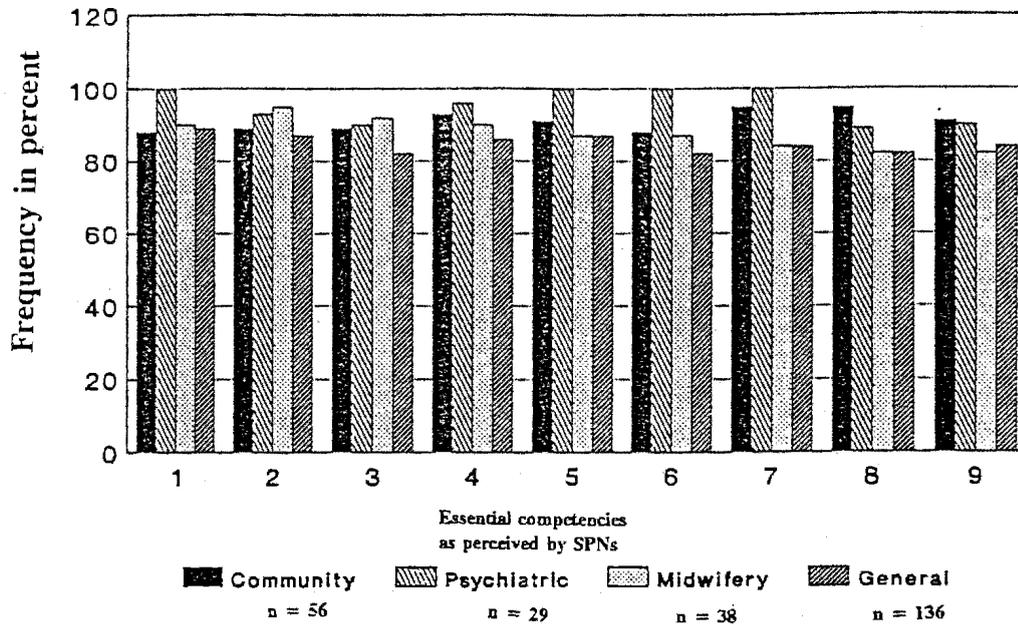


FIGURE 5.1 Essential competencies as perceived by SPNs

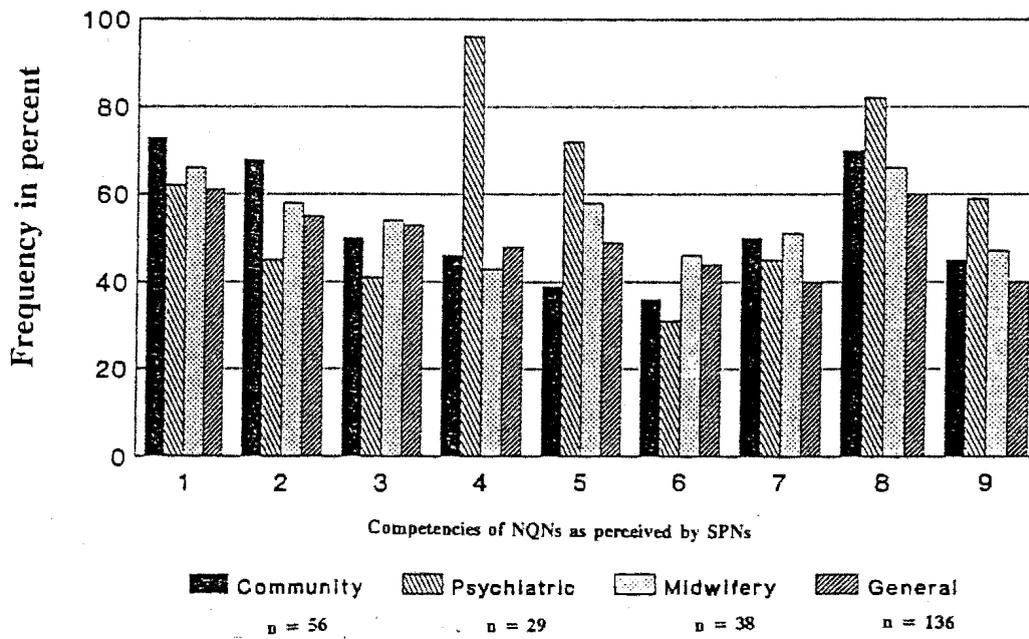


FIGURE 5.2 Competencies of NQNs in all four nursing units as perceived by SPNs

1. Obtain adequate information from a patient.
2. Assess a patient's needs.
3. Define a patient's problem.
4. Formulate a nursing care plan.
5. Record accurately nursing diagnosis.
6. Specify nursing intervention in order of priority.
7. Identify preventive actions to minimise patient risk.
8. Teach a patient's family members about the patient's/client's needs.
9. Produce clear and accurate reports.

The following competencies were perceived as most essential by 100 percent of the SPNs from the psychiatric nursing unit:

- ▶ obtaining adequate information from a patient;
- ▶ accurately recording the nursing diagnosis;
- ▶ specifying nursing interventions in order of priority; and
- ▶ identifying preventive actions to minimise patient risk.

Problem solving and clinical judgement competencies evaluated in this study were all related to the nursing process.

Literature discussed in chapter two section 2.6.1 revealed similar opinions and perceptions that competencies relating to the nursing process were expected of NQNs (Benner, 1984:13; Fitzpatrick et al 1992:1214; Joyce-Nagata et al 1989:316).

Part B of table 5.1 reveals the competencies of NQNs in the four clinical nursing units, namely

community, psychiatric, midwifery and general units as perceived by SPNs. The relationship between the expected competencies and actual competencies of NQNs was expected. It was also expected that the higher the perceptions of expected competencies by SPNs, the greater the chance for NQNs to perform the action competently. However, figures 5.1 and 5.2 reveal diverse perceptions. The SPNs perceived the NQNs as being incompetent in some of the competencies outlined in table 5.1.

**Table 5.2: Competencies perceived to be essential by SPNs in all four Nursing Units (Part A) and the competencies of NQNs (Part B) as perceived by the SPNs.**

ITEM	COMPETENCIES	CLINICAL NURSING UNITS											
		COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 39			GENERAL n = 136		
		F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
			%	%		%	%		%	%		%	%
	<b>PROBLEM-SOLVING</b>												
10	Discriminate and synthesise information obtained from assessment	55	90,9	41,9	29	93,1	44,8	35	69,4	45,4	134	73,1	40,6
	<b>CLINICAL JUDGEMENT</b>												
11	Interpret verbal and non-verbal clues from clients	56	89,3	69,6	29	86,2	73,4	37	74,8	61,1	135	74,8	57,5
12	Prioritise patient's problems	56	94,6	46,4	29	96,6	72,4	38	86,0	59,4	136	86,0	67,4
13	Plan and organise one's work-day	56	85,7	41,0	29	96,6	57,2	36	78,4	52,6	136	76,5	44,9
	<b>TEACHING</b>												
14	Identify learning needs of patients/clients and student nurses	56	89,3	58,9	29	93,1	65,5	38	81,6	65,8	134	78,4	47,1
15	Set objectives for teaching	56	83,9	55,4	29	82,8	51,7	38	73,7	45,9	136	77,2	47,0
16	Use teaching strategies effectively	56	85,7	58,9	28	89,3	64,3	38	76,3	50,0	136	75,0	41,2
17	Use teaching aids in teaching patients	56	94,6	71,4	29	89,7	75,9	38	81,6	71,1	136	78,7	53,7
18	Demonstrate skill in effective communication	56	87,5	46,4	29	93,1	79,3	38	81,6	65,8	136	78,7	53,6
19	Design educational programmes for the patient and nurses	56	89,3	25,0	29	89,7	39,9	38	68,4	42,1	136	74,3	41,2
	<b>ADMINISTRATION/MANAGEMENT</b>												
20	Work with constraints, e.g. time limits, shortage of staff	55	69,1	67,3	29	89,7	67,8	38	57,9	39,5	136	56,3	31,6
21	Delegate aspects to care of peers	56	89,3	71,5	29	82,8	72,4	38	68,4	47,3	136	73,5	42,5
22	Implement policies and procedures as needed	56	87,5	48,2	29	89,3	53,6	38	65,8	35,1	136	72,1	33,1
23	Evaluate own practice	56	78,6	32,1	29	79,3	62,0	38	73,7	47,4	136	69,9	33,3
24	Manage conflict effectively	56	73,2	16,1	29	68,3	10,3	38	65,8	29,0	136	66,9	23,7
25	Commit themselves to unit objectives	56	78,6	35,7	29	89,7	62,1	38	68,4	44,7	136	74,6	33,5

Further descriptions of the findings illustrated in table 5.1 were done simultaneously with the descriptions of the findings illustrated in table 5.2. This was done in order to provide a thorough analysis of cognitive competencies, namely, problem solving, clinical judgement, teaching and administration and management. This resulted in inconsistent scaling displayed in figures 5.3, 5.4, 5.5 and 5.6.

### 5.2.1 Competencies of NQNs in problem solving, as perceived by SPNs

Figure 5.3 reveals variations among the four nursing units' SPNs in their perception of NQNs' competencies.

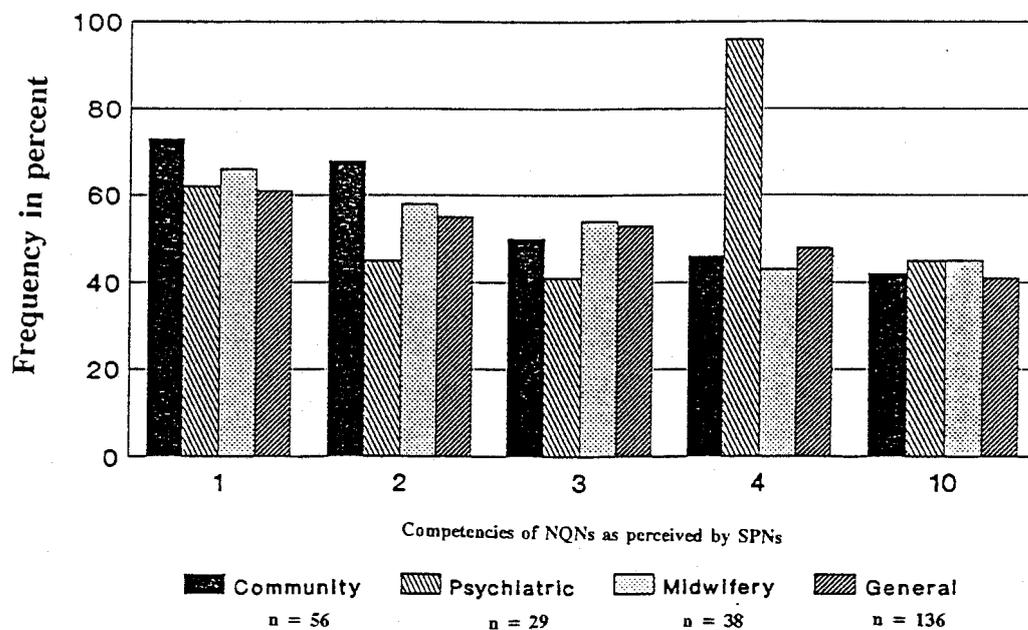


FIGURE 5.3. Competencies of NQNs in all four nursing units, in problem solving, as perceived by SPNs

1. Obtain adequate information from a patient.
2. Assess patient's needs.
3. Define a patient's problem.

4. Formulate a nursing care plan.
10. Discriminate and synthesise information obtained from assessment.

Figure 5.3 reveals that only competency one, "Obtaining adequate information from a patient", was perceived by SPNs to be competently performed by NQNs in all four nursing units namely, community (72.7 percent); psychiatric (62 percent); midwifery (65.8 percent); and general (60.8 percent).

Competency two of table 5.1, "Assessing patient's needs", was perceived by SPNs (67.9 percent; 57.9 percent; 55.2 percent respectively) to be competently performed by NQNs in the community, midwifery, and general units. NQNs in the psychiatric nursing unit were perceived to be incompetent in this respect by 44.8 percent of the SPNs. Assessment could be a major problem with psychiatric patients, as they are quite often violent, disorientated and sometimes not accompanied by relatives on admission. Competency three of table 5.1, "Defining a patient's problem", was also perceived by SPNs (41.3 percent) in the psychiatric nursing unit, to be incompetently performed by NQNs. It transpires from these findings that in order to accurately define a patient's problem, one should first make a thorough assessment of a patient's physical and psycho-social needs, then clearly state a patient's problem.

Competency four of table 5.1, "Formulating a nursing care plan", was only perceived by 45.5 percent of SPNs in the community nursing unit, 43.2 percent in midwifery and 48.2 percent in the general nursing unit to be competently performed by NQNs, whereas NQNs in the psychiatric nursing unit were perceived to be competent in performing this competency by 96.4 percent of the SPNs. This could reveal that NQNs were efficiently grounded in psychiatric nursing

knowledge. Formulation of a nursing care plan is based on the scientific principles and facts underlying a specific condition. Although findings revealed poor performance in their assessment of a new patient, NQNs might have utilised assessment findings made by their seniors successfully when formulating a nursing care plan. The study done by Joyce-Nagata et al (1989:318) revealed similar findings by indicating that graduates in Mississippi, USA, were not efficiently prepared in the stage of assessment. However, it was revealed that graduates were competent in formulating a plan of care with clients, in Mississippi.

"Formulating a nursing care plan" in the midwifery unit might not be a usual practice as patients might be discharged immediately after delivery. Overcrowding of patients and shortage of midwives in the area where the study was done might be contributory problems. It could be expected that formulating of nursing care plans should be competently performed by NQNs in the general nursing units such as medical, surgical and paediatric units. These units admit patients with various conditions which need varied nursing care plans. Units such as operating theatre and out-patient departments might have influenced the findings, as they do not admit patients. These findings seem to concur with the literature discussed in chapter two section 2.6.1, indicating that NQNs were unable to formulate nursing care plans. Ignatavicius (1983:20) revealed that documenting care plans on cardexes was a weakness in East Coast, USA. Hurst et al (1991:1454) in England, revealed that NQNs could implement the plan of care irrespective of their being poor planners. Lathlean & Corner (1991:5) also evidenced that in England newly registered nurses could not formulate a long term plan for patient care.

SPNs of the four nursing units perceived NQNs to be incompetent in discriminating and synthesising information obtained from assessment, as indicated by low percentages of SPNs:

community (41.9 percent), psychiatric (44.8 percent), midwifery (45.4 percent) and general (40.6 percent). Community, midwifery and general SPNs could have been expected to perceive NQNs to be competent in discriminating and synthesising information, as they revealed that NQNs were competent in assessing patients' needs and in defining patients' problems. The three competencies are related to one another in the nursing process. A nurse should first discriminate and synthesise information obtained from assessment before she arrives at a nursing diagnosis.

It could be argued on the basis of these findings that NQNs were perceived not to be competent in performing the nursing process by the SPNs. Troskie (1993:58) also revealed that NQNs in the RSA experienced a greater lack of competency in identifying the social needs of the patient, planning and evaluating nursing care, than in doing nursing procedures. Joyce-Nagata et al (1989:316) revealed unevidenced competencies by nurse managers such as identifying the needs of a patient, recording nursing diagnosis and planning of care in Mississippi, USA. Planning of care also received low percentages in studies done in the USA and England (Ignatavicius, 1983:20; Hurst et al 1991:1444; and Lathlean & Corner, 1991:5). The findings indicated that NQNs concentrated on the "doing" aspects of nursing at the expense of assessing, planning and evaluation of patients' needs. SPNs in the clinical setting should take cognisance that nursing care plans are the source of clinical learning experience in basic nursing programmes. As preceptors to student nurses, it could be expected of them to reinforce the use of nursing care plans as a teaching strategy.

### **5.2.2 Competencies of NQNs in clinical judgement as perceived by SPNs**

Clinical judgement competencies identified in this study were closely linked to the implementation of the nursing process. Figure 5.4 reveals that NQNs in all four nursing units were perceived not

to be competent in aspects of clinical judgement by the SPNs.

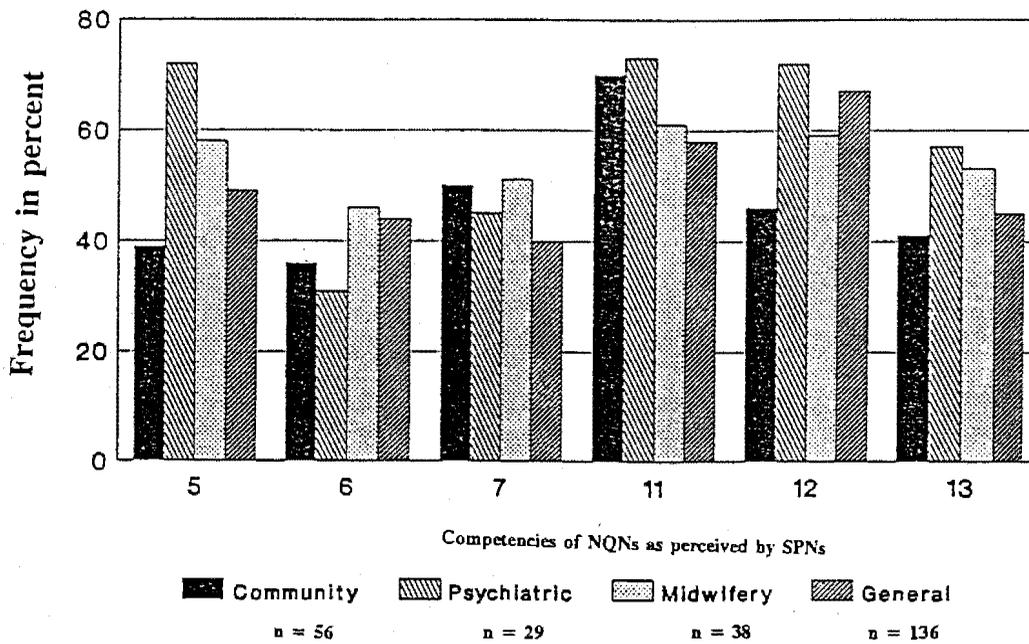


FIGURE 5.4 Competencies of NQNs in all four nursing units, in clinical judgement, as perceived by SPNs

5. Record accurately nursing diagnosis.
6. Specify nursing intervention in order of priority.
7. Identify preventive actions to minimise patient risk.
11. Interpret verbal and non-verbal clues from clients.
12. Prioritise patient's problems.
13. Plan and organise one's work day.

The findings illustrated in figure 5.4 reveal that only competency 11 (Interpretation of verbal and non-verbal clues from clients) was perceived by the SPNs to be competently performed by NQNs in all four nursing units: community (70 percent), psychiatric (73 percent), midwifery (61 percent), and general (58 percent). SPNs from psychiatric (71 percent), midwifery (58 percent)

and general (67 percent) perceived NQNs to be competent in "prioritising patients' problems" (competency 12), whereas NQNs in the community nursing unit were perceived to be incompetent by 59 percent of the SPNs. Although NQNs in the psychiatric nursing unit were perceived to be incompetent in "defining patient's problem" and "assessing patient's needs" as revealed in figure 5.3, they were perceived to be competent in prioritising a patient's problems. SPNs in the four nursing units perceived competency six (Specify nursing intervention in order of priority). to be incompetently performed by NQNs as follows:

- ▶ community (37.5 percent);
- ▶ psychiatric (31 percent);
- ▶ midwifery (45.9 percent); and
- ▶ general (44.4 percent).

The findings may imply that the nursing process was minimally implemented in the community health services, especially in the clinics, because they did not admit patients. Seventy-one percent of the SPNs in the psychiatric nursing unit, and fifty-eight percent in the midwifery unit perceived NQNs to be competent in accurately recording nursing diagnosis.

Competency seven of table 5.1, "Identifying preventive actions to minimise patient risk", was perceived by 40 percent of SPNs in the general nursing unit to be competently performed by NQNs. The findings revealed that 50 percent and 57 percent of operating theatre and paediatric SPNs respectively indicated that NQNs were competent in identifying preventive actions to minimise patient risk. Only 25 percent of SPNs in the surgical unit perceived NQNs to be competent in this regard.

To summarise the findings, the inability to exercise clinical judgement by NQNs was perceived

mostly by SPNs in the community nursing unit and general nursing unit. SPNs in the psychiatric nursing unit, perceived competencies six and seven, "specify nursing intervention in order of priority" and "identify preventive actions to minimise patient risk", to be incompetently performed by NQNs. SPNs in the midwifery unit perceived competency six (specify nursing intervention in order of priority) to be incompetently performed by NQNs.

Studies focused on evaluating competencies of NQNs in the specific nursing unit were not found. However, studies revealing incompetency in clinical judgement activities by NQNs (which seem to tally with the findings of this study) were discussed in chapter two section 2.6.4. Sanford et al (1992:73) in Dallas, USA, revealed that new graduates (80 percent) did not achieve an acceptable level of 80 percent on the clinical judgement scale. Itano (1989:124) supports the view that with experience and practice NQNs could become competent in making clinical judgements. Itano further reveals that in Hawaii HSJMs (registered nurses) collected more clues than senior student nurses.

### **5.2.3 Competencies of NQNs in teaching as perceived by SPNs**

In figure 5.5 the graphs reveal the competencies of NQNs in teaching, as perceived by the SPNs.

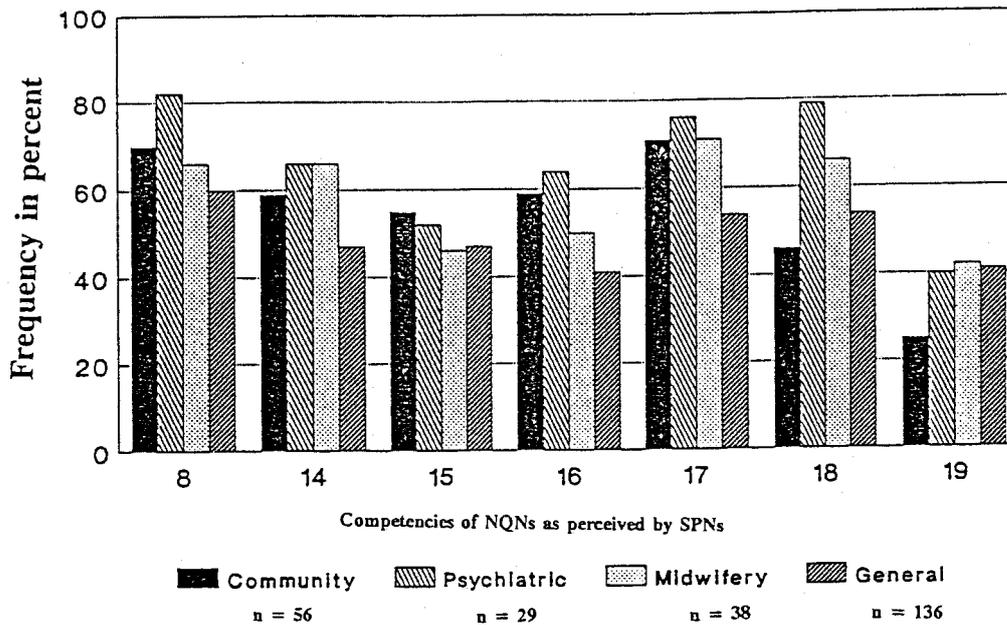


FIGURE 5.5 Competencies of NQNs in all four nursing units in teaching as perceived by SPNs

8. Teach a patient's family members about the patient's needs.
14. Identify learning needs of patients/clients and student nurses.
15. Set objectives for teaching.
16. Use teaching strategies effectively.
17. Use teaching aids in teaching patients.
18. Demonstrate competency in effective communication.
19. Design educational programmes for the patient and nurses.

The findings revealed in figure 5.5 indicate that NQNs in all four nursing units were perceived by the SPNs to be competent in teaching patients' family members (competency eight) and also in using teaching aids (competency 17). SPNs in the community, psychiatric and midwifery units indicated that NQNs were competent in performing the following:

- ▶ identifying learning needs of patients and student nurses (59 percent; 66 percent; and 66 percent respectively).
- ▶ using teaching strategies effectively (58 percent, 64 percent and 50 percent respectively).

"Setting objectives for teaching" (competency 15) was perceived by the SPNs to be competently performed by NQNs in the community and psychiatric nursing units. Whereas "demonstrating competency in effective communication" (competency 18) was perceived by the SPNs to be incompetently performed by NQNs in the community nursing unit only, all SPNs from all four nursing units perceived "designing educational programmes for the patient and nurses" (competency 19) to be incompetently performed by NQNs. This competency could require NQNs to do situational analysis of patients'/nurses' needs, resources, learning habits and to plan time and space. For students, NQNs would need to analyse the curriculum, the level of training and also to explore clinical learning objectives to be accomplished, as well as available clinical learning facilities. However, SPNs indicated that it was an expected competency of NQNs upon entering the work setting. In order to enhance the development of this competency, this aspect could be regularly included in the in-service education programmes of professional nurses of all four nursing units.

Lack of teaching competencies by NQNs as perceived by SPNs in the general nursing units could be noted with concern. Paediatric SPNs (52 percent) perceived competency 19 (design educational programmes) to be non-essential. Only one study discussed in chapter two section 2.6.5, revealed that nurses employed in hospitals were considerably less active in health education than those nurses in public health services in the USA (Ackerman et al 1981:37). Ackerman's findings seem to concur with the findings revealed in figure 5.5 of this study. NQNs in the community nursing units were perceived to be more competent in teaching skills than their

counterparts in the general nursing units. Teaching and collaboration were the difficult areas for new graduates to implement according to Vanetzian and Higgins (1990:274) in the USA.

The fact that the teaching role was essential in the clinical setting was supported by the findings revealed in tables 5.1 and 5.2. SPNs in all four nursing units perceived the teaching competencies as being essential. Milde & Heim (1991:401) revealed that in midwestern institutions in Iowa, USA, both educators and students considered the following as part of the nurse's role:

- ▶ assessment of individual group learning needs;
- ▶ developing learning objectives;
- ▶ implementing teaching plan; and
- ▶ evaluating learning.

Conceptual views indicated by Gleit & Graham (1984:25) purported that most nurses did not have the communication skills necessary for patient/client teaching. The findings of this study did not concur with their views. SPNs in the three nursing units, namely psychiatric (79.3 percent), midwifery (65.8 percent) and general (53.6 percent) perceived NQNs to be capable of demonstrating competency in effective communication.

In conclusion, offering courses and workshops could improve the teaching abilities of professional nurses. This was proved to be beneficial in the study done by Murdaugh (1980:1073). Registered nurses who underwent a course on the principles of teaching and learning, showed improved effectiveness in teaching patients with myocardial infarction and congestive cardiac failure.

### 5.2.4 Competencies of NQNs in management and administration as perceived by SPNs

The description of findings on administration and management competencies were based on the seven competencies perceived to be essential by the SPNs of all four nursing units revealed in table 5.2. Figure 5.6 illustrates the competencies of NQNs as perceived by SPNs.

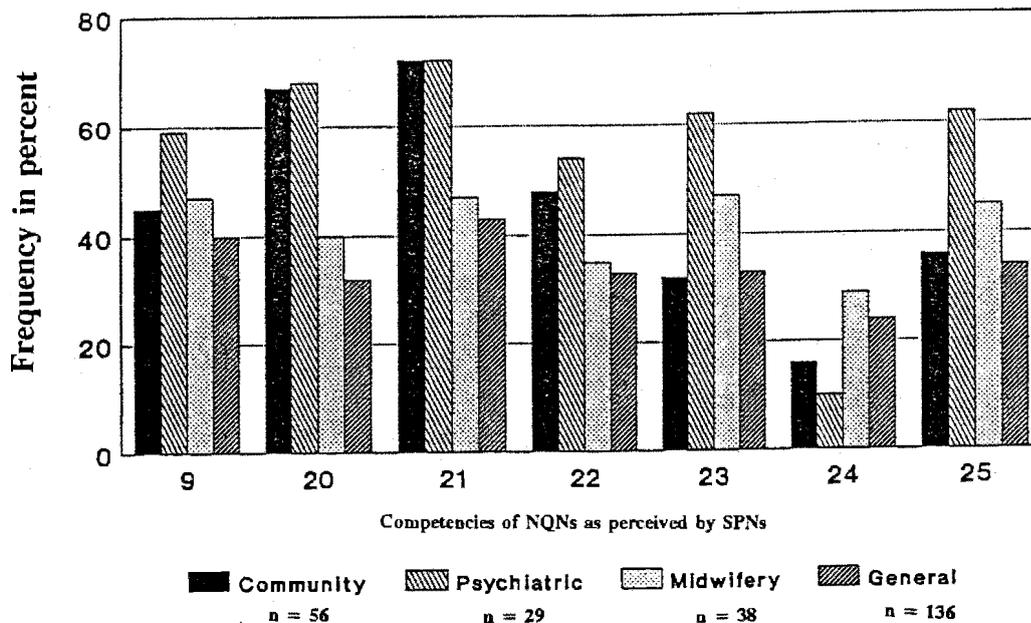


FIGURE 5.6. Competencies of NQNs in all four nursing units in administration/ management as perceived by SPNs

9. Produce clear and accurate reports.
20. Work within the limits of constraints such as time limits and shortage of staff.
21. Delegate aspects of care to peers.
22. Implement policies and procedures as needed.
23. Evaluate own practice.
24. Manage conflict effectively.
25. Commit themselves to unit objectives.

Figure 5.6 reveals that NQNs in the psychiatric nursing units were perceived by the SPNs to be

competent in most aspects of administration and management competencies as compared with NQNs in other nursing units, namely community, midwifery and general. The administrative and management competencies which were perceived by SPNs as being adequately performed by NQNs in the psychiatric nursing unit were the following:

- ▶ produce clear and accurate reports;
- ▶ work within constraints such as time limits;
- ▶ delegate aspects of care to peers;
- ▶ evaluate own practice; and
- ▶ commit themselves to unit objectives.

Only one competency, (24) "manage conflict effectively" was perceived by SPNs to be incompetently performed by NQNs in the psychiatric nursing unit.

NQNs in the community nursing unit were perceived by SPNs to be competent in performing only two competencies, namely "working within constraints" and "delegating aspects of care to peers". SPNs in the midwifery unit and general nursing unit perceived NQNs not to be competent in performing all seven management competencies as illustrated in figure 5.6. "Managing conflict effectively" was perceived by the SPNs to be incompetently performed by NQNs in all four nursing units.

It could be argued that managing conflict could not be mastered at once by NQNs. It needs gradual development upon exposure to a variety of settings. It was revealed in the profile of the SPNs discussed in Chapter four that the majority of NQNs occupied fourth and lower positions in the unit hierarchy. It might happen that NQNs occupying those positions had fewer opportunities to manage unit conflicts.

The SPNs from the clinical teaching department (57 percent), out-patient department (52 percent) and operating theatre (51 percent), perceived NQNs to be competent in drafting the on-off duty roster, whereas in all six general clinical units NQNs were perceived to perform inadequately in "leading team conferences". This competency might be expected of more experienced registered nurses.

In conclusion, these findings might reveal that the administration and management competencies were not adequately treated during the professional preparation of NQNs in the areas concerned. Similar findings were revealed by studies done in other countries. Lathlean & Corner (1991:2) cited Vaughan and Humphries who both revealed that in England management and administrative practice featured high on the list of requests for inclusion in basic training of nurses.

**Table 5.3: Cognitive competencies perceived to be non-essential by the SPNs in all four clinical nursing units (Part A), and the competencies of NQNs (Part B), as perceived by the SPNs.**

ITEM	COMPETENCIES	CLINICAL NURSING UNITS											
		COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 39			GENERAL n = 136		
		F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
			%	%		%	%		%	%		%	
	<b>RESEARCH</b>												
1	Identify researchable problems	56	44,6	30,3	29	34,5	17,2	37	45,9	34,2	135	43,0	25,0
2	Initiate research	56	37,5	16,1	29	24,1	11,9	38	18,4	18,4	135	40,0	24,5
3	Read and critically analyse research	56	41,1	12,5	29	20,7	7,4	38	23,7	16,2	136	36,8	21,4
4	Use research data	56	42,9	16,3	28	25,0	7,7	37	32,4	13,5	136	44,9	23,1
5	Determine the applicability of the research results	56	44,6	10,7	27	22,2	8,0	37	32,4	14,7	136	44,1	25,8

Table 5.3 reveals that research competencies were predominantly perceived not to be essential by the SPNs in the four nursing units. Figure 5.7 illustrates how the SPNs perceived these competencies.

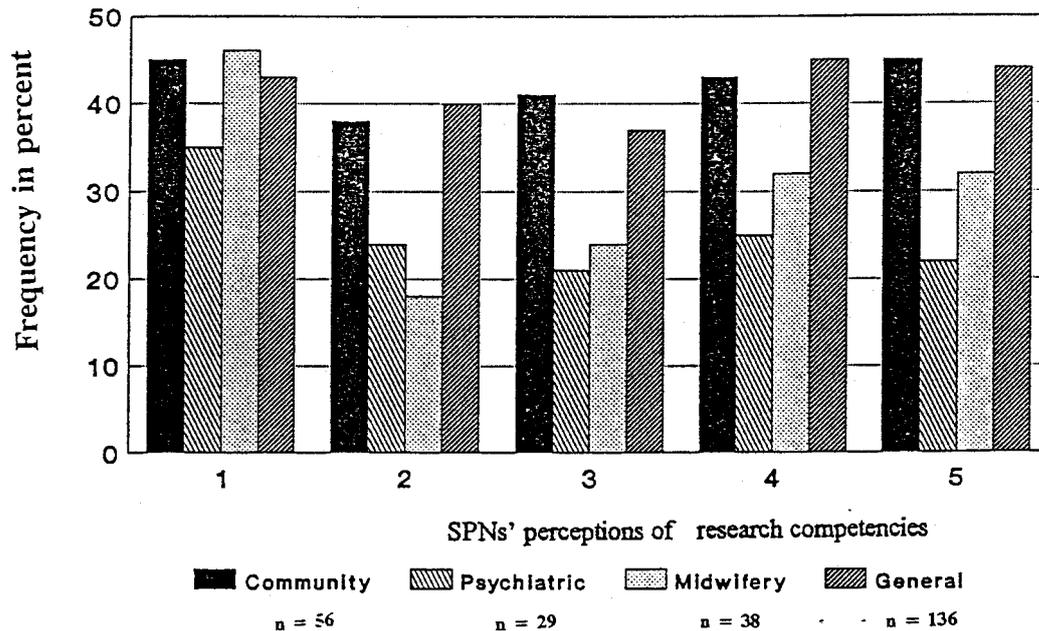


FIGURE 5.7. SPNs' perceptions of research competencies in all four nursing units.

1. Identify researchable problems.
2. Initiate research.
3. Read and critically analyse research.
4. Use research data.
5. Determine the applicability of the research results.

Figure 5.7 reveals that research competencies were perceived lowest by the psychiatric SPNs, followed by the midwifery SPNs. The graph lines for the general SPNs and community SPNs

appeared relatively higher.

Diverse perceptions on "research competencies" were evidenced, and SPNs viewed them as "desirable but not essential":

- ▶ community (32 percent);
- ▶ psychiatry (32 percent);
- ▶ midwifery (39 percent); and
- ▶ general (33 percent).

The findings could imply that SPNs who participated in this study were not research orientated.

The findings seemed to contradict the conceptual views raised by Du Preez (1990:27) in the RSA and Fitzpatrick et al (1992:1212) in England. These authors assert that a professional nurse should be committed to encouraging research in nursing. SPNs viewed the competencies as "useful, should not be required" at NQNs' level of experience:

- ▶ community (25 percent);
- ▶ psychiatric (42 percent);
- ▶ midwifery (26 percent); and
- ▶ general (27 percent).

Apparently these SPNs felt that research should not be expected of NQNs upon entering the work setting. When SPNs would expect NQNs to be engaged in research processes was not established by this research.

Research is essential in nursing, so that the body of scientific knowledge may be developed and a high standard of patient care assured (Du Preez 1990:27). In a study done in Israel by Ehrenfeld & Eckerling (1991:224-231) on "Perceptions and attitudes of registered nurses to research", it

was revealed that registered nurses perceived research activities such as reading research and applying research findings as part of the nurse's role. The findings in this research do not support those of Ehrenfeld & Eckerling. However, the two authors did reveal that "initiate research" was ranked lowest when considering the nurse's essential role.

Regarding the competencies of NQNs in the four nursing units illustrated in table 5.3, findings concurred with the expectations expressed in part A. NQNs could not display competency in skills which their seniors viewed as not being essential. Figure 5.8 illustrates the competencies of NQNs in research as perceived by SPNs.

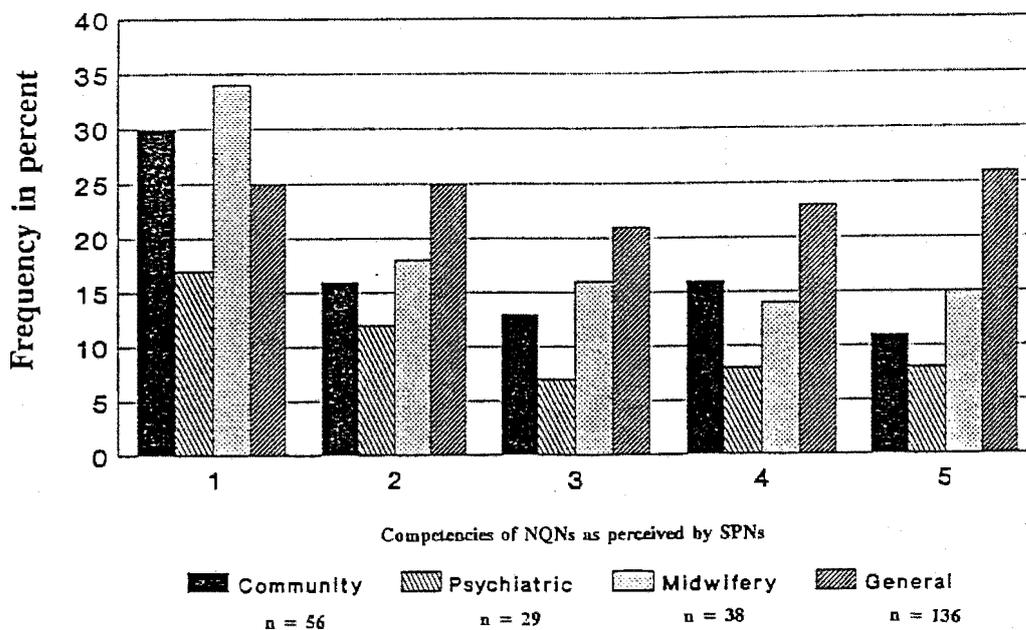


FIGURE 5.8. Competencies of NQNs in research as perceived by SPNs

Studies evaluating the competencies of NQNs in various nursing units were unattainable. However, the literature reviewed in chapter two section 2.6.2, revealed lack of research knowledge as being a universal problem. Joyce-Nagata et al (1989:314) revealed in the USA that

the following research competencies were not evidenced in nursing practice by nursing administrators:

- ▶ conducting minimally complex studies; and
- ▶ applying findings of own research.

The study done by Troskie (1993:54) seems to be supported by these findings by revealing that both NQNs and their supervisors agreed that the nurse in the RSA did not have the necessary background to do research. These findings do not concur with Fitzpatrick et al (1992:1212) in England. They assert that a professional nurse should be able to read and critically analyse research and determine the applicability of the results to the clinical setting. Fawcett (1984) cited by Ehrenfeld and Eckerling (1991:231) in Israel, distinguished levels of utilising research data by indicating that nurses with masters or higher degrees could be expected to conduct investigations and studies, while registered nurses on a lower educational level were expected to read research, share findings with others and apply them in their practice.

Lack of research knowledge by professional nurses revealed in this study and also in Troskie's study (1990) could be cause for concern in the RSA.

TABLE 5.4 Competencies of NQNs as perceived by SPNs in the community nursing unit

ITEM	COMPETENCIES	COMMUNITY NURSING UNIT n = 56		
		F	PART A %	PART B %
1	Carry out a mini-epidemiological study	56	48.2	26.1
2	Organise role-plays with clients	56	82.1	33.9
3	Compose educational songs	56	73.2	25.5
4	Maintain accountability for own care	54	89.3	46.4
5	Influence and lead others	56	80.4	33.0

"Carrying out a mini-epidemiological study" was perceived not to be essential by the SPNs (48.2 percent) in the community health services. Forty-two percent of the SPNs perceived the competency to be "desirable but not essential", meaning that "it would be nice if every NQN could perform the competency, but it is not essential". Conducting an epidemiological study could be beneficial in the community health services. Nurses would be able to provide community services relevant to the disease profile revealed by the study.

The following competencies were perceived to be essential by the SPNs:

- ▶ organise role-plays with clients (82.1 percent);
- ▶ compose educational songs (73.2 percent);
- ▶ maintain accountability for own care (89.3 percent); and
- ▶ influence and lead others (80.4 percent).

Regarding the competencies of NQNs, all five indicated in table 5.4 were perceived by SPNs to be incompetently performed by NQNs. It was revealed in table 5.3 that SPNs perceived research competencies not to be essential and also inadequately performed by NQNs. The findings supported NQNs' inability to conduct mini-epidemiological studies.

Organising role-play and composing a song could require unique talents. However, their use should be encouraged in primary health care, especially among South African rural communities where the rate of illiteracy could be high. These two strategies could be powerful instruments to enhance comprehension of a health message. Literature supporting the use of role-play and composing songs in the community health services was not found. Nevertheless, role-play and

educational songs were perceived to be essential by the SPNs in this study.

SPNs indicated that NQNs were not competent in maintaining accountability for providing care, and influencing and leading others. The two competencies concern the administration and management of a unit. These findings seem to contradict the findings revealed in table 4.10 where it was revealed that 41 percent of NQNs in the community health services were perceived by SPNs to be occupying 2nd or 3rd in charge positions. It could, therefore, be expected that these NQNs might have gained confidence in their nursing practices. These expectations seem to be supported by Troskie's findings (1993:56). This research revealed that NQNs in the community in the RSA worked in isolation and they did not always have access to other personnel for support.

TABLE 5.5 Competencies of NQNs as perceived by SPNs in the psychiatric nursing unit

ITEM	COMPETENCIES	PSYCHIATRIC NURSING UNIT n = 29		
		F	PART A %	PART B %
1	Clearly state one's assessment of a mentally ill patient	29	93.1	58.6
2	Manage crisis intervention	27	69.0	13.7
3	Carry out admission and discharge of patients according to Mental Health Act no. 18 of 1973	28	65.5	44.8

Table 5.5 reveals findings of response by the psychiatric nursing unit. The three competencies were perceived by the SPNs to be essential in the psychiatric nursing unit. Regarding the

competencies of NQNs, SPNs (58.6 percent) indicated that NQNs performed competency one, "clearly state one's assessment of a mentally ill patient", competently. The findings seem to contradict the findings illustrated in table 5.1. SPNs (69 percent) perceived NQNs to be incompetent in specifying nursing intervention in order of priority.

The following administrative/management competencies were perceived by SPNs to be inadequately performed by NQNs in the psychiatric nursing unit:

- ▶ managing crisis intervention; and
- ▶ carrying out admission and discharge of patients according to Mental Health Act no. 18 of 1973.

Findings revealed by Troskie (1993:58) in the RSA indicated that NQNs experienced problems in counselling patients with emotional stress or trauma. These findings might support the findings illustrated in table 5.5 that NQNs were not competent in managing crisis intervention. Interpretation of acts could be perceived to be difficult for NQNs, as Acts are written in legal language. It could be suggested that in-service education be provided by SPNs on a regular basis in order to assist NQNs' comprehension of what is entailed in the Acts. Specific literature supporting or contradicting these findings was not found.

TABLE 5.6 Competencies of NQNs as perceived by SPNs in the midwifery and general clinical units

ITEM	COMPETENCIES	CLINICAL NURSING UNITS					
		MIDWIFERY n = 38			GENERAL n = 136		
		F	Part A %	Part B %	F	Part A %	Part B %
1	Draft on-off duty roster	37	76.3	73.0	136	80.9	45.9
2	Prepare for doctor's rounds	37	86.5	62.2	135	88.1	69.5
3	Influence and lead others	38	65.8	42.1	135	68.1	25.9

Table 5.6 reveals that both midwifery and general SPNs perceived the illustrated competencies to be essential. Expecting NQNs to influence and lead others was generally perceived by the SPNs to be "useful, should not be required" at NQNs' level of experience. This could be possible as NQNs might assume duties occupying lower positions. However, Chapter four table 4.10 (the profile of the SPNs), reflected that some NQNs in these units occupied second or third positions which required them to lead others.

The findings of Part B revealed that SPNs perceived NQNs to be competent in preparing for doctors' rounds in both nursing units. NQNs were perceived to be competent in drafting the on-off duty roster in the midwifery unit by 73 percent of SPNs whereas 54 percent of SPNs in the general unit viewed NQNs to be incompetent. Influencing and leading others was perceived to be inadequately performed by NQNs in both groups, the general and midwifery units.

Literature discussed in chapter two section 2.6.3 expected a professional nurse to have management knowledge in leading others and control (Du Preez 1990:27; Kelly in Kershaw 1990:61). These authors' views seem not to concur with the findings of this study. Although NQNs were fully-fledged managers, it could not be expected of them to handle complex situations such as leadership and controlling activities of others. The study done by Lewis (1990:808) in the UK revealed the sister-in-charge as apparently having a strong sense of her position as a leader, responsible for everything that goes on in her ward. The study done by Lowane (1990:58) in the former Gazankulu health service (falling within the Northern Province of the RSA since 1994), also supported the perception that NQNs were not capable of leading others, by revealing that leadership and supervision roles were hardly mastered by NQNs during their professional preparation.

### **5.3 PERCEPTIONS OF SPNS ON AFFECTIVE COMPETENCIES**

Table 5.7 reveals competencies perceived to be essential by SPNs in all four nursing units and the competencies of NQNs, as perceived by the SPNs. This table reveals varied levels of perception regarding adaptive and adjustment competencies. The psychiatric SPNs persistently perceived the competencies lowest. This group perceived "adjusting to work environment" to be non-essential. Community and psychiatric SPNs perceived interpersonal competencies and communication, and caring and ethics competencies to be essential.

Table 5.8 reveals that SPNs in the health centres persistently perceived the four competencies to be more important than the SPNs at the clinics perceived them to be:

- ▶ being confident in their nursing practices;
- ▶ communicating information to other health teams;

- ▶ **applying meaningful touch; and**
- ▶ **coordinating with other community services.**

**Table 5.7: Competencies perceived to be essential by SPNs in all four nursing units (Part A), and the competencies of NQNs (Part B) as perceived by the SPNs.**

ITEM	COMPETENCIES	CLINICAL NURSING UNITS											
		COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 38			GENERAL n = 136		
		F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
			%	%		%	%		%	%		%	
	<b>ADAPTIVE/ADJUSTIVE</b>												
1	Be sensitive to people's feelings	56	83,9	76,8	29	69,0	72,4	38	68,4	65,8	136	67,6	55,8
2	Accept criticism from staff	56	85,7	64,3	29	72,4	72,4	38	78,4	64,9	136	72,8	50,8
3	Be confident in their nursing practices	56	73,2	50,0	29	55,2	41,3	37	78,9	44,7	136	75,0	37,5
4	Adjust to work environment	56	85,7	57,2	29	48,3	65,5	38	81,6	64,8	135	77,2	51,9
	<b>INTERPERSONAL/COMMUNICATION</b>												
5	Communicate a feeling of acceptance of each client	56	94,6	78,1	29	93,1	79,3	37	84,2	70,2	133	80,7	66,9
6	Promote the client's right to privacy	56	94,6	87,3	29	86,2	82,7	37	91,9	68,5	135	86,0	69,1
7	Explain nursing procedures to a client prior to performing them	56	94,6	82,1	29	89,7	86,2	38	91,9	78,4	133	86,7	63,2
8	Communicate information to other health team members	56	91,1	65,4	29	89,7	72,4	38	94,6	76,3	136	83,1	57,0
9	Apply meaningful touch	56	82,1	41,9	29	89,7	59,0	36	75,7	57,9	134	73,3	46,6
10	Seek assistance when necessary	56	92,9	89,5	29	89,7	79,3	37	91,9	76,3	136	88,2	64,2
	<b>CARING AND ETHICS</b>												
11	Create safe environment for clients/patients	56	96,4	75,0	29	96,6	79,3	38	92,1	71,1	134	89,7	63,5
12	Listen to a patient	56	94,6	75,0	29	96,6	82,3	38	92,1	73,7	133	89,7	56,4
13	Support human dignity while engaging in professional practice	56	96,4	69,7	29	89,7	72,4	38	78,9	55,2	135	86,0	47,7

ITEM	COMPETENCIES	CLINICAL NURSING UNITS											
		COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 38			GENERAL n = 136		
		F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
			%	%		%	%		%	%		%	
14	Respect patient's freedom of choice and right to make a decision	56	91,1	60,7	29	89,7	72,4	37	78,9	52,7	135	80,9	42,1
15	Inform a patient about his progress	56	91,1	55,3	29	89,7	44,8	38	89,5	63,2	136	73,5	40,4
16	Practise within the scope of practice of a professional nurse	56	96,4	66,1	29	82,8	79,3	37	86,8	60,5	136	89,3	50,2
17	Demonstrate knowledge of the ethics of nursing	56	89,3	37,5	29	82,8	75,8	37	73,7	39,5	135	79,4	39,8

**Table 5.8: Competencies perceived to be essential by SPNs in the community health clinical units (community health clinics and community health centres)**

<b>COMPETENCIES</b>	<b>%</b>	<b>%</b>
	<b>CLINICS SENIOR PROFESSIONAL NURSES n = 12</b>	<b>HEALTH CENTRES SENIOR PROFESSIONAL NURSES n = 42</b>
Be confident in their nursing practices	50	83
Communicate information to other health teams	75	95
Apply meaningful touch	58	88
Coordinate with other community services	67	93

### **5.3.1 Competencies of NQNs in adaptive/adjustive competencies as perceived by SPNs**

The community SPNs perceived all the adaptive/adjustive competencies illustrated in table 5.7 to be competently performed by NQNs. "Be confident in their nursing practices" was also perceived by the SPNs to have been displayed by NQNs in the community health services. The findings seem to tally with the findings of the study done in the USA by Van Ess Coeling (1990:28) who revealed that organisational socialisation processes had a direct effect on the NQNs' adaptation process. NQNs in the community setting were revealed to be working in isolation, even assuming first in charge positions (Troskie 1993:56), in the RSA. SPNs (81 percent) at the clinics perceived NQNs to be more confident in their nursing practices than NQNs in the health centres were perceived to be. These findings seem to prove that there was no relationship between essential competencies and the perceived adaptive/adjustive competencies of NQNs. Table 5.8 reveals that SPNs at the health centres perceived this competency more important than SPNs at the clinics.

The findings in table 5.7 further revealed that the competency, "be confident in their nursing practices" was perceived to be inadequate in NQNs in the psychiatric, midwifery and general nursing units. The socialisation process during professional preparation of NQNs could also play a role in making them confident in their nursing practices. These findings seem to be supported by Lowane (1990:73) who recorded that fourth year student nurses in the former Gazankulu hospitals (falling within the Northern Province of the RSA since 1994) indicated that they were not confident in practising clinical skills. Lathlean & Corner (1991:8) also revealed similar findings among newly qualified registered nurses in England.

"Accepting criticism from staff" and "adjusting to work environment" were perceived by the SPNs

to be adequate on the part of NQNs in all four nursing units illustrated in table 5.7. These findings could help to improve attitudes and relationships between NQNs and SPNs. Van Ess Coeling (1990:28) revealed that NQNs in midwestern institutions in the USA could not accept criticism, as their seniors were using an indirect manner of criticism. Lowane (1990:73) also revealed that registered nurses used negative criticism to teach students in the former Gazankulu hospitals (falling within the Northern Province of the RSA since 1994). These findings indicate that criticism by seniors might have hindered the nurses concerned from adjusting to the work environment. Henderson (1982:181) revealed that NQNs of Sturt CAE in Australia were perceived to be above hospital graduates in accepting criticism from other staff members.

Figure 5.9 displays a graphic presentation of perceived competencies of NQNs in the four nursing units.

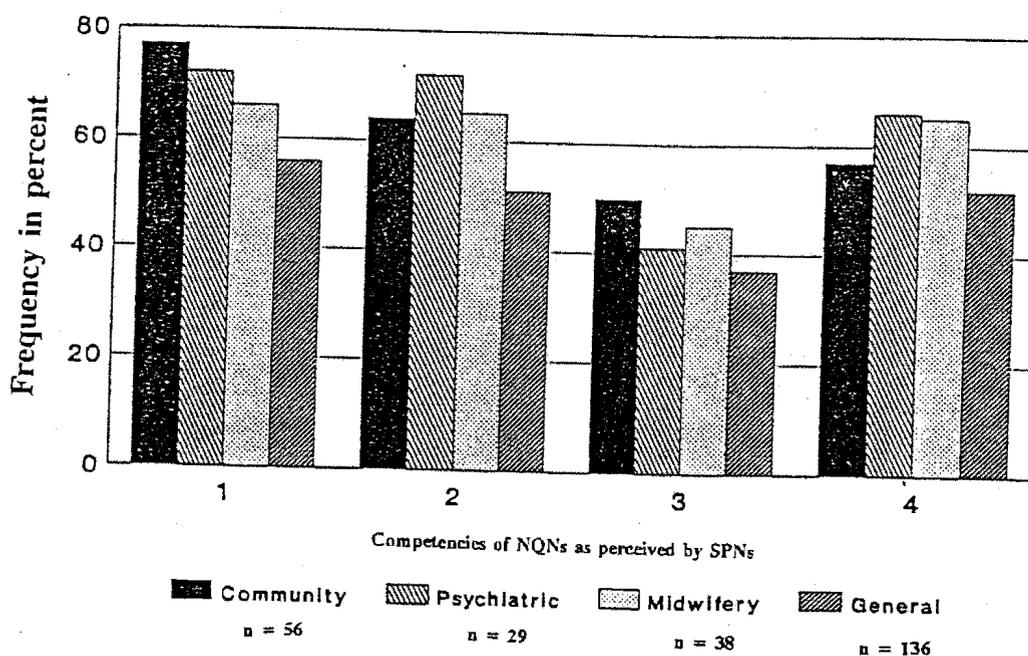


FIGURE 5.9. Competencies of NQNs in all four nursing units in adaptive/adjustive competencies as perceived by SPNs

1. Be sensitive to people's feelings.
2. Accept criticism from staff.
3. Be confident in their nursing ability/practices.
4. Adjust to work environment.

The findings on adaptive/adjustive competencies revealed that NQNs concerned did not have adjustment problems in their clinical areas of work, as perceived by the SPNs.

### 5.3.2 Competencies of NQNs in interpersonal communications as perceived by SPNs

The competencies of NQNs in the four nursing units namely community, psychiatric, midwifery

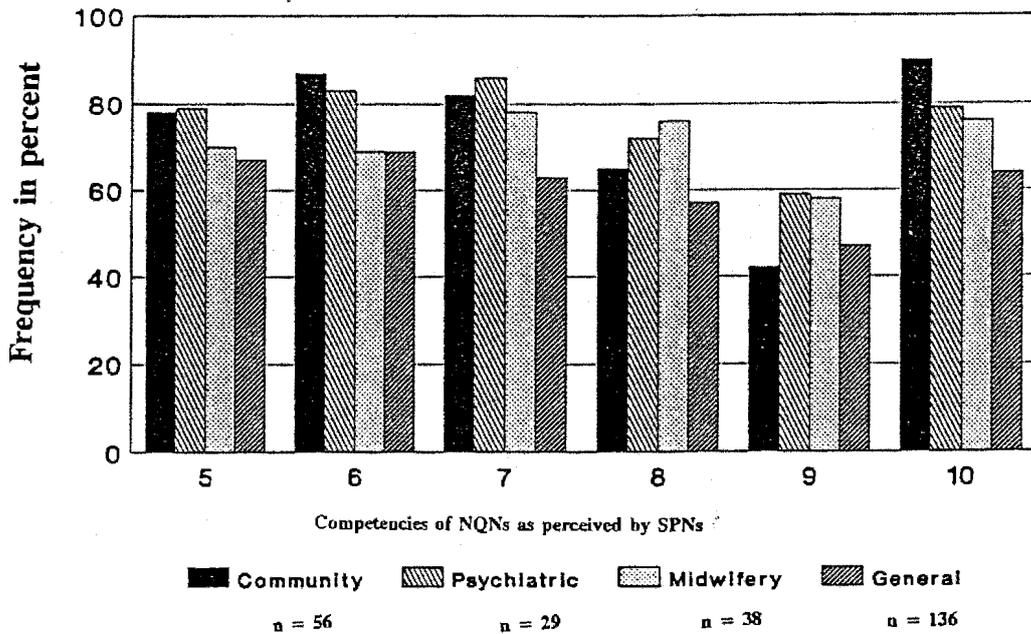


FIGURE 5.10 Competencies of NQNs in all four nursing units in interpersonal communications, as perceived by SPNs.

5. Communicate a feeling of acceptance of each client.
6. Promote the client's right to privacy.

7. Explain nursing procedures to a client prior to performing them.
8. Communicate information to other health team members.
9. Apply meaningful touch.
10. Seek assistance when necessary.

The findings illustrated in figure 5.10 revealed that only competency nine, "apply meaningful touch", was perceived by the SPNs to be inadequately performed by NQNs in the community and general nursing units. Shortage of professional nurses in the community health services could be a contributory factor. NQNs in the community clinical setting might not have sufficient time to massage a woman in labour, nor to calm a crying or anxious child. NQNs in the general nursing units, especially paediatric units could be expected to apply therapeutic touch. Nurses should play the role of mother to children whose mothers are not staying with them during hospitalisation. The persistently low perceptions of NQNs' competency in "applying meaningful touch" revealed by the SPNs of the two nursing units, namely community and general, seemed to support the connotation that touching of a patient is no longer a therapeutic action but might imply contracting a disease. Nurses are being habituated to apply precautionary measures such as wearing gloves, masks and gowns where necessary when rendering nursing care. A young patient might perceive a nurse to be a monster, and this might delay recuperation. The implication is that the gloves apply meaningful touch on behalf of the nurse.

Applying meaningful touch was perceived by SPNs (59 percent and 57 percent respectively) to be competently performed by NQNs in the psychiatric and midwifery units. Psychiatric patients might appear to be childish in their behaviour. They might demand attention from nurses. Touching could play a vital role in rehabilitating a patient who presents with social neglect

problems. Therapeutic touch could play a vital role in alleviating pain during labour. It could be argued that therapeutic touch is commonly practised in the labour room. Studies supporting or contradicting these findings were not found.

The following four competencies were perceived by SPNs to be competently performed by NQNs in all four nursing units. For percentages, refer to table 5.7:

- ▶ communicating a feeling of acceptance to each patient;
- ▶ promoting the patient's right to privacy;
- ▶ explaining nursing procedures to a patient prior to performing them; and
- ▶ seeking assistance when necessary.

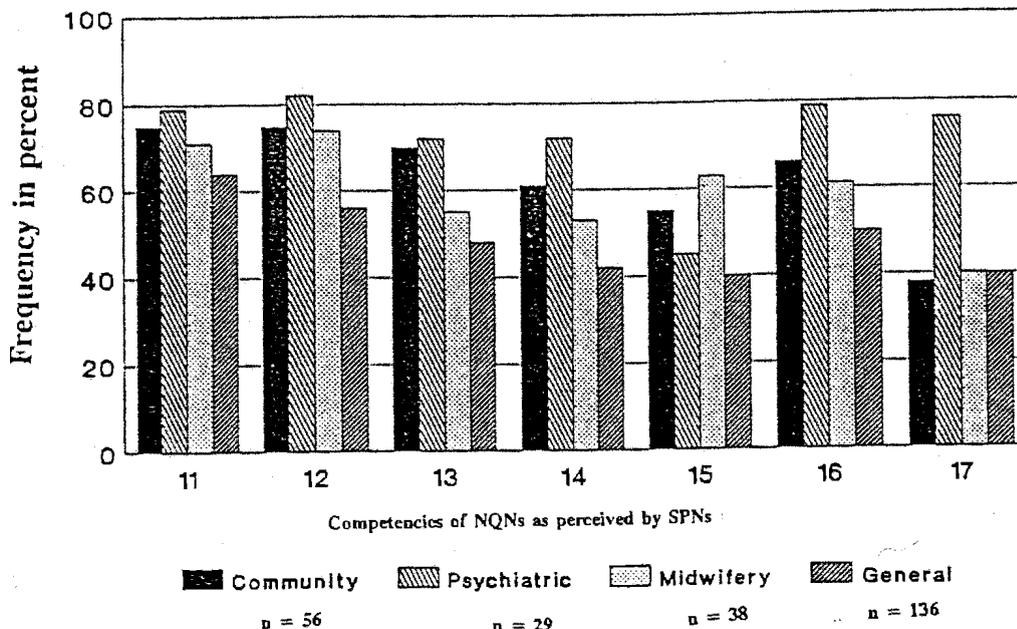
These findings do not seem to support Troskie's findings (1993:57) which revealed that NQNs in the RSA were not capable of handling communication and interpersonal relations. Only 35 percent of supervisors (n=238) indicated that NQNs were competent in "explaining procedures". The findings of this study were supported by Vanetzian & Higgins (1990:273) in the USA. These two authors revealed that supervisors evaluated NQNs' performance on similar items as satisfactory. The findings could imply that SPNs involved in this study were good role models. Good interpersonal communication is enhanced when there is co-operation, trust and mutual respect in a unit.

The perceptions of SPNs on "seeking assistance when necessary" by NQNs in all four nursing units could support the impression that SPNs and NQNs maintained good interpersonal relationships. NQNs in the community clinical setting might experience problems when in need of a second opinion, as it was revealed before that they worked alone most of the time. This competency might quite often be practised in the midwifery unit. An NQN should learn to seek

a second or third opinion when unsure in the midwifery unit. The mother and the baby could be endangered by mismanagement in labour by an NQN. Vanetzian & Higgins (1990:273), in the USA, also revealed that new graduates sought assistance when necessary. Girot (1993:118) identified NQNs in England who were scared to seek assistance when necessary by studying their body language and what it revealed.

The findings reflected in figure 5.10 reveal that SPNs perceived communicating with patients not to be a problem among NQNs in the four nursing units. SPNs perceived NQNs to be competent in explaining nursing procedures to patients, and communicating a feeling of acceptance. These findings did not tally with Shuldham's findings cited in Lathlean & Corner (1991:73), in England, indicating that NQNs might have limited experience in communicating with a wide range of patients. The Health Service Ombudsman's report cited by Lathlean & Corner (1991:73-74) revealed failures in communication regarding nurses in England.

**5.3.3 Competencies of NQNs in caring and ethics as perceived by SPNs**



**FIGURE 5.11** Competencies of NQNs in caring and ethics as perceived by SPNs

11. Create a safe environment for clients/patients.
12. Listen to a patient.
13. Support human dignity while engaging in professional practice.
14. Respect patients' freedom of choice and rights to make decisions.
15. Inform a patient about his progress.
16. Practise within the scope of practice of a professional nurse.
17. Demonstrate knowledge of the ethics of nursing.

Figure 5.11 reveals that NQNs of all four nursing units were perceived to be competent in performing the following competencies by more than 50 percent of the SPNs:

- ▶ creating a safe environment for clients/patients;
- ▶ listening to a patient; and
- ▶ practising within the scope of practice of a professional nurse.

Practising within the scope of practice of a professional nurse is a requirement laid down by the SANC. The scope of practice (R2598) describes the acts and procedures in broad principles to serve as guidelines for professional nurses' practices. "Listening to a patient" was also revealed as a competency NQNs wished to learn more of during training in the former Gazankulu health services (falling within the Northern Province of the RSA since 1994) (Lowane 1990:90). NQNs were perceived to be competent in listening to a patient despite the fact that they could not apply therapeutic touch to patients as revealed in figure 5.10. It needs to be observed that applying the two competencies simultaneously when rendering nursing care could imply a powerful healing process.

SPNs (67 percent) in the operating theatre indicated that NQNs mastered listening to patients. These findings seemed to be contradicted by SPNs (67 percent) in the clinical teaching department who indicated that NQNs were not competent in listening to patients.

The following competencies were perceived by the SPNs to be incompetently performed by NQNs in the general clinical units only:

- ▶ supporting human dignity while engaging in professional practice (47.7 percent); and
- ▶ respecting patients' freedom of choice and right to make decisions (42.1 percent).

These two competencies were also related to implementation of ethics of nursing. Joyce-Nagata et al (1989:316), in Mississippi, USA, revealed that these competencies were not evidenced by nursing administrators when evaluating new graduates' performance. Sweeney et al (1980:39) revealed that patients expected nurses to maintain professional decorum and demonstrating ethical behaviour in the USA. "Demonstrating knowledge of the ethics of nursing" was perceived by SPNs (73 percent) to be competently performed by NQNs in the psychiatric nursing unit only. Research done in other countries revealed similar findings. "Informing a patient about his illness" was perceived to be competently performed by NQNs in the community health and midwifery units. Girot (1993:116) in England, revealed patients' perceptions which supported these findings. Patients wanted to be informed of their own illness, its causes, as well as its prognosis. Nurse-client interaction in the community setting is based mainly on health education concerning the problem identified. Ackerman et al (1981:41) seemed to concur with these findings by revealing that public health nurses were considerably more active in health education than those nurses employed in hospitals in the USA.

NQNs in the psychiatric and general nursing units were perceived to be incompetent in informing patients about their progress. Informing a patient about his illness could be difficult with psychiatric patients, especially during the acute stage. Nevertheless, this competency was considered essential by SPNs in the psychiatric nursing unit. It could be beneficial to teach NQNs various tactics of approaching psychiatric patients at different stages of illness. The NQNs in surgical units could be expected to be competent, as patients waiting for operations need a thorough explanation about the nature of such an operation. However, studies supporting these views were not found.

Only one affective competency (working under pressure), was mainly perceived by SPNs to be non-essential in all four nursing units. "Working under pressure" could be associated with the shortage of nursing staff, unduly long working hours, inadequate facilities, lack of incentives and promotions, and low income. However, this study did not explore the sources of pressure. Working under pressure could also affect the competency of nurses, particularly NQNs. Regarding the competencies of NQNs in working under pressure, SPNs perceived unsafe performance. NQNs of all four nursing units were perceived to be incompetent. It could be beneficial for health authorities to do a situational analysis concerning the working conditions of the areas concerned.

TABLE 5.9 Competencies of NQNs as perceived by SPNs in the community nursing unit

COMPETENCIES	COMMUNITY NURSING UNIT n = 56		
	F	PART A %	PART B %
Visit clients and their families	56	81.8	57.8
Co-ordinate with other community services (church, creche and school)	56	87.5	45.4
Prepare clients for self-care in the community	56	89.3	58.2

The three competencies revealed in table 5.9 were perceived to be essential by SPNs in the community nursing unit. Table 5.9 only revealed that NQNs in the community health services were perceived by the SPNs to be incompetent in co-ordinating with other community services. Co-ordinating with other services could be directly linked to the position NQNs occupied in the hierarchy. It could be common practice that co-ordinating with other services be done by their seniors all the time. SPNs should take cognisance of the fact that development of such competency could be improved if NQNs were exposed to this form of delegation, and also involving NQNs in attending community meetings which might be held in the area concerned. Visiting clients and their families, and preparing clients for self-care in the community, were perceived by the SPNs to be competently performed by NQNs. Studies supporting or contradicting these findings were not found.

TABLE 5.10 Competencies of NQNs as perceived by SPNs in the psychiatric, midwifery and general nursing units

COMPETENCIES	CLINICAL NURSING UNITS								
	n = 29 PSYCHIATRIC			n = 38 MIDWIFERY			n = 136 GENERAL		
	F	Part A %	Part B %	F	Part A %	Part B %	F	Part A %	Part B %
Caring for a patient who is displaying anxiousness	29	86.2	62.0	37	78.4	65.8	135	77.0	36.3
Contribute to the growth of others	26	75.9	68.9	38	68.4	47.4	133	75.0	36.0

Table 5.10 reveals that the two competencies were perceived by SPNs to be expected of NQNs upon entering the work setting in all three nursing units. Only general SPNs perceived caring for a patient displaying anxiousness to be incompetently performed by NQNs. In the psychiatric and midwifery units NQNs were perceived to be competent by the SPNs. Psychiatric patients might be demanding, provocative and also need attention. These behaviours might have influenced NQNs' development of competency. Patients in the midwifery unit might differ in their labour pain perceptions. Some might remain calm while others need more attention. Girot (1993:116) revealed similar findings in her study conducted in England. Final-year students lacked patience with demanding patients. They preferred working with up-and-about patients.

Only psychiatric SPNs (68.9 percent) perceived NQNs to be competent in "contributing to the growth of others by sharing knowledge and expertise". NQNs in the midwifery and general nursing units were perceived by the SPNs to be incompetent. These findings seem to support the study done by Troskie (1993:58) in the RSA, which revealed that NQNs' ability to provide

personnel development was rated by their supervisors at only 16.8 percent being competently performed.

Caring and ethical competencies illustrated in table 5.7 were perceived by the SPNs to be incompetently performed by NQNs in the general nursing units. These competencies were the following:

- ▶ supporting human dignity while engaging in professional practice;
- ▶ respecting patients' freedom of choice and rights to make decisions;
- ▶ informing a patient about his progress; and
- ▶ demonstrating knowledge of the ethics of nursing.

This could cause concern that ethics was not adequately integrated during the training of NQNs. Development of ethical competencies in the clinical setting could be enhanced by NQNs' participating in compiling nursing care plans, and also by involving them in supervising student nurses' interactions with patients.

Table 5.7 further reveals that NQNs in all four clinical nursing units were perceived to be competent to practise within the scope of practice of a professional nurse by SPNs. These findings seemed to be supported by the fact that these NQNs were perceived to be competent in seeking assistance when necessary.

In conclusion, the findings illustrated in table 5.7 reveal that adaptive/adjustive competencies were competently performed by NQNs in all four clinical nursing units except one, namely, "Be confident in their nursing practices". Only NQNs in the community health services were perceived by the SPNs to be competent in this respect. Interpersonal/communication competencies were all

perceived by SPNs to be adequately performed by NQNs in the midwifery and psychiatric nursing units. "Applying meaningful touch" was perceived by the SPNs to be incompetently performed by NQNs in the community and general clinical nursing units.

Caring and ethical competencies were all perceived by the SPNs to be competently performed by NQNs in the midwifery and community nursing units. Only one competency out of seven was perceived by the SPNs to be incompetently performed by NQNs in the psychiatric nursing unit, "inform a patient about his progress". NQNs in the general clinical nursing units were perceived by the SPNs to be competent in performing only three out of seven competencies. These were the following:

- ▶ creating a safe environment for clients/patients;
- ▶ listening to a patient; and
- ▶ practising within the scope of practice of a professional nurse.

#### **5.4 PERCEPTIONS OF SPNS ON PSYCHOMOTOR COMPETENCIES**

Table 5.11 illustrates competencies perceived to be essential by SPNs in all four the clinical nursing units namely community, psychiatric, midwifery and general units. The findings revealed that more than 80 percent of the SPNs perceived each of the assessment competencies listed in the questionnaires to be essential. SPNs differed in their perceptions of the following competencies:

- ▶ maintenance of safety, hygiene and physical comfort and nutrition competencies;
- ▶ administration of treatment and care competencies;
- ▶ carrying out of aseptic technique competencies;
- ▶ maintenance of elimination competencies; and

- ▶ critical care competencies.

Table 5.11 reveals that competency 13, "Perform venepuncture for IV infusion" was perceived to be non-essential by SPNs in the psychiatric nursing unit. Only 37.9 percent of the SPNs perceived this competency to be essential. Although this competency was perceived to be essential by the SPNs in the three nursing units, namely community (73.1 percent), midwifery (59.5 percent) and general (60.2 percent), the percentages of SPNs were relatively low when compared to the rest of the competencies. Performing venepuncture for IV infusion was perceived to be essential by 93.1 percent of the registered nurse group and 100 percent by the nurse educators group in the study done by Clayton in the USA, described in Chaska (1983:130). The study by Clayton also revealed that all competencies illustrated in table 5.11 were perceived to be essential by Georgia nurses. Only "assessing nutritional status" was perceived to be non-essential in Clayton's study, contrary to the findings revealed in table 5.11.

**Table 5.11: Competencies perceived to be essential by four SPNs in all four nursing units (Part A), and the competencies of NQNs (Part B) as perceived by the SPNs**

ITEM	COMPETENCIES	CLINICAL NURSING UNITS											
		COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 38			GENERAL n = 136		
		F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
			%	%		%	%		%	%		%	
	<b>ASSESSMENT</b>												
1	Monitor, measure accurately temperature, pulse, respiration and blood pressure	56	94,6	94,6	29	89,7	89,7	37	94,7	94,4	136	93,4	85,2
2	Interpret vital data	56	94,6	80,4	29	96,6	96,6	38	86,8	59,0	136	95,6	80,0
3	Recognise and intervene in life threatening situations	56	96,4	57,1	29	93,1	89,7	37	94,7	58,3	134	83,1	40,0
4	Identify and intervene in deviations from normal	56	92,9	55,3	29	89,7	79,3	37	88,9	44,4	135	83,1	55,1
	<b>MAINTENANCE OF SAFETY, HYGIENE, PHYSICAL COMFORT AND NUTRITION</b>												
5	Function in appropriate role in fire/disaster procedure	56	87,5	43,2	29	79,3	44,8	38	68,4	37,8	134	67,7	71,8
6	Employ suicide precautions	56	83,9	48,2	29	89,7	65,5	38	73,2	73,7	133	72,0	73,9
7	Employ medico-legal risk precautions	56	91,1	57,2	29	96,6	69,0	38	86,8	55,6	136	82,4	69,7
8	Assess nutritional status of patients	56	92,9	85,7	29	96,6	96,6	38	92,1	94,2	136	89,6	70,9
	<b>ADMINISTRATION OF TREATMENT AND CARE</b>												
9	Prepare and administer medication safely	56	96,4	89,3	27	96,6	72,4	37	89,5	81,6	132	91,1	80,0
10	Give IV medication through a drip chamber	56	92,9	88,7	29	96,6	69,0	37	94,7	86,9	135	89,6	70,7
11	Dilute intravenous medication aseptically	56	91,6	72,8	26	89,9	62,0	38	86,8	86,8	135	86,7	70,1

ITEM	COMPETENCIES	CLINICAL NURSING UNITS											
		COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 38			GENERAL n = 136		
		F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
			%	%		%	%		%	%		%	
12	Add medication into IV therapy without contamination	54	89,3	80,0	26	86,2	64,3	38	89,5	84,2	134	90,3	68,2
13	Perform venepuncture for IV infusion	53	73,1	51,7	25	37,9	35,7	38	59,5	50,0	134	60,2	36,8
	<b>MAINTENANCE OF ELIMINATION BY PATIENT</b>												
14	Perform urine testing	56	98,2	98,2	28	55,2	61,6	38	94,7	94,7	135	93,4	85,1
	<b>CRITICAL CARE</b>												
15	Maintain patient's airway	51	87,5	51,8	26	62,1	71,5	36	83,8	75,6	130	85,5	70,0
16	Suctioning (e.g. orally, nasally or via endotracheally)	55	89,3	57,1	26	55,2	57,1	35	81,6	57,9	133	86,4	61,3

The study done by Sweeney & Regan (1982:37) revealed that three study groups in the USA, namely faculty, new graduates and nursing service personnel, rated "perform venepuncture" as a non-nursing skill. The SPNs in the psychiatric nursing unit indicated similar findings. Thirty percent of the SPNs perceived this competency to be non-nursing. Kieffer (1984:200) revealed that in the study undertaken in Kentucky, USA, "maintaining of intravenous infusion" was considered to be very important. According to these findings it could be argued that the role of a nurse involves maintaining intravenous infusions, but not necessarily performing venapunctures. Performing venepunctures was taught during the professional preparation of student nurses in the RSA. Consequently, the NQNs in the RSA should be able to perform this procedure competently.

The following competencies were perceived to be essential, in the study done by Kieffer (1984:200) in Kentucky, USA:

- ▶ monitoring and measuring temperature, pulse and blood pressure;
- ▶ oral medication administration;
- ▶ intake and output measurement;
- ▶ IV medication administration via IV drips; and
- ▶ urine testing.

These findings were perceived to be similar to the findings revealed in table 5.11. These competencies are commonly taught in the basic programme of NQNs and they could therefore be expected to display competency. Sweeney & Regan (1982:39) in the USA seemed not to concur with the findings of this study on "administering medication through intravenous infusion". This competency was perceived by the faculty nurse educators to be a bonus whereas nursing service personnel and baccalaureate graduates perceived the competency to be essential. Administering medication by a registered professional nurse is supported in the scope of practice

(R2598) outlined in chapter two section 2.4.

#### 5.4.1 Competencies of NQNs in assessment as perceived by SPNs

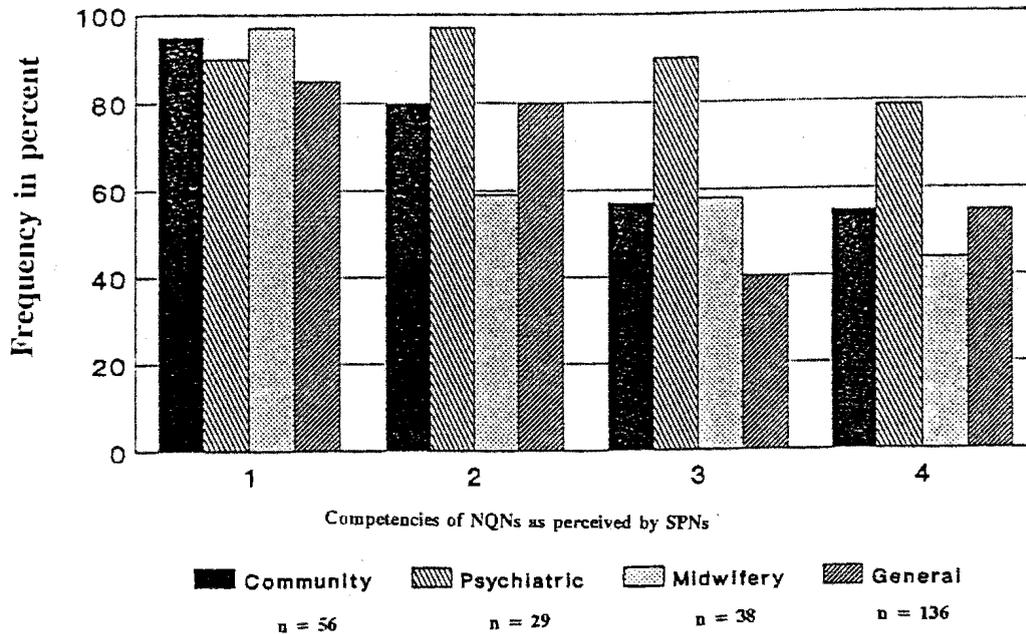


FIGURE 5.12 Competencies of NQNs in assessment in all four nursing units as perceived by SPNs

1. Monitor, measure accurately temperature, pulse, respiration and blood pressure.
2. Interpret vital data.
3. Recognise and intervene in life threatening situations.
4. Identify and intervene in deviations from normal behaviour.

The findings in figure 5.12 reveal that community and psychiatric SPNs perceived NQNs to be competent in performing all four assessment competencies. Both groups perceived competency one, "monitoring and measuring temperature, pulse, respiration (TPR) and blood pressure (BP)", to have been mastered by NQNs. "Identifying and intervening in deviations from normal behaviour" was perceived by the SPNs to be incompetently performed by NQNs in the midwifery units. Only 44.4 percent of the SPNs indicated that NQNs were competent. These findings

BP) and two (interpreting vital data). NQNs were perceived to be competent in performing these two competencies.

The general SPNs perceived NQNs to be incompetent in recognising and intervening in life-threatening situations. NQNs' ability to perform this competency could be improved by making them aware of these life-threatening situations in various general clinical units, namely medical, surgical, operating theatre, OPD and paediatrics. Life-threatening situations could be many and varied, for example, improper control of room temperature in theatre might cause wound sepsis or using spoiled medicines might cause toxication in patients. Studies revealing the competencies of NQNs in assessment competencies were not found. However, studies discussed previously revealed that these competencies were expected of NQNs in the clinical setting. It could be argued that psychomotor assessment was a strength during professional preparation of NQNs.

#### **5.4.2 Competencies of NQNs in maintenance of safety, hygiene, physical comfort and nutrition as perceived by SPNs**

The general SPNs perceived all competencies pertaining to maintenance of safety, hygiene, physical comfort and nutrition to be competently performed by NQNs. The first three competencies, namely "function in appropriate role in fire/disaster procedures", "employ suicide precautions" and "employ medico-legal risk precautions" could be linked with recognising and intervening in life-threatening situations in which NQNs were perceived to be incompetent in the general nursing units. Clayton in Chaska (1983:130) revealed that these three competencies were expected of NQNs by registered nurses and a nurse educators group in Georgia, USA. The competencies of new graduates in this regard was not evaluated by Clayton.

SPNs in the other three nursing units, namely community (43.2 percent), psychiatric (44.8 percent), and midwifery (37.8 percent) perceived NQNs to be incompetent in functioning in an appropriate role in fire/disaster procedure. It could be expected that community nurses should gain expertise in fire/disaster procedures. Most clinics were in rural areas without communication systems. Community disasters could be numerous and varied, and this might possibly not be recognised by community nurses. The following competencies were perceived by SPNs at the clinics to be competently performed by NQNs:

- ▶ recognising and intervening in life-threatening situations;
- ▶ identifying and intervening in deviations from normal behaviour;
- ▶ employing suicide precautions; and
- ▶ employing medico-legal risk precautions.

It could be beneficial if NQNs at the health centres could be assisted to achieve competency through in-service education in these competencies. Community members are likely to rely on nurses' rendering services in a particular area. Nurses have the responsibility to educate the community to identify any deviation detrimental to clients' health. Serious fire disasters could also occur in the psychiatric nursing unit. NQNs need to be prepared efficiently to handle fire disaster procedures. In-service education could be employed regularly in this regard. Fire practice sessions with psychiatric patients could be very important.

"Assessing nutritional status of patients" was perceived by the SPNs to be competently performed by NQNs in all four nursing units as follows:

- ▶ community (85.7 percent);
- ▶ psychiatric (96.6 percent);
- ▶ midwifery (94.2 percent); and

- ▶ general (70.9 percent).

Studies contradicting these findings were not found. However, this competency, "assessing nutritional status of patients", was perceived to be non-essential by USA registered nurses in the study by Clayton in Chaska (1983:127).

Figure 5.13 presents a graphic illustration of the competencies of NQNs in all four nursing units as perceived by the SPNs.

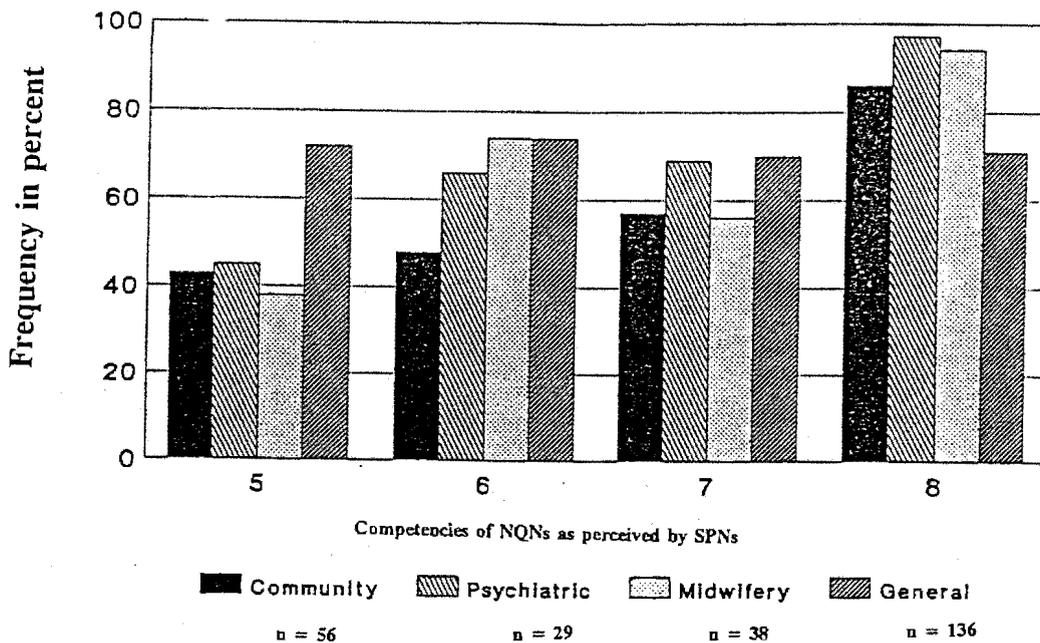


FIGURE 5.13 Competencies of NQNs in maintenance of safety, hygiene, physical comfort and nutrition, as perceived by SPNs

5. Function in appropriate role in fire/disaster procedure.
6. Employ suicide precautions.
7. Employ medico-legal risk precautions.
8. Assess nutritional status of patients.

SPNs from the various nursing units seemed to differ in their perceptions regarding the competencies of NQNs in maintaining of safety, hygiene, physical comfort and nutrition. NQNs in the general nursing units were perceived by the SPNs to be more competent than NQNs in the other three units with regard to the four competencies indicated in figure 5.13.

#### 5.4.3 Competencies of NQNs in administration of treatment and care as perceived by SPNs.

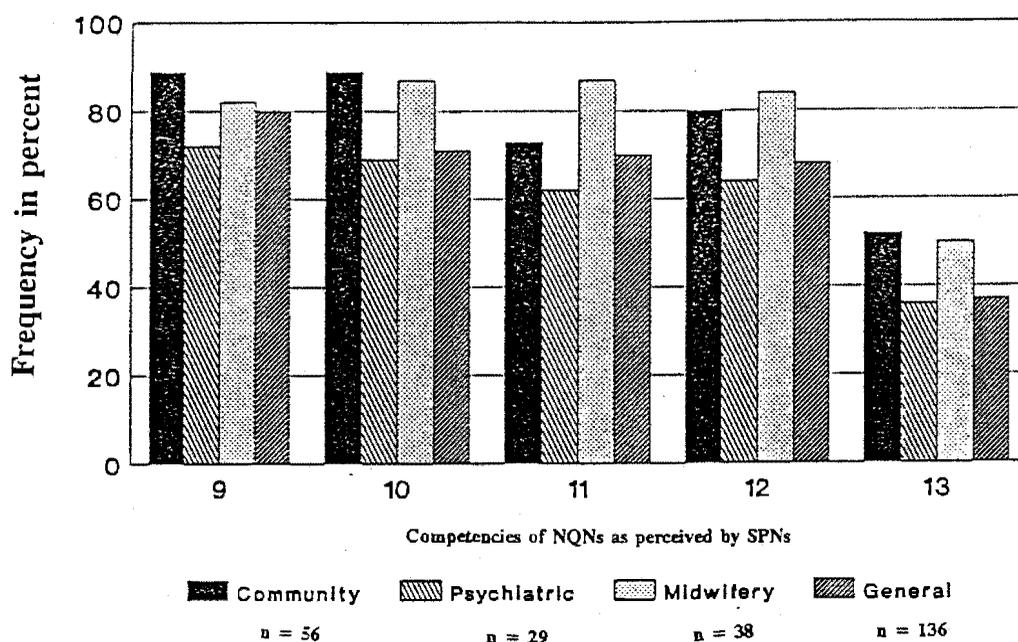


FIGURE 5.14 Competencies of NQNs in administration of treatment and care as perceived by SPNs

9. Prepare and administer medication safely.
10. Give IV medication through a drip chamber.
11. Dilute intravenous medication aseptically.
12. Add medication into IV therapy without contamination.
13. Perform venepuncture for IV infusion.

The findings illustrated in figure 5.14 reveal that NQNs in all four nursing units were perceived by the SPNS to be competent in performing the following competencies:

- ▶ preparing and administering medication safely;
- ▶ giving IV medication through a drip chamber;
- ▶ diluting intravenous medication aseptically; and
- ▶ adding medication into IV therapy without contamination.

These findings could imply that aspects of administering treatment and care were emphasised during clinical teaching of NQNs. It could be argued that NQNs were more effectively prepared to perform psychomotor competencies than in cognitive competencies such as clinical judgement and nursing process as illustrated in figures 5.3 and 5.4.

Respondents of the study done by Sweeney et al (1980:39) in the USA placed manual competencies as the first ability that the graduate should have. However, patients in the aforementioned study chose provision of emotional support as nurses' key behaviour. Kieffer (1984:202), in Kentucky, USA, revealed similar findings, for instance, that medication administration was perceived most frequently practised skills in the clinical setting where new graduates were employed. The findings revealed that SPNs in the general clinical nursing units perceived NQNs to be competent in performing the following competencies:

- ▶ preparing and administering medication safely;
- ▶ adding medication into IV therapy without contamination; and
- ▶ giving IV medication through a drip chamber.

SPNs (100 percent) in the operating theatre perceived NQNs to have mastered these competencies. SPNs in the clinical teaching department perceived NQNs to be incompetent in this regard. It could be argued that these preceptors, as persons involved in providing further guidance

and support to NQNs, were not yet satisfied with NQNs' competencies in the clinical nursing units.

"Performing venepuncture for IV infusion" was perceived by the SPNs to be incompetently performed by NQNs in all four nursing units. These findings seem to indicate that the insertion of an intravenous drip was minimally practised in the four clinical nursing units. It should be realised that this competency should be competently performed by professional nurses as it could be considered a life-saving action. The scope of practice of a registered nurse (R2598) in the RSA is not restrictive. Professional nurses should act to maintain the fluid and electrolyte balance of patients. In order to facilitate development of competency by NQNs in the four clinical nursing units, SPNs could instill confidence in NQNs by allowing them to insert IV infusions.

#### **5.4.4 Competencies of NQNs in maintenance of elimination by patient, as perceived by SPNs**

"Performing urine testing" was revealed to be the only competency perceived to be essential by the SPNs in all four nursing units. This competency was also perceived by SPNs to be competently performed by NQNs in all four the nursing units:

- ▶ community (98.2 percent);
- ▶ psychiatric (61.6 percent);
- ▶ midwifery (94.7 percent); and
- ▶ general (85.1 percent).

The following competencies were perceived by the SPNs to be essential and competently performed by NQNs in the three clinical nursing units, namely community, midwifery and general:

- ▶ inserting an indwelling urinary catheter;

group and nurse educators group in the USA. However, these competencies illustrated in table 5.12 were ranked in the middle frequency/ importance range by Kieffer (1984:200), indicating that these competencies were regarded minimally practised by new graduates in Kentucky, USA.

It needs to be realised that "maintaining elimination by patients" (Scope of practice of a registered nurse R2598) applies to all patients including psychiatric patients. SPNs in the psychiatric nursing unit could facilitate development of competency by NQNs by influencing NQNs to care for physical illness of psychiatric patients in the psychiatric nursing unit. Such practices would provide teaching opportunities for NQNs and would also help them observe the principle of nursing the patient in totality.

#### **5.4.5 Competencies of NQNs in critical care as perceived by SPNs**

Only two competencies, namely "maintain patient's airway" and suctioning (e.g. orally, nasally or endotracheally) were perceived by the SPNs to be essential and competently performed by NQNs in all four nursing units. Table 5.13 reveals variations of perceptions of critical care competencies among SPNs in all four nursing units.

**Table 5.13: SPNs' perceptions of critical care competencies in all four clinical nursing units (some competencies applicable in a specific clinical nursing unit only).**

COMPETENCIES	CLINICAL NURSING UNITS											
	COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 38			GENERAL n = 136		
	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
		%	%		%	%		%	%		%	
Introduce an oropharyngeal airway	37	67,9	23,2	25	24,1	17,2	55	45,9	24,3	133	46,3	15,8
Perform cardio pulmonary resuscitation	38	80,4	25,0	23	41,4	25,0	56	73,7	21,6	132	69,1	8,3
Utilise ambubag resuscitation	38	80,4	33,9	23	44,8	35,0	56	75,7	32,4	132	70,6	25,8
Perform a tracheostomy	33	35,7	8,9	22	17,2	3,4	-	-	-	128	15,7	4,5
Prepare a patient for a special X-ray (barium meal)	-	-	-	-	-	-	54	66,7	66,7	135	77,9	41,4
Monitor a respirator	-	-	-	21	34,5	17,9	52	42,9	17,1	126	55,2	15,2
Apply general anaesthetic during operation	-	-	-	-	-	-	50	11,8	8,8	128	10,5	0,7
Measure central venous pressure	-	-	-	-	-	-	-	-	-	126	25,6	5,2
Treat anaphylactic shock	38	89,3	23,2	-	-	-	-	-	-	133	80,6	35,8
Monitor a woman on pitocin drip	36	87,5	48,2	-	-	-	56	71,1	44,7	-	-	-
Manage the second stage of labour	38	96,4	55,4	-	-	-	56	94,7	68,4	-	-	-
Resuscitate a newborn	38	94,6	23,2	-	-	-	56	81,6	36,8	-	-	-
Manage a cord prolapse	38	96,4	19,6	-	-	-	56	76,3	28,9	-	-	-
Perform a vacuum extraction	-	-	-	-	-	-	54	27,0	38,9	-	-	-
Manage a woman with eclampsia	-	-	-	-	-	-	56	76,3	28,9	-	-	-
Insert a tracheostomy tube	-	-	-	-	-	-	-	-	-	130	35,8	8,3
Care for an intercostal underwater drainage	-	-	-	-	-	-	-	-	-	124	74,1	28,8

The following competencies revealed in table 5.13 were identified by the SPNs of all four nursing units:

- ▶ introducing an oropharyngeal airway;
- ▶ performing cardio-pulmonary resuscitation; and
- ▶ utilising ambubag resuscitator.

Only SPNs (67 percent) from the community nursing unit perceived "introducing oropharyngeal airway" to be essential. SPNs from the psychiatric unit perceived the three competencies indicated above to be non-essential. However, "performing cardio-pulmonary resuscitation" and "utilising ambubag resuscitator" were perceived to be essential competencies by SPNs in the community, midwifery and general nursing units. These findings seemed to be supported by Clayton in Chaska (1983:129) who indicated that these three competencies were expected of new graduates by both the registered nurse group and nurse educators' group in Georgia, USA.

Regarding the competency of NQNs in the three competencies/activities, SPNs perceived NQNs to be incompetent in applying the resuscitation measures. These findings could be a major cause for concern in all four nursing units. The implication might be that basic preparation of NQNs in this regard was not adequate. Delivering a distressed baby in need of resuscitation could not be uncommon in the community health services and in the midwifery units. Patients in the psychiatric and general nursing units might have cardiac arrests due to adverse reaction to medication. With regard to these findings it could be argued that there is a need to reinforce resuscitation competencies in the orientation programmes and in-service education of all nursing units.

The following competencies were perceived by SPNs (60 percent) at the clinics to be competently performed by NQNs:

- ▶ performing cardio-pulmonary resuscitation; and
- ▶ utilising ambubag resuscitator.

The findings could imply that NQNs at the clinics were perceived to be performing competencies more competently than NQNs at the health centres. This could be attributed to the fact that NQNs in most of the clinics practised as independent practitioners due to the shortage of SPNs, whereas at the health centres there could be three or more SPNs above NQNs as discussed in chapter four section 4.7. These two competencies were perceived by operating theatre SPNs (50 percent) to be competently performed by NQNs. Only 36 percent of surgical SPNs indicated that NQNs utilised the ambubag resuscitator competently.

"Performing a tracheostomy" was perceived to be non-essential by community (64.3 percent), psychiatric (82.8 percent) and general (84.3 percent) SPNs. In all three groups, over 53 percent of the SPNs perceived "performing a tracheostomy" to be a "non-nursing" action. The findings seem to be supported by studies which evaluated competencies expected of new graduates upon entering the work setting, as discussed in the chapter on relevant literature. These studies support the principle of care for tracheostomy and not "performing a tracheostomy" (Clayton in Chaska 1983:129; Kieffer 1984:201; Sweeney & Regan 1982:40). During data collection some SPNs were interviewed in order to obtain information concerning the presence of tracheostomy sets. All agreed that they did not have tracheostomy sets in the units. "Inserting a tracheostomy tube" was only evaluated as being important by 35 percent SPNs allocated to the general nursing units. Forty-seven percent of the SPNs perceived it to be "useful, should not be required at the level of NQNs' experience". This tallied with the perceived competencies displayed by NQNs. SPNs (81.5 percent) perceived NQNs to be incompetent in this regard.

A nurse could perform a tracheostomy as a life-saving measure. Although this procedure is a complex one, it could be incorporated in the programmes of advanced post-basic nursing courses such as intensive care, theatre technique, trauma care, advanced midwifery and clinical assessment, treatment and care. Community health nurses involved in this study worked mostly in rural areas. A situational analysis could be done to ascertain whether the nurses working in the community health field, would need to be able to perform tracheostomies. Should such a need exist, in-service education should be provided by doctors and each community health service should be supplied with the equipment to perform tracheostomies.

SPNs in the midwifery and general nursing units were requested to identify the following competencies in critical care:

- ▶ preparing a patient for a special X-ray (barium meal);
- ▶ monitoring a respirator; and
- ▶ applying general anaesthetic during operation.

"Preparing a patient for a special X-ray" was perceived to be essential by SPNs of both groups. The midwifery SPNs (66.7 percent) revealed that NQNs were competent in this regard, whereas only 41.4 percent of the general SPNs perceived NQNs to be competent. "Monitoring a respirator" and applying general anaesthetic during operation" were perceived to be non-essential by both the groups of SPNs. "Applying general anaesthetic" was perceived by 80 percent of the SPNs to be a "non-nursing" competency. The findings could be acceptable as this competency might endanger the life of a patient if not properly performed. With regard to these findings, it could be argued that registered nurses were aware of the scope of practice outlined in R2598 as

amended.

The following competencies were identified by community and midwifery SPNs only:

- ▶ monitoring a woman on pitocin drip;
- ▶ managing the second stage of labour;
- ▶ resuscitating a newborn; and
- ▶ managing a cord prolapse.

These four competencies were perceived to be essential by SPNs of both groups. Percentages are provided in table 5.13. These four competencies were perceived as being essential by both nurse educators and registered nurses in the study done by Sweeney et al (1980:38) in the USA.

Regarding the competencies of NQNs in these four competencies, only one competency from each group was perceived by the SPNs to be adequately performed by NQNs. The community SPNs (55.4 percent) perceived NQNs to be competent in managing the second stage of labour, whereas only 36.8 percent of midwifery SPNs were positive. The fact that NQNs in a midwifery unit might have received better guidance and support compared to NQNs in the clinics who worked with more registered nurses in a unit, was discussed in section 4.7 of chapter four. These findings reveal that NQNs in the clinics practising alone as independent practitioners due to shortage of senior registered nurses, develop greater competency. NQNs in the midwifery clinical unit were perceived by SPNs to be competent in monitoring a woman on pitocin drip. NQNs in the community health services were perceived to be incompetent.

NQNs in both clinical nursing units were perceived to be incompetent in resuscitating a newborn and in managing a cord prolapse as illustrated in table 5.13. This could reveal that handling

delivery emergencies was inadequately treated during professional preparation of NQNs. These findings were generally supported by previously discussed findings of this study which revealed that NQNs were not competent to perform cardio-pulmonary resuscitation and use ambubag resuscitation.

Table 5.13 revealed that the following competencies were requested to be identified by the SPNs in the midwifery unit only:

- ▶ performing a vacuum extraction; and
- ▶ managing a woman with eclampsia.

Performing a vacuum extraction was perceived to be desirable but not essential by more than 60 percent of SPNs, implying that it would be helpful if NQNs could perform the competency, but it is not essential. Managing a woman with eclampsia, although perceived to be essential by the SPNs, was perceived to be incompetently performed by NQNs.

In conclusion, the findings illustrated in table 5.13 on perceptions of SPNs on critical care competencies revealed that SPNs perceived NQNs to be incompetent. These findings seemed to be supported by various studies such as that by Clayton, Broome & Ellis (1989:72). These authors identified critical care as one aspect that needed preceptorship experience in the final quarter of student nurses in Georgia, USA. Vanetzian and Higgins (1990:273) also revealed that new graduates rated themselves very low on all dimensions of critical care in the USA. It could be argued that allowing inexperienced nurses to practise emergency measures on patients could be dangerous. In order to facilitate competency by nurses, a situational analysis in the areas concerned could be done to ascertain the availability of models and dolls suitable to enable nurses to practise thoroughly before these procedures are performed on patients.

#### **5.4.6 Perceptions of SPNs on carrying out of aseptic technique procedures**

Perceptions of SPNs on carrying out of aseptic technique procedures were discussed separately from other psychomotor competencies illustrated in table 5.11, as these competencies were persistently perceived to be non-essential by psychiatric SPNs. Table 5.14 provides detailed information.

Table 5.14: SPNs' perceptions of carrying out aseptic technique procedures in all four clinical nursing units (some competencies were applicable in specific clinical nursing units only)

COMPETENCIES	CLINICAL NURSING UNITS											
	COMMUNITY n = 56			PSYCHIATRIC n = 29			MIDWIFERY n = 38			GENERAL n = 136		
	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B	F	Part A	Part B
		%	%		%	%		%	%		%	
Set a sterile trolley	56	94,6	85,7	27	44,8	42,8	38	92,1	89,5	135	88,1	60,6
Use instruments in a sterile field	56	94,4	91,1	27	37,9	42,8	38	97,4	81,6	136	90,4	56,6
Apply local anaesthetic	55	89,3	51,8	26	17,9	33,3	38	86,8	56,3	130	40,2	28,1
Suture wounds/episiotomy	56	75,0	53,5	28	28,6	78,6	38	92,1	50,0	133	39,1	27,0
Dress wounds	56	96,4	92,9	26	41,4	39,3	38	97,4	89,5	136	91,0	81,8
Perform episiotomy	56	96,4	48,3	-	-	-	38	92,1	60,5	-	-	-
Prepare a patient for operation	-	-	-	27	34,3	42,9	38	97,4	81,6	136	90,4	66,2
Drape a woman during delivery	-	-	-	-	-	-	38	97,4	86,8	-	-	-
Glove and gown appropriately	-	-	-	-	-	-	38	97,4	86,8	-	83,8	64,9

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Competencies perceived non-essential by a particular group of SPNS.

Table 5.14 reveals that only community and midwifery SPNs perceived all aseptic technique competencies to be essential. Regarding the competencies of NQNs, both the community and midwifery SPNs perceived NQNs to be competent except in "performing episiotomy", where the community SPNs perceived NQNs to be incompetent. This could happen as high risk mothers needing episiotomies should be referred to the hospital.

The general SPNs perceived the following competencies to be non-essential:

- ▶ applying local anaesthetic; and
- ▶ suturing wounds.

More than 30 percent of the SPNs indicated that both competencies were "desirable but not essential". Another 24 percent of the SPNs indicated that applying local anaesthetic was a non-nursing competency. In the general and psychiatric nursing units, unlike in the midwifery and community nursing units, nurses might not perform these two procedures. However, professional nurses could suture simple non-complex wounds "at discretion" and this would require applying local anaesthetic. It would be beneficial to examine whether these two competencies were included in the professional preparation programmes of NQNs reflected in this study. Regarding the competencies of NQNs on the above two competencies, table 5.14 revealed that NQNs were perceived by the SPNs to be incompetent. However, this table further revealed that NQNs were perceived to be competent in the other five competencies. Operating theatre NQNs were perceived to be more competent than NQNs allocated to the medical, surgical, paediatric and OPD by the following percentage of the SPNs:

- ▶ setting a sterile trolley for operation (88 percent);
- ▶ using instruments in a sterile field (76 percent); and
- ▶ gloving and gowning appropriately (84.5 percent).

The psychiatric SPNs perceived all aseptic technique procedures to be non-essential. These competencies could, however, be essential in the psychiatric nursing unit. SPNs (79 percent) in the psychiatric nursing unit perceived NQNs to be competent in "suturing of wounds". These findings seemed to be contradictory to those provided in table 5.14. The table indicates that NQNs in the psychiatric nursing unit were perceived by SPNs to be incompetent in the following competencies:

- ▶ setting a sterile trolley;
- ▶ using instruments in a sterile field; and
- ▶ applying local anaesthetic.

TABLE 5.15 Competencies of NQNs as perceived by SPNs in the community nursing unit

COMPETENCIES	n = 56 COMMUNITY NURSING UNIT		
	F	PART A	PART B
Teach clients a well balanced diet	56	94.6	87.5
Demonstrate simple cooking methods	56	80.4	68.8
Prescribe medicines relevant to the condition	56	87.5	32.1
Detect untoward symptoms of medication	56	91.1	42.8
Immunise children under five years of age	56	92.9	73.2
Interpret immunisation schedule correctly	56	92.9	83.9
Take malaria smear	56	83.9	82.9
Apply GOBIFFF + F concept	56	96.4	73.2

Table 5.15 reveals competencies identified by the SPNs of community health services only. All eight competencies were perceived by the SPNs to be essential and competently performed by NQNs except the following:

- ▶ prescribing medicines relevant to the condition; and
- ▶ detecting untoward symptoms of medication.

This might imply that NQNs were not adequately prepared on aspects of medicine and medication. Regulation R2598 only allows registered professional nurses to prescribe the nursing regimen to meet the need of a patient or client. Lack of competency by NQNs as perceived by SPNs in this regard, necessitates thorough in-service education on prevailing conditions and the relevant medication. Disease-medication regimes might prove to be stereotyped behaviour, but it would be essential to provide guidelines in the community services to ensure safe nursing practice. Studies evaluating similar competencies to those described in table 5.15 were not found.

TABLE 5.16 Competencies of NQNs as perceived by SPNs in the psychiatric nursing unit

COMPETENCIES	n = 29 PSYCHIATRIC NURSING UNIT		
	F	Part A	Part B
Apply physical restraints to violent patients	28	79.3	71.5
Demonstrate knowledge of the use of psychiatric medication	29	89.3	100.0
Control schedule 5, 6 and 7 medication	29	89.7	74.1

The three competencies in table 5.16 were perceived to be essential by the SPNs in the psychiatric clinical units, and competently performed by NQNs. These findings could imply that NQNs were

adequately prepared to hand out medicines and were well informed about medication pertaining to psychiatric conditions.

TABLE 5.17 Competencies of NQNs as perceived by SPNs in the midwifery and community nursing units

COMPETENCIES	CLINICAL NURSING UNITS					
	COMMUNITY n = 56			MIDWIFERY n = 38		
	F	PART A %	PART B %	F	PART A %	PART B %
Determine rate, rhythm, location of foetal heart	56	96,4	65,5	37	94,7	84,2
Perform vaginal examination	56	92,9	53,6	37	92,1	50,0
Monitor and accurately record labourgraph	56	92,9	51,8	38	86,8	50,0
Palpate and evaluate fundus height	56	94,6	71,4	37	86,5	72,9
Examine the placenta	55	89,3	84,0	36	94,6	89,2
Perform perineal care after delivery	56	92,9	87,5	38	94,7	84,2
Inspect and record vaginal discharge	56	92,9	82,1	36	89,5	79,0
Perform vulval swabbing	56	92,9	82,1	36	94,6	86,5
Administer an enema	56	96,4	92,2	37	92,1	89,5
Inspect lochia	56	96,4	98,2	37	86,5	81,6

Table 5.17 reveals that both community and midwifery SPNs perceived the illustrated competencies to be essential. NQNs were perceived by both groups of SPNs to be competent in performing all these competencies. The findings could imply that NQNs were adequately prepared in rendering basic midwifery procedures. However, NQNs need to be instructed in handling emergency midwifery care as indicated in table 5.13. These competencies were also considered essential in a study undertaken in the USA (Sweeney & Regan 1982:37).

TABLE 5.18 Competencies of NQNs as perceived by SPNs in the general nursing unit

COMPETENCIES	GENERAL NURSING UNIT n = 136		
	F	PART A	PART B
Maintain patient's body alignment	133	84.3	56.0
Maintain immobilisation by traction	135	81.1	42.3
Maintain support by slings and bandages	134	87.3	59.7
Feed a patient per naso gastric tube	135	88.7	59.4
Perform gastrostomy feeding	130	80.8	34.4
Feed a helpless patient	134	90.2	72.8
Perform application of plaster casts	129	28.8	12.8
Perform application of traction	129	40.5	16.8
Apply inhalations	135	88.2	67.1

Table 5.18 reveals that seven competencies out of nine were perceived by the SPNs to be essential in the general clinical units. Performing application of plaster casts and tractions were considered to be non-essential. Above 50 percent of the SPNs perceived these two competencies to be non-nursing.

Regarding the competencies of NQNs, table 5.18 reveals the following competencies to be incompetently performed:

- ▶ maintaining immobilisation by traction;
- ▶ performing gastrostomy feeding;
- ▶ performing application of plaster casts; and
- ▶ performing application of tractions.

Performing gastrostomy feeding might be a rare procedure in the areas included in this study. Learning by simulation might have been done during training of NQNs, and a particular NQN might never have seen the procedure performed on a patient.

Studies evaluating the competencies of NQNs indicated in table 5.18 were not found.

## **5.6 CONCLUSION**

In conclusion, the findings revealed in tables 5.11, 5.13 and 5.14 could be summarised as follows: Assessment competencies were all perceived to be essential by the SPNs and competently performed by NQNs of all four nursing units. Only one competency out of four, "recognise and intervene in life-threatening situations" was perceived by the SPNs to be incompetently performed by NQNs in the general nursing units.

Maintenance of safety, hygiene, physical comfort and nutrition competencies were all perceived to be essential by the SPNs in all four clinical nursing units. The psychiatric SPNs perceived performing venepuncture for IV infusion to be non-essential and incompetently performed by NQNs. SPNs in the general clinical units perceived NQNs to be incompetent in performing venepuncture for IV infusion. The community health SPNs perceived the following competencies to be incompetently performed by NQNs:

- ▶ functioning in appropriate role in fire/disaster procedure; and
- ▶ employing suicide precautions.

Functioning in an appropriate role in fire/disaster was also perceived by the SPNs to be incompetently performed by NQNs in the midwifery unit.

Only "performing urine testing" in maintenance of elimination by patient competencies was perceived to be essential by the SPNs and competently performed by NQNs in all four nursing units. The psychiatric SPNs perceived the following competencies to be non-essential and incompetently performed by NQNs:

- ▶ inserting an indwelling catheter;
- ▶ administering an enema; and
- ▶ collecting specimens for investigation (urine, blood).

Only two critical care competencies out of 19 were perceived by the SPNs to be essential and competently performed by NQNs in all four nursing units as indicated by table 5.11. NQNs were perceived by the SPNs to be incompetent in all aspects of critical care applicable in all four nursing units (for detailed information refer to table 5.13). Only "managing the second stage of labour" was perceived by the SPNs to be competently performed by NQNs in the midwifery and

community clinical units.

Table 5.14 revealed that carrying out of aseptic technique procedures were all perceived to be non-essential by the psychiatric SPNs. The general SPNs also perceived "applying local anaesthetic" and "suturing wounds" to be non-essential and incompetently performed by NQNs. In the psychiatric clinical nursing unit, NQNs were perceived to be incompetent in all six the competencies except "suturing of wounds". NQNs in the midwifery unit were perceived by the SPNs to be competent in performing all nine aseptic technique competencies.

The following tables 5.19 A, B, C and D present competencies perceived to be essential by the SPNs and incompetently performed by NQNs in the various clinical nursing units (A - community; B - psychiatric; C - midwifery; D - general). This study therefore suggests that the identified competencies illustrated in these tables be regarded as an orientation list of competencies to be mastered by NQNs affected by this research.

The competencies perceived to be non-essential by the SPNs illustrated in tables 5.20 A, B, C and D might differ from one geographical area to another. Lack of research knowledge as perceived by the SPNs of this study might indicate a need for a critical review of the curriculum by nurse educators.

Table 5.21 presents differences in perceptions between SPNs working at the health centres and SPNs at the clinics concerning the competencies of NQNs. Table 5.22 presents differences in perceptions among the SPNs working in the general clinical nursing units, namely medical, surgical, clinical teaching department, OPD, operating theatre and paediatric units concerning the

competencies of NQNs.

**Table 5.19 (a): Delineated essential competencies as perceived by SPNs and incompetently performed by NQNs in all four clinical units.**

**A. COMMUNITY CLINICAL UNIT**

<b>COMPETENCIES</b>		
<b>COGNITIVE</b>	<b>AFFECTIVE</b>	<b>PSYCHOMOTOR</b>
1. Define a client's problems	1. Apply meaningful touch	1. Function in appropriate role in fire/disaster procedure
2. Formulate a nursing care plan	2. Coordinate with other community services (church, crèche and school)	2. Employ suicide precautions
3. Discriminate and synthesise information obtained from assessment	3. Demonstrate knowledge of the ethics of nursing	3. Perform venepuncture for IV infusion
4. Prioritise client's problems		4. Prescribe medicines relevant to the conditions.
5. Record nursing diagnosis accurately		5. Detect untowards symptoms of medication
6. Plan and organise one's work day		6. Perform episiotomy
7. Specify nursing intervention in order of priority		7. Perform cardio-pulmonary resuscitation
8. Demonstrate skills in effective communication		8. Utilise ambubag resuscitation
9. Evaluate learning		9. Treat anaphylactic shock
10. Organise role plays with clients		10. Monitor a woman on pitocin drip
11. Compose educational songs		11. Resuscitate a newborn infant
12. Design educational programmes for the clients and nurses		12. Manage a cord prolapse
13. Implement policies and procedures as needed		
14. Maintain accountability from own care		
15. Evaluate own practice		
16. Manage conflict effectively		
17. Commitment to unit objectives		
18. Influence and leading others		

**Table 5.19 (b): Delineated essential competencies as perceived by SPNs and incompetently performed by NQNs in all four clinical units.**

**B. PSYCHIATRIC CLINICAL UNIT**

<b>COMPETENCIES</b>		
<b>COGNITIVE</b>	<b>AFFECTIVE</b>	<b>PSYCHOMOTOR</b>
1. Assess patient's physical and psychosocial needs	1. Inform a patient about his progress	1. Function in appropriate role in fire/disaster procedure
2. Define a patient's problem	2. Alleviate a patient's stress and anxiety	2. Check blood products for proper identification
3. Discriminate and synthesise information obtained from assessment	3. Be confident in nursing practices	
4. Specify nursing intervention in order of priority		
5. Identify preventive actions to minimise patient risk		
6. Evaluate learning		
7. Design educational programmes for clients		
8. Manage crisis intervention		
9. Manage stress		
10. Carry out admission and discharge of patients according to Mental Health Act no. 18 of 1973		

**Table 5.19 (c): Delineated essential competencies as perceived by SPNs and incompetently performed by NQNs in all four clinical units.**

**C. MIDWIFERY CLINICAL UNIT**

**COMPETENCIES**

**COGNITIVE**

**AFFECTIVE**

**PSYCHOMOTOR**

1. Formulate nursing care plan for woman in antenatal clinic and puerperium
2. Discriminate and synthesise information
3. Specify nursing intervention in order of priority during first stage of labour
4. Set objectives for teaching
5. Use teaching strategies effectively
6. Design educational programmes for the clients and nurses
7. Produce clear and accurate reports
8. Work with constraints, e.g. time limits
9. Delegate aspects of care to peers
10. Implement policies and procedures as needed
11. Evaluate own practice
12. Manage conflicts effectively
13. Commitment to unit objectives
14. Influence and leading others

1. Exercise patience with demanding patients during labour
2. Alleviate woman's pain during labour
3. Demonstrate knowledge of ethics in nursing
4. Contribute to the growth of others by sharing knowledge and expertise
5. Be confident in nursing practices

1. Recognise and intervene in deviations from normal behaviour during pregnancy, labour and puerperium
2. Function in appropriate role in fire/disaster procedure
3. Perform venepuncture for IV infusion
4. Perform cardio-pulmonary resuscitation
5. Utilise ambubag resuscitator
6. Monitor a woman on pitocin drip
7. Resuscitate a newborn
8. Manage a cord prolapse
9. Manage a woman with eclampsia

Table 5.19 (d): Delineated essential competencies as perceived by SPNs and incompetently performed by NQNs in all four clinical units.

**D. GENERAL CLINICAL UNIT**

**COMPETENCIES**

COGNITIVE		AFFECTIVE		PSYCHOMOTOR	
1.	Formulate a nursing care plan	1.	Be confident in nursing practices	1.	Recognise and intervene in life threatening situations
2.	Discriminate and synthesise information obtained from assessment	2.	Work under pressure	2.	Identify and intervene in deviations from normal behaviour
3.	Plan and organise one's work day	3.	Apply meaningful touch	3.	Function in appropriate role in fire/disaster procedure
4.	Specify nursing intervention in order of priority	4.	Caring for a patient who is displaying anxiousness.	5.	Employ medico-legal risk precautions
5.	Identify preventive actions to minimise patient risks	5.	Support human dignity while engaging in professional practice	6.	Maintain immobilisation by traction
6.	Identify learning needs of nurses and patients	6.	Respect patients freedom of choice and decision-making rights	7.	Perform gastrostomy feeding
7.	Set objectives for teaching	7.	Inform patients about their illness	8.	Perform venepuncture for IV infusion
8.	Use teaching strategies effectively	8.	Demonstrate knowledge of the ethics of nursing	9.	Care of intercostal underwater drainage
9.	Design educational programme for clients and nurses	9.	Contribute to the growth of other by sharing knowledge and expertise	10.	Perform cardio-pulmonary resuscitation
10.	Produce clear and accurate reports			11.	Prepare a patient for a special X-ray (TVP, barium meal)
11.	Work with constraints, e.g. time limits			12.	Monitor a respirator
12.	Delegate aspects of care to peers				
13.	Implement policies and procedures as needed				
14.	Maintain accountability for own care				
15.	Draft on-off duty roster				
16.	Lead team conferences				
17.	Evaluate own practice				
18.	Manage conflict effectively				
19.	Commit themselves to unit objectives				
20.	Influence and leading others				

**Table 5.20 (a): Delineated non essential competencies as perceived by SPNs in all four clinical nursing units.**

**A. COMMUNITY CLINICAL UNIT**

**COMPETENCIES**

**COGNITIVE**

**AFFECTIVE**

**PSYCHOMOTOR**

1. Identify researchable community/nursing problems
2. Initiate research
3. Read and critically analyse research
4. Use research data
5. Determine the applicability
6. Carry out a mini-epidemiological study

1. Work under pressure

1. Perform tracheostomy

**Table 5.20(b): Delineated non essential competencies as perceived by SPNs in all four clinical nursing units.**

**B. PSYCHIATRIC UNIT**

**COMPETENCIES**

**COGNITIVE**

**AFFECTIVE**

**PSYCHOMOTOR**

1. Identify researchable psychiatric problems
2. Initiate research
3. Read and critically analyse research
4. Use research data
5. Determine the applicability of the results in the clinical setting
6. Manage stress

1. Work under pressure
2. Adjust to work environment

1. Feed patient per naso gastric tube
2. Perform a venepuncture for IV infusion
3. Set sterile trolley for special procedures
4. Prepare a patient for operation
5. Use instruments in a sterile field
6. Suture wounds
7. Dress wounds
8. Apply local anaesthetic
9. Collect specimen for investigation
10. Insert an indwelling urinary catheter
11. Introduce oropharyngeal airway
12. Perform cardio-pulmonary resuscitation
13. Utilise ambubag resuscitator
14. Monitor a respirator
15. Perform tracheostomy

**Table 5.20 (c): Delineated non essential competencies as perceived by SPNs in all four clinical nursing units.**

**C. MIDWIFERY CLINICAL UNIT**

**COMPETENCIES**

**COGNITIVE**

**AFFECTIVE**

**PSYCHOMOTOR**

1. Identify researchable midwifery problems

1. Work under pressure

1. Perform gastrostomy feeding

2. Initiate research

2. Perform a vacuum extraction

3. Read and carefully analyse research

3. Monitor a respirator

4. Use research data.

4. Apply general anaesthetic during caesarian section.

5. Determine the applicability of the results in the clinical setting.

**D. GENERAL CLINICAL UNIT**

**COMPETENCIES**

**COGNITIVE**

1. Identify researchable nursing problems
2. Initiate research
3. Read and carefully analyse research
4. Use research data
5. Determine the applicability of the results in the clinical settings

**AFFECTIVE**

1. Work under pressure

**PSYCHOMOTOR**

1. Perform application of plaster and casts
2. Perform application of traction
3. Perform minor incisions
4. Suture wounds
5. Apply local anaesthetic
6. Introduce oropharyngeal airways
7. Insert a tracheostomy tube
8. Perform a tracheostomy
9. Apply general anaesthetic during operations
10. Measure central venous pressure.

**Table 5.20(b): Delineated non essential competencies as perceived by SPNs in all four clinical nursing units.**

**B. PSYCHIATRIC UNIT**

Table 5.21: Competencies of NQNs as perceived by SPNs at the community health clinics and at the health centres.

COMPETENCIES	COMMUNITY NURSING UNITS	
	CLINICS	HEALTH CENTRES
	% SENIOR PROFESSIONAL NURSES n = 12	% SENIOR PROFESSIONAL NURSES n = 42
ESSENTIAL COMPETENCIES		
Identify learning needs of clients and student nurses	67	95
Be confident in nursing practices	50	83
Communicate information to other health team members	75	95
Apply meaningful touch	58	88
Coordinate with other community services (church, creche, school)	67	93

## COMPETENCIES OF NQNs

Initiate research	43	10
Read and critically analyse research	33	7
Determine the applicability of the results in the community	42	2
Evaluate learning	67	33
Maintain accountability from own care	75	40
Evaluate own practice	58	26
Recognise and intervene in life threatening situations	83	50
Identify and intervene in deviations from normal behaviour	83	48
Employ suicide precautions	75	43
Employ medico-legal risk precautions	83	50
Demonstrate simple cooking methods	92	62
Perform cardio pulmonary resuscitation	50	19
Resuscitate a newborn	50	17

Table 5.22: Competencies of NQNs as perceived by SPNs in the general nursing units.

COMPETENCIES	n = 32 MEDICAL	n = 32 SURGICAL	n = 7 CLINICAL DEPT.	n = 27 OPD	n = 6 OPERATING THEATRE	n = 28 PAEDIATRICS
	%	%	%	%	%	%
<b>ESSENTIAL COMPETENCIES</b>						
Use teaching aids when teaching patients	84,38	75,00	85,71	81,48	83,33	47,86
<b>COMPETENCIES OF NQNs</b>						
Identify preventive actions to minimise patient risk	33,48	25,00	14,29	34,44	50,50	57,14
Draft on-off duty roster	37,51	43,75	57,14	51,86	50,50	44,44
Lead team conferences	16,31	12,90	0,00	22,58	9,63	38,71
Listen to patients	67,75	71,88	42,86	65,66	63,67	62,97
Prepare and administer medication safely	68,75	87,51	57,14	76,92	83,33	89,29
Add medication into IV therapy without contamination	71,88	73,34	42,86	69,23	6,00	60,72
Give IV medication through a drip chamber	65,63	74,19	42,29	73,08	100,00	67,86
Introduce oropharyngeal airway	3,23	25,00	14,29	3,85	50,00	18,52
Insert a tracheostomy tube	0,00	15,63	28,58	3,85	0,00	3,70
Utilise ambubag resuscitator	6,06	36,36	6,06	21,21	12,12	18,18
Monitor a respirator	9,68	13,33	0,00	19,43	50,00	10,71
Measure central venous pressure	0,00	6,25	14,29	0,00	33,33	0,00

## CHAPTER 6

### ANALYSIS, PRESENTATION, INTERPRETATION AND DESCRIPTION OF FINDINGS OBTAINED FROM THE GENERAL PERCEPTIONS OF SPNS ON THE COMPETENCIES OF NQNS

#### 6.1 INTRODUCTION

This chapter presents the analysis, interpretation and description of findings obtained from the general perceptions of SPNs in all four nursing units, namely community (n=56), psychiatric (n=29), midwifery (n=38) and general (n=136). As indicated in chapter three, the chapter on methodology, section 3.5.1, the purpose of this section is to obtain the global views of the SPNs on the competencies of NQNs, and the SPNs' suggestions on how to improve the competency of NQNs.

The SPNs in all four the nursing units answered the following question: "What degree of deficiency do you believe to exist in competency performance by NQNs?" The following key was used:

1 = greatest deficiency;

2 = deficiency;

3 = lesser deficiency;

4 = not a deficiency.

Keys one and two were merged to denote "deficiency". Where 50 percent or more of the SPNs indicated that they regarded a competency as being deficient, this study accepted it as a deficiency.

## 6.2 DEGREE OF DEFICIENCY IN THE COMPETENCIES OF NQNS AS PERCEIVED BY SPNS

TABLE 6.1 Degree of deficiency in competencies of NQNs in all four nursing units as perceived by SPNs (This study regarded 50 percent and above as deficiency).

DEFICIENT COMPETENCIES	CLINICAL NURSING UNITS			
	COMMUNITY % (n = 56)	PSYCHIATRIC % (n = 29)	MIDWIFERY % (n = 38)	GENERAL % (n = 136)
Problem solving	37.5	20.6	48.6	51.5
Teaching of clients and nurses	21.5	24.1	42.1	38.5
Research	69.6	75.9	73.7	78.0
Clinical judgement	32.8	46.5	57.9	48.9
Administrative/Management	60.7	65.5	63.1	65.6
Implementation of the nursing process	44.6	55.2	47.4	50.0
Adjustive/adaptive competency	23.2	25.1	34.2	39.3
Interpersonal relations/communication	35.7	20.6	29.0	34.6
Caring	42.8	30.0	44.7	42.2
Ethical	46.4	51.7	56.7	59.2

### 6.2.1 Problem-solving competency

Table 6.1 reveals that the SPNs in the community, psychiatric and midwifery units did not perceive problem solving by NQNs to be a deficiency, while SPNs in the general nursing units perceived problem solving to be a deficiency. However, figure 5.3 revealed specific problem-solving competencies which were perceived by the SPNs of all four nursing units to be incompetently performed by NQNs.

The problem-solving competencies identified by the SPNs in all four the nursing units were directly related to the implementation of the nursing process. Table 6.1 reveals that only the psychiatric (55 percent) and general (50 percent) SPNs regarded the implementation of the nursing process to be deficient. This study therefore recommends that the nursing process competencies which were perceived by SPNs in figure 5.3 to be incompetently performed by NQNs in the four nursing units, should form an integral part of the orientation programme offered by the nursing unit concerned. Although the basic principles of the nursing process, namely assessment, planning, implementation and evaluation are universally applied, it might occur that a particular clinical nursing unit utilises nursing process documents differently to the way they are used in other clinical units.

#### **6.2.2 The competency of teaching clients and nurses**

Table 6.1 reveals that "teaching clients and nurses" was perceived by SPNs not to be a deficiency when observing NQNs in all four clinical units.

#### **6.2.3 Research competency**

Research competency was perceived by SPNs to be deficient in all four the clinical nursing units (for percentages see table 6.1). These findings revealed in table 6.1 tallied with the findings illustrated in table 5.3. All research competencies identified by the SPNs in the questionnaires of each of the four clinical nursing units, were perceived to be incompetently performed by NQNs.

#### **6.2.4 Clinical judgement competency**

Table 6.1 reveals that only SPNs (58 percent) in the midwifery unit perceived NQNs to be deficient in applying clinical judgement. However, tables 5.1 and 5.2 reveal that specific clinical

judgement competencies were perceived by SPNs in all four the clinical nursing units to be incompetently performed by NQNs.

#### **6.2.5 Administration and management competency**

The ability of NQNs in the administration and management of a unit was perceived to be a deficiency by SPNs in all four the nursing units. These findings tallied with the findings revealed in tables 5.1 and 5.2. Administrative/management competencies revealed in these two tables (5.1 and 5.2) were perceived to be incompetently performed by NQNs in all four clinical nursing units, namely community, psychiatric, midwifery and general nursing units.

#### **6.2.6 Adjustive/adaptive competency**

Table 6.1 reveals that SPNs in all four the study groups perceived the adjustive/adaptive competency not to be a deficiency among NQNs. These findings tallied with the findings revealed in table 5.7. NQNs were perceived by SPNs to be competent in performing adjustive/adaptive competencies. It would be beneficial if SPNs were requested to identify tactics they have applied to enable NQNs to adjust quickly to the culture of a unit. These tactics would be regarded as positive contributions towards the orientation process of NQNs in a particular nursing unit.

#### **6.2.7 Interpersonal/communication competency**

Interpersonal/communication competency was perceived by SPNs not to be a deficiency in any of the four clinical nursing units. These findings tallied with the findings revealed in table 5.7.

#### **6.2.8 Caring competency**

Table 6.1 reveals that the SPNs perceived the caring competency not to be a deficiency in all four

the clinical nursing units. These findings tally with the findings revealed in table 5.7.

### **6.2.9 Ethical competency**

Table 6.1 reveals that only the SPNs in the community nursing unit perceived applying ethical competencies by NQNs not to be a deficiency.

In conclusion, the following learning competencies need further analysis to determine the extent to which they are incorporated in the professional preparation programmes of NQNs in the geographic area of this study:

- ▶ problem solving (implementation of the nursing process);
- ▶ research;
- ▶ administration and management of a clinical unit; and
- ▶ nursing ethics.

“How do you view the following aspects as causes contributing towards the incompetence of NQNs?”

The following key was used to describe each cause:

1 = very important;

2 = important;

3 = unimportant; and

4 = negligible.

Aspects deemed to be “very important” and “important” were considered together as causes contributing towards NQNs’ incompetency. This study regarded a frequency of 50 percent and above to constitute “a cause”. Although SPNs may not be directly involved in the curriculum

development process, they may be in a position to contribute towards identifying the shortfalls affecting clinical teaching and learning during the professional preparation of NQNs.

Table 6.2: SPNs' perceptions of causes which could contribute towards NQNs' incompetency.

CAUSES	CLINICAL NURSING UNITS			
	COMMUNITY n = 56	PSYCHIATRIC n = 29	MIDWIFERY n = 38	GENERAL % n = 136
Implementation of the R425 curriculum	62.5	31.0	43.2	52.7
Clinical accompaniment	62.5	55.2	67.5	69.9
Attitudes of NQNs	65.3	72.4	65.8	71.4
Attitudes of SPNs	12.5	55.1	36.9	41.4

### 6.3 CAUSES CONTRIBUTING TOWARDS NQNS' INCOMPETENCY

#### 6.3.1 The implementation of the R425

The implementation of the R425 curriculum leading to registration as a nurse (general, community and psychiatric) and midwife, was perceived by SPNs to be a contributory cause of NQNs' incompetency in the community and general nursing units. The SPNs in the midwifery and psychiatric nursing units did not seem to share this perception. The motivation for this study discussed in chapter one (section 1.2), indicates that the implementation of the clinical curriculum (R425) as identified by nurse educators in the RSA, might not succeed in enabling NQNs to be competent clinical nurse practitioners in their first professional appointments.

These findings seem also to support the memorandum drafted by the former HMC of the RSA discussed in chapter one (section 1.2), which indicated that midwifery, general nursing and community nursing education appeared to be inadequate (RHOSA memorandum 4 August 1992). However, the findings of this study revealed that the SPNs in the midwifery unit perceived the implementation of the curriculum of the R425 course not to be a cause contributing to NQNs' incompetency. The inadequacy in the implementation of the clinical curriculum could be further analysed, taking into consideration aspects such as clinical accompaniment of student nurses by tutors, availability of facilities/resources for learning, the amount of time spent by students in the clinical units, and the sisters' competency in clinical teaching.

### **6.3.2 Clinical accompaniment**

Table 6.2 reveals that SPNs in all four nursing units perceived clinical accompaniment to be a cause contributing towards incompetency by NQNs in the clinical nursing units. This supports the afore-mentioned recommendation that analysis or investigation be done concerning problems affecting clinical accompaniment by tutors.

### **6.3.3 Attitudes of NQNs**

Table 6.2 reveals that SPNs in all four nursing units perceived the attitudes of NQNs to be a cause contributing towards incompetency by NQNs. During interviews SPNs would easily complain about NQNs' attitudes, but it proved difficult for them to spell out precisely what negative attitudes NQNs were actually displaying. Others commented that NQNs regarded themselves to be highly educated and thus superior to the SPNs. NQNs regarded SPNs to be adhering to the "old practices".

#### 6.3.4 Attitudes of SPNs

Table 6.2 reveals that only the psychiatric SPNs (55 percent) regarded attitudes of SPNs to be a cause contributing towards incompetency by NQNs. The findings revealed by the psychiatric SPNs seem to be supported by various studies. Girot (1993:116) revealed that sisters commented that newly qualified graduates knew nothing; they actually expected to be "spoon-fed" all the way. Lathlean & Corner (1991:6) also indicated staff attitudes as a major reason affecting newly registered nurses' competency, in their study undertaken in England. Lowane (1990:59) revealed that sisters' attitudes were a hindrance to student nurses' learning in the clinical situation in the health services of the former Gazankulu (falling within the Northern Province of the RSA since April 1994).

Although response to "others" in table 6.2 was not indicated by specific percentages, when the findings were analysed, it was revealed that 52 percent (29 SPNs) in the community nursing unit, 63 percent in midwifery and 68 percent of SPNs in the general nursing units commented that NQNs were dodging responsibility during training. Furthermore, the SPNs perceived the NQNs to be suffering from a "superiority complex" attributable to their many qualifications.

The SPNs in the other three nursing units, namely community, midwifery and general nursing units, perceived attitudes of SPNs not to be a cause of incompetency in NQNs. Further research would be required to determine how the NQNs perceived SPNs' attitudes and vice-versa.

#### 6.4 COMPETENCIES WHICH SPNS EXPECT NQNS TO PERFORM EFFICIENTLY UPON ENTERING THE CLINICAL NURSING UNIT

In each clinical nursing unit, namely community, psychiatric, midwifery and general nursing units,

not all the SPNs answered question three of section three of the questionnaires. Data from all four nursing units' questionnaires were analysed. The findings are reflected in table 6.3, revealing the SPNs' perceptions of the competencies expected of NQNs upon entering the clinical nursing units, namely community, psychiatric, midwifery and general nursing units. Varying competencies were identified in the questionnaires completed by the SPNs of each study group. Similar responses were not repeated, but a tick was indicated next to the first response. All responses from each questionnaire were analysed in the same manner to get a definite frequency. The competencies which appear in table 6.3 are those listed from the highest to the lowest percentage and scored above 40 percent as perceived by the SPNs.

TABLE 6.3 Expected competencies of NQNs as perceived by SPNs in all four the clinical nursing units (community, psychiatric, midwifery and general).

<b>COMMUNITY NURSING UNIT n = 56</b>		
<b>COMPETENCIES</b>	<b>FREQUENCY</b>	<b>PERCENTAGE</b>
No response	25	44.6
Managing a woman in 1st and 2nd stage of labour	31	55.4
Resuscitating a newborn infant	30	53.6
Assessment of a client	29	51.8
Interpersonal communications	26	46.4
Managing an emergency	25	44.6
Management and administration	25	44.6
<b>PSYCHIATRIC NURSING UNIT n = 29</b>		
No response	13	44.8
Assessment of a psychiatric patient	16	55.2
Communication competencies	14	48.3
Management of procedures according to Mental Health Act No. 18 of 1973	14	48.3
Crisis intervention	12	41.4
Medico-legal risks	12	41.4

<b>MIDWIFERY UNIT n = 38</b>		
No response	10	26.3
Assessment of a woman in labour	28	73.7
Managing a woman in labour	26	68.4
Resuscitating a newborn	24	63.2
Delivering a woman	22	57.9
Cutting and suturing episiotomy	21	55.3
Detect fetal distress	20	52.6
Seek assistance where necessary	16	42.1
<b>GENERAL NURSING UNIT n = 136</b>		
No response	75	55.1
Nursing process	61	44.9
Doing ward rounds with doctors	58	42.6

Table 6.3 reveals that NQNs are commonly expected to:

- ▶ assess a patient;
- ▶ handle an emergency;
- ▶ manage the clinical unit

SPNs in the community and midwifery units expected NQNs to be competent in carrying out midwifery practices. This study therefore recommends that the competencies identified by the SPNs in each clinical nursing unit should be considered when developing the orientation programmes and in-service education programmes of the respective clinical nursing units.

However, further research could be done to examine the NQNs' needs to acquire these competencies.

## **6.5 COMPETENCIES PERCEIVED BY SPNS TO BE TOO DIFFICULT TO BE MASTERED BY NQNS**

This question intended to solicit SPNs' perceptions concerning the competencies they perceived as being too difficult for mastery by NQNs upon entering the work situation. The description of the findings are reflected in table 6.4.

TABLE 6.4 Competencies perceived by SPNs to be too difficult to be mastered by NQNs in the clinical nursing units.

<b>MIDWIFERY UNIT n = 38</b>		
No response	21	55.3
Delivering a breech	17	44.7
Managing cord prolapse	17	44.7
Resuscitating a newborn infant	16	42.1
Handing a woman delivered a stillborn	11	28.9
Diagnosing cephalopelvic disproportion	11	28.9
<b>GENERAL NURSING UNIT n = 136</b>		
No response	95	69.9
Handling an emergency	41	30.1
Supervision and delegation	39	28.6
Care of the dying patient	39	28.6
Teaching of nursing students	38	27.9
Applying nursing ethics	31	22.8

<b>COMMUNITY NURSING UNIT n = 56</b>		
No response	38	67.9
Managing a cord prolapse	18	32.1
Prescribing medications	18	32.1
Managing anaphylactic shock	14	25.0
Conducting a difficult delivery	13	23.2
Resuscitation of a newborn infant	13	23.2
Decision making	12	21.4
<b>PSYCHIATRIC NURSING UNIT n = 29</b>		
No response	20	69.0
Managing a violent patient	9	31.0
Interpreting Mental Health Act	8	27.6
Crisis intervention	7	24.1
Ward management	7	24.1

In conclusion, although these competencies were perceived to be “difficult” for NQNs to master, they were perceived to be essential by the SPNs in their respective nursing units. Therefore, these competencies could be given priority when planning in-service education sessions in the clinical nursing units.

## 6.6 PERIOD OF PRACTICAL EXPERIENCE REQUIRED FOR NQNS TO PERFORM AT A SATISFACTORY LEVEL

Question five of section three of the questionnaires of each nursing unit requested the SPNs to indicate the duration of the period which NQNs required to practise in order to perform nursing activities at a competent level. Table 6.5 provides detailed information.

TABLE 6.5 Period of practical experience required for NQNs to perform at satisfactory level.

PERIOD	CLINICAL NURSING UNITS							
	COMMUNITY n = 56		PSYCHIATRIC n = 29		MIDWIFERY n = 38		GENERAL n = 136	
	F	%	F	%	F	%	F	%
0 - 3 months	0	0.0	2	7.0	3	7.8	6	4.4
3 - 6 months	10	17.9	0	0.0	5	13.2	23	17.0
6 - 9 months	13	23.2	11	37.9	13	34.2	27	19.8
9 - 12 months	17	30.3	13	44.8	12	31.6	55	40.4
Not yet observed	16	28.6	3	10.3	5	13.2	25	18.4
<b>TOTAL:</b>	56	100.0	29	100.00	38	100.0	136	100.0

The following graph indicates that the majority of the SPNs in all four nursing units regarded a period of between nine and twelve months to be required for NQNs to perform at a competent level, followed by a period of between six and nine months.

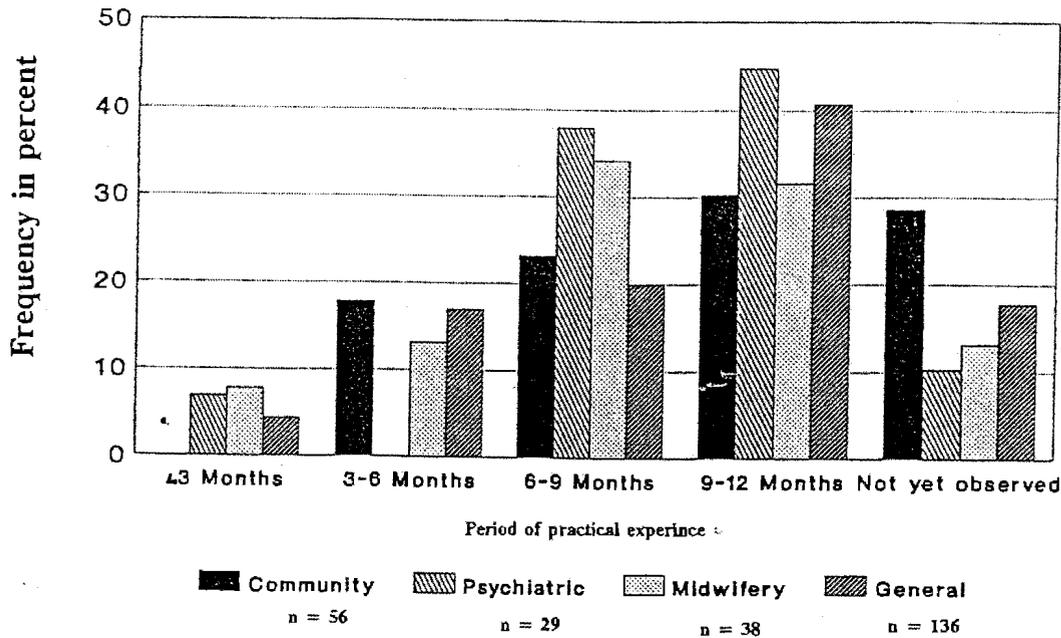


FIGURE 6.1 Period of practical experience required for NQNs to perform at satisfactory level.

It could therefore be argued that frequent rotation of NQNs in the clinical nursing units is a hindrance in the development of competency. Correct placement of NQNs in the clinical field could also affect development of competency. It would be beneficial if a study could be conducted in order to obtain NQNs' viewpoint on how placement upon entrance to the work setting has affected development of competency.

## 6.7 SUGGESTIONS ON HOW TO IMPROVE NQNS' COMPETENCIES

Question six of section three attempted to obtain SPNs' viewpoint concerning "what can be done to improve the competencies of NQNs in the clinical nursing units?". Similar responses were not

repeated, but during analyses of the findings a tick was placed after the first response. Comments from the nursing units namely community, psychiatric, midwifery and general nursing units, were first analysed separately as the SPNs' priorities differed.

The following statements were regarded by the SPNs as suggestions to improve NQNs' competencies in the four clinical nursing units (community, psychiatric, midwifery and general):

- ▶ NQNs should improve their attitude during training (66 percent; 79 percent; 64 percent and 63 percent respectively);
- ▶ clinical teaching should be improved (psychiatric: 78 percent; midwifery: 58 percent; and general: 80 percent);
- ▶ SPNs needed orientation programmes to be applied in their nursing units (59 percent; 60 percent; 51 percent; and 82 percent respectively);
- ▶ SPNs in the community nursing unit (68 percent) suggested that NQNs should work in the midwifery unit before being allocated to the community nursing units;
- ▶ SPNs in the psychiatric nursing unit (63 percent) suggested that a psychiatric component should be optional during NQNs' training; and
- ▶ SPNs in the general nursing units (77 percent) suggested that clinical facilities such as nursing staff, equipment and teaching materials should be improved.

Although the offering of an orientation programme was not considered a priority by SPNs in the community, psychiatric and midwifery units, it could influence the competencies of NQNs in a particular nursing unit. The study done by Troskie (1993:56) in the RSA, revealed that orientation contributed towards the competency of NQNs. Orientation programmes for new graduate nurses proved to be effective in other countries. Cooney (1992:218) indicated that implementing an

orientation programme for new graduates stimulated the need to develop the preceptor programme in the USA; Feeley & Gerez-Lirette (1992:801) expressed that the implementation of the McGill model facilitated nurses' development of expertise in Canada.

This study therefore recommends that research be conducted, using the health services sample of this study to determine the effect of orientation programmes offered in staff development. SPNs could be made aware that by offering an orientation programme many things could be achieved such as socialisation of NQNs in the unit; development of advanced skills; and stimulating a particular NQN to follow a post-basic course or any form of continuing education.

## **6.8 CONCLUSION**

Chapters five and six revealed the general perceptions of the competencies expected of NQNs by SPNs, which is the purpose of this study. Table 6.6 summarises the essential competencies as perceived by the SPNs and the competencies of NQNs as perceived by SPNs in all four the clinical nursing units. These competencies, though not claiming to be the only competencies applying to a specific clinical nursing unit, could be considered to be a basis for developing a list of competencies to be mastered by NQNs in their first professional position in a specific clinical nursing unit.

TABLE 6.6 Essential competencies as perceived by the SPNs and the competencies of NQNs (as perceived by SPNs) in all four the clinical nursing units. (Specific competencies apply to specific clinical nursing units only.)

C means Competent (1); and

INC means Incompetent (0).

ESSENTIAL COMPETENCIES	CLINICAL NURSING UNITS							
	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	C	INC	C	INC	C	INC	C	INC
<b>PROBLEM SOLVING</b>								
Obtain adequate information from a patient	1		1		1		1	
Assess patients' needs	1			0	1		1	
Define a patient's problem	1			0	1		1	
Formulate a nursing care plan		0	1			0		0
Discriminate and synthesise information obtained from assessment.		0		0		0		0

ESSENTIAL COMPETENCIES	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	C	INC	C	INC	C	INC	C	INC
<b>CLINICAL JUDGEMENT</b>								
Record accurately nursing diagnosis		0	1		1			0
Specify nursing intervention in order of priority		0		0		0		0
Identify preventive actions to minimise patient risk	1			0	1			0
Interpret verbal and non-verbal clues from clients	1		1		1		1	
Prioritise patient's problems		0	1		1		1	
Plan and organise one's work-day		0	1		1			0
<b>TEACHING</b>								
Teach a patient's family members about the patient's/client's needs	1		1		1		1	
Produce clear and accurate reports		0	1			0		0
Identify learning needs of patients/clients and student nurses	1		1		1			0
Set objectives for teaching	1		1			0		0
Use teaching strategies effectively	1		1		1			0
Use teaching aids in teaching patients	1		1		1		1	

ESSENTIAL COMPETENCIES	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	C	INC	C	INC	C	INC	C	INC
<b>TEACHING</b>								
Demonstrate skill in effective communication		0	1		1		1	
Design educational programmes for the patient and nurses		0		0		0		0
<b>ADMINISTRATION/ MANAGEMENT</b>								
Work within constraints of time limits	1		1			0		0
Delegate aspects of care to peers	1		1			0		0
Implement policies and procedures as needed		0	1			0		0
Evaluate own practice		0	1			0		0
Manage conflict effectively		0		0		0		0
Commit oneself to unit objectives		0	1			0		0
<b>ADAPTIVE/ADJUSTIVE</b>								
Be sensitive to people's feelings	1		1		1		1	
Accept criticism from staff	1		1		1		1	
Be confident in their nursing practices	1			0		0		0
Adjust to work environment	1		1		1		1	
<b>INTERPERSONAL/ COMMUNICATION</b>								
Communicate a feeling of acceptance of each client	1		1		1		1	
Promote the client's right to privacy	1		1		1		1	

<b>ESSENTIAL COMPETENCIES</b>	<b>n = 56 COMMUNITY</b>		<b>n = 29 PSYCHIATRIC</b>		<b>n = 38 MIDWIFERY</b>		<b>n = 136 GENERAL</b>	
	<b>C</b>	<b>INC</b>	<b>C</b>	<b>INC</b>	<b>C</b>	<b>INC</b>	<b>C</b>	<b>INC</b>
Explain nursing procedures to a client prior to performing them	1		1		1		1	
Communicate information to other health team members	1		1		1		1	
Apply meaningful touch		0	1		1			0
Seek assistance when necessary	1		1		1		1	
<b>CARING AND ETHICS</b>								
Create safe environments for clients	1		1		1		1	
Listen to a patient	1		1		1		1	
Support human dignity while engaging in professional practice	1		1		1			0
Respect patients' freedom of choice and rights to make decisions	1		1		1			0
Inform a patient about his progress	1			0	1			0
Practice within the scope of a professional nurse	1		1		1		1	
Demonstrate knowledge of the ethics of nursing		0	1			0		0
<b>ASSESSMENT</b>								
Monitor, measure accurately TPR and BP	1		1		1		1	
Interpret vital data	1		1		1		1	
Recognise and intervene in life threatening situations	1		1		1			0
Identify and intervene in deviations from normal behaviour	1		1			0	1	

ESSENTIAL COMPETENCIES	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	C	INC	C	INC	C	INC	C	INC
<b>MAINTENANCE OF SAFETY, HYGIENE, PHYSICAL AND NUTRITION</b>								
Function in appropriate role in fire/disaster procedure		0		0		0	1	
Employ suicide precautions		0	1		1		1	
Employ medico-legal risk precautions	1		1		1		1	
Assess nutritional status of patients	1		1		1		1	
<b>ADMINISTRATION OF TREATMENT AND CARE</b>								
Prepare and administer medication safely	1		1		1		1	
Give IV medication through a drip chamber	1		1		1		1	
Dilute intravenous medication aseptically	1		1		1		1	
Add medication into IV therapy without contamination	1		1		1		1	
<b>MAINTENANCE OF ELIMINATION BY PATIENT</b>								
Perform urine testing	1		1		1		1	
<b>CRITICAL CARE</b>								
Maintain patient's airway	1		1		1		1	
Suctioning (e.g. Orally, nasally or endotracheally)	1		1		1		1	
Introduce an oropharyngeal airway		0		0		0		0
Perform cardio pulmonary resuscitation		0		0		0		0
Utilise ambubag resuscitation		0		0		0		0





ESSENTIAL COMPETENCIES	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	C	INC	C	INC	C	INC	C	INC
Contribute to the growth of others by sharing knowledge and expertise			1			0		0
Treat anaphylactic shock		0						0
Monitor a pitocin drip		0			1			
Manage the second stage of labour	1					0		
Resuscitate a newborn		0				0		
Manage a cord prolapse		0				0		
Manage a woman with eclapsia						0		
Care for an intercostal underwater drainage								0
Set a sterile trolley	1				1		1	
Use instruments in a sterile field	1				1		1	
Apply local anaesthetic	1				1			0
Suture wounds/episiotomy	1				1			
Dress wounds	1				1		1	
Perform episiotomy		0			1			
Prepare a patient for operation					1		1	
Drape a woman during delivery					1			
Glove and gown appropriately					1		1	
Teach clients a well balanced diet	1							
Demonstrate simple cooking methods	1							
Prescribe medicines relevant to the condition		0						



ESSENTIAL COMPETENCIES	n = 56 COMMUNITY		n = 29 PSYCHIATRIC		n = 38 MIDWIFERY		n = 136 GENERAL	
	C	INC	C	INC	C	INC	C	INC
Maintain immobilisation by traction								0
Maintain support by slings and bandages							1	
Feed a patient per naso gastric tube							1	
Perform gastrostomy feeding								0
Feed a helpless patient							1	
Apply inhalations							1	
Insert an indwelling catheter	1				1		1	
Administer an enema	1				1		1	
Collect specimens for investigations (urine, blood)	1				1		1	
Perform venepuncture for IV infections	1				1			0

Chapter seven will provide the summary of findings and conclusions, limitations, recommendations and the implications of the findings for future research.

## **CHAPTER 7**

# **SUMMARY OF FINDINGS, LIMITATIONS, RECOMMENDATIONS, IMPLICATIONS OF THE FINDINGS FOR FUTURE RESEARCH, AND CONCLUSIONS**

### **7.1 INTRODUCTION**

This chapter provides a brief overview of the study, emphasising specific major findings, conclusions, limitations, and implications of these findings and recommendations for improved nursing practice and for future nursing research.

In 1985 the regulations and the directives of the course for the education and training of a nurse (general, psychiatric and community) and midwife, leading to registration with the SANC were published (R425 of February 1985). NQNs referred to in this study, completed this training programme to register as professional nurses.

In section 1.2 of this thesis, it is indicated that since 1992 the HMC of the RSA and the RHOSA have questioned the competencies of the NQNs who followed the R425 programme for the education and training of a nurse (general, psychiatric and community) and midwife (RHOSA memorandum 4 August 1992). Another study (Troskie 1990:v) indicated that the competency of NQNs in general might be questionable in the RSA. This research further investigated SPNs' views of the competencies of NQNs in the four clinical nursing units, namely community, psychiatric, midwifery and general units.

## **7.2 PURPOSE**

The study was undertaken to endeavour to identify the expected competencies of NQNs at entry-level position. The purpose of the study was to identify the competencies which SPNs expect of NQNs, to identify NQNs' psychomotor, affective and cognitive competencies as perceived by SPNs, and to ascertain whether there were differences among the perceptions of SPNs concerning the competencies of NQNs in the general, community, midwifery and psychiatric nursing units.

## **7.3 METHODOLOGY**

Descriptive surveys were employed to investigate the problem, "The competencies of newly qualified nurses as viewed by senior professional nurses". The study used questionnaires for collecting data. Questionnaires were delivered by the researcher and also collected by the researcher after completion. SPNs working at thirteen hospitals, that is, six in the former Gazankulu, three in the former Venda, and four in the former Lebowa health services (falling within the Northern Province of the RSA since April 1994) constituted the subjects of this study. Scientific sampling techniques were not employed as the total population of 396 SPNs was studied. This study obtained responses from 259 SPNs.

## **7.4 RESEARCH RESULTS**

### **7.4.1 Section one**

Section one of all four nursing units' questionnaires described the profile of the SPNs. The important findings concerning the SPNs' profile were the following:

- ▶ the majority of the SPNs (54.1 percent) fell within the range of 31-40 years years of age. Twelve SPNs out of 259 were 51 years and older;
- ▶ seventy-eight percent of the SPNs had completed at least one year as SPNs;
- ▶ a high percentage of the SPNs (85 percent of  $n = 259$ ) had more than one year of experience in their present clinical nursing units; the highest percentage of SPNs having more than one year of experience in their present clinical nursing units was revealed in the psychiatric unit where 93 percent of the SPNs had more than one year of experience in psychiatric nursing units;
- ▶ a few respondents (80, or 30.9 percent of  $n = 259$ ) had clinical specialisation qualifications such as:
  - intensive care (seven);
  - paediatric nursing (twelve);
  - clinical assessment, treatment and care (twenty-five);
  - oncology nursing (two);
  - advanced midwifery (eighteen);
  - operating theatre (six); and
  - orthopaedic nursing (three);
- ▶ the majority of the SPNs (68 percent of  $n = 259$ ) were occupying first or second in charge positions in the clinical nursing units;
- ▶ more than half of the SPNs (60 percent of  $n = 259$ ) indicated that NQNs were occupying fourth or lower positions in the clinical unit hierarchy;
- ▶ SPNs (63 percent of  $n = 259$ ) were engaged in studies;
- ▶ the majority of the SPNs (198 or 76.4 percent of  $n = 259$ ) completed education and training in the basic general three-year diploma course (in terms of R879 of 2 May 1975

of SANC) as amended.

In conclusion, the professional and personal backgrounds of the SPNs were perceived to be essential in this study. The findings revealed that SPNs who participated in this study were experienced in the nursing field, and therefore able to report their perceptions about the NQNs' competencies in the respective clinical nursing units, namely community, psychiatric, midwifery and general units.

#### **4.2 Section two**

Section two of the four nursing units' questionnaires described the findings on what competencies SPNs expect NQNs to have upon entering the work setting, and the NQNs' competencies as perceived by SPNs. The expected competencies of NQNs and the competencies of NQNs as perceived by SPNs, have been summarised in chapter six (table 6.6). This chapter will summarise information concerning the findings of this study in relation to findings obtained from the literature reviewed in chapter two:

what competencies SPNs expect NQNs to have upon entering the work setting; and which cognitive, psychomotor and affective competencies NQNs have upon entering the work setting as perceived by SPNs.

##### **7.4.2.1 Cognitive competencies**

###### **► Problem solving.**

All five the problem solving competencies outlined in the questionnaires of the four clinical units were perceived by the SPNs to be expected competencies of NQNs upon entering the work setting. Specific problem solving competencies were perceived by SPNs to be incompetently

formed by NQNs in all four the clinical nursing units. The implementation of the nursing process was perceived by SPNs to be a deficiency.

Problem solving (the implementation of the nursing process) could be regarded as the basis of the actions and procedures outlined in the scope of practice of the registered nurse (R2598). All these procedures outlined in the R2598 are based on the principles of assessment, plan of action, implementation and evaluation by a registered professional nurse.

The findings of this study concerning problem solving, tally with the findings of studies discussed in chapter two (Hurst et al 1991:1444-1455; Ignatavicius 1983:20; Joyce-Nagata et al 1989:314-320; Lathlean & Corner 1991:5). Other studies revealed that with experience a nurse might become a better problem solver than an inexperienced nurse (Chang & Gaskill 1991:813-817); Holden & Klingner 1988:23-29; Makhatini 1992:66-68). The NQNs in this study could therefore be expected to become better problem solvers with further professional experience. Nevertheless, the findings of this study indicated that NQNs were not perceived to be competent problem solvers by the SPNs.

► **Research.**

All research competencies outlined in the questionnaires were perceived by SPNs to be non-essential for professional nursing practice and incompetently performed by NQNs in all four the clinical nursing units. Similar findings were revealed in the studies done by Ehrenfeld & Eckerling (1991:224-231); Joyce-Nagata et al (1989:314-320); and Troskie (1993:58). Research could be of importance in the improvement of nursing practice and the growth of scientific nursing knowledge. Professional nurses could be motivated to follow continuing education courses in

order to develop research competency and to enhance research in nursing.

▶ **Clinical judgement.**

Clinical judgement competencies were all perceived to be essential by SPNs in all four the clinical nursing units. Specific clinical judgement competencies illustrated in table 6.6 were perceived by SPNs to be incompetently performed by NQNs in all four the clinical nursing units. Sanford et al (1992:70-74) revealed that NQNs were not competent in the clinical judgement ability in Dallas, USA.

▶ **Teaching.**

All competencies pertaining to teaching in a particular clinical nursing unit were perceived by SPNs to be essential. However, table 6.6 reveals that specific teaching competencies were perceived by SPNs to be incompetently performed by NQNs in all four the clinical nursing units. The findings were supported by the findings obtained from other studies (Ackerman et al 1981:37-43; Lowane 1990:109-115; Milde & Heim 1991:397-402; Murdaugh 1980:1073-1078; Troskie 1993:58; Vanetzian & Higgins 1990:269-275).

The scope of practice of the registered nurse (R2598) emphasises that a registered nurse should teach and counsel clients and their families in order to promote optimal health. Teaching principles should be considered to be important during the education and training of student nurses.

▶ **Administrative/Management.**

All the administrative/management competencies were perceived by SPNs to be expected competencies of NQNs upon entering the work setting. Table 6.6 reveals that the majority of

these competencies were incompetently performed by the NQNs in all four the clinical nursing units. SPNs perceived administrative/management skill to be a deficiency. These findings concur with findings obtained from other studies (Lathlean & Corner 1991:6; Lewis 1990:81; Lowane 1990:58-59). Teaching NQNs how to manage the activities of the nursing unit could be facilitated by ensuring that the NQN works hand in hand with an SPN. This particular SPN will be able to provide support and guidance when needed by the NQN. According to these findings it could be argued that there might be a need to reinforce management competencies in the in-service education and orientation programmes of NQNs in all four the clinical units, namely community, psychiatric, midwifery and general units.

#### **7.4.2.2 *Affective competencies***

##### **▶ Adaptive/adjustive.**

One competency (work under pressure), out of five competencies outlined in the questionnaires, was perceived to be non-essential by the SPNs in all four the nursing units, and incompetently performed by NQNs. The other four competencies in this category were perceived by SPNs to be essential and competently performed by NQNs. The findings tally with research reports by Henderson (1982:181), Lathlean & Corner (1991:8) and Lowane (1990:73). These authors revealed that NQNs were able to adjust in the work settings.

##### **▶ Interpersonal relations/communications**

All interpersonal/communication competencies were perceived by the SPNs to be expected competencies of NQNs upon entering the work setting. The SPNs perceived these competencies not to be a deficiency. That is, NQNs were perceived to be competent in performing these competencies. Only one competency (apply meaningful touch) was perceived to be inadequately

performed by NQNs in the general and community nursing units. Similar studies seemed not to concur with these findings. NQNs were perceived to lack interpersonal communication skills (Giro 1993:114-119; Shuldham in Lathlean & Corner 1991:73-74). Similar findings were revealed by Henderson (1982:181) and Vanetzian & Higgins (1990:269-275).

► **Caring and ethics**

The SPNs in all four nursing units indicated that caring and ethical competencies were expected of NQNs upon entering the work setting. As indicated in table 6.6, SPNs perceived NQNs to be competent in performing caring competencies in all four the clinical units, but they were perceived to be incapable of demonstrating the knowledge of ethics in nursing. Similar findings were revealed by Astedt-Kurki & Häggman-Laitila (1992:1195-1199), Joyce-Nagata et al (1989:316), Chipman (1991:171-175), and Komorita et al (1991:23-29).

In conclusion, the findings revealed that nurse educators and SPNs in the clinical situation seemed to have succeeded in teaching affective competencies to NQNs. The findings could indicate that SPNs were good role models in the clinical situation.

**7.4.2.3 Psychomotor competencies**

Table 6.6 reveals the following psychomotor competencies as being perceived by the SPNs of all four the clinical units to be essential (competencies expected of NQNs upon entering the work setting). SPNs perceived the majority of these competencies to be competently performed by the NQNs (table 6.6):

- assessment competencies;
- maintenance of safety, hygiene, physical comfort and nutrition competencies; and

- ▶ administration of treatment and nursing care competencies.

Specific carrying out of aseptic technique competencies and critical care competencies were perceived by SPNs of the psychiatric clinical nursing unit to be non-essential in psychiatric nursing practice. Table 6.6 reveals that SPNs perceived NQNs in the community, midwifery and general nursing units to be competent in carrying out aseptic technique competencies.

Critical care competencies were perceived by the SPNs to be incompetently performed by NQNs in all four the clinical nursing units. These findings seem to concur with other studies (Schwirian 1978:350; Troskie 1993:58; Vanetzian & Higgins 1990:273). The essential psychomotor competencies illustrated in table 6.6 were all perceived to be essential in other studies (Clayton in Chaska 1983:124-127; Kieffer 1984:198-202; Sweeney et al 1980:40-41).

- Are there differences between the expected and the performed competencies of NQNs as perceived by the SPNs?

Differences between the expected competencies and the actual competencies of NQNs as perceived by the SPNs were expected. Figures 5.1 and 5.2 of chapter five reveal that SPNs perceived the NQNs to be incompetent in some of the competencies SPNs considered to be essential. Table 5.19 a; b; c and d delineate essential competencies, as perceived by SPNs, and incompetently performed by NQNs in all four the clinical units, namely community, psychiatric, midwifery and general units respectively.

One assumption of this study states that, "SPNs expect NQNs to be competent in performing specific cognitive, affective and psychomotor competencies based on the scope of practice of a

registered nurse (R2598)".

Table 6.6 reveals that specific competencies were identified by the SPNs to be essential. However, not all these competencies were perceived by the SPNs to be competently performed by NQNs in the four clinical nursing units, namely community, psychiatric, midwifery and general units. The finding revealed in table 6.6 could lead to the conclusion that SPNs were aware of the competencies falling within the scope of practice of a professional registered nurse (R2598) in the RSA. This study therefore recommends that these competencies, perceived as being essential by the SPNs, might be considered to be activities (procedures) underlying the prescribed guidelines for professional nurses' practice described in the regulation (R2598). Brown & Jaros (1990:19) indicate that the R2598 is not always correctly interpreted by nurse clinicians, nurse managers and nurse educators. These competencies, however, should not be regarded to be the only competencies satisfying the description of the acts and procedures outlined in the scope of practice of a registered nurse (R2598). Clinical competencies are many and varied, and differ from one clinical nursing unit to another.

- Are there differences among the perceptions of SPNs concerning the competencies of NQNs in the general, community, midwifery and psychiatric clinical nursing units?

Variations in the perceptions of SPNs concerning the essential competencies and the competencies of NQNs were revealed in all four the clinical nursing units. For instance, the psychiatric SPNs perceived NQNs to be competent in performing affective competencies related to caring and interpersonal relationships. Only two out of 22 competencies were perceived by SPNs to be incompetently performed by NQNs in the psychiatric nursing units, followed by the community and the midwifery groups (three out of 22). Contradictory to the aforementioned findings, the

SPNs in the general nursing units perceived NQNs to be incompetent to perform nine out of 22 competencies outlined in the questionnaire.

SPNs in the psychiatric nursing units perceived the following psychomotor competencies outlined in table 5.20(b) to be non-essential, whereas SPNs in the other three clinical units, namely community, midwifery and general, considered these competencies to be essential:

- feeding a patient per naso-gastric tube;
- performing a venepuncture for IV infusion;
- setting a sterile trolley for special procedures;
- preparing a patient for operation;
- using instruments in a sterile field;
- suturing wounds;
- dressing wounds;
- applying local anaesthetic;
- collecting specimens for investigation (urine; blood);
- inserting an indwelling urinary catheter;
- introducing oropharyngeal airway;
- performing cardio-pulmonary resuscitation; and
- utilising ambubag resuscitator.

These findings therefore support the assumption of this study, stating that the competencies of NQNs might vary, depending upon the type of patients being nursed in the clinical nursing unit (general, psychiatric, community health and midwifery units).

- Which competencies of the NQNs need to be improved, as perceived by the SPNs?

The SPNs in all four the clinical nursing units perceived NQNs to be lacking the following competencies:

- problem solving (implementation of the nursing process);
- research;
- administration and management of a clinical unit;
- nursing ethics; and
- critical care.

Furthermore, SPNs in all four the clinical units perceived the following competencies to be most important, and expected NQNs to perform them efficiently upon entering the work setting:

- assessment of a patient/client;
- handling of an emergency;
- managing a clinical unit; and
- maintaining interpersonal communication in the clinical units.

Another assumption of this study states that, “SPNs expect NQNs to function as independent practitioners within the scope of practice of a registered nurse (R2598)”.

The findings in section 4.9 of chapter four revealed that SPNs indicated that they were aware that NQNs needed support and guidance from SPNs, thus supporting that in reality the status of an NQN could be considered to be that of a novice who still needs mentoring in the professional situation. Although a preceptor programme for NQNs was recommended by a few SPNs (28.6 percent of  $n = 259$ ) it could be beneficial to have such programmes based on the clinical specialities. This particular preceptor would require expertise in a particular clinical area such as

preceptor to delineate acts and procedures falling within the scope of practice of a registered nurse (R2598). These programmes could be offered in the form of workshops or short courses.

With regard to these findings, it could be recommended that there might be a need to reinforce these competencies in the orientation programme and in-service education of all nursing units, namely community, psychiatric, midwifery and general units.

#### 7.4.3 Section three

Section three of the questionnaires in all four the clinical units, namely community, psychiatric, midwifery and general units, describe the global perceptions of the SPNs regarding the competencies of NQNs. The following important findings were revealed.

- The SPNs in all four the clinical nursing units perceived the following to be causes contributing towards incompetency by NQNs (community, psychiatric, midwifery and general units):
  - clinical accompaniment of student nurses by tutors (62.5 percent; 55.2 percent; 67.5 percent; and 69.9 percent respectively); and
  - the attitudes of NQNs (65.3 percent; 72.4 percent; 65.8 percent; and 71.4 percent respectively).
  
- Table 6.5 reveals that the majority of SPNs regarded the period needed to enable NQNs to perform activities at a satisfactory level in their respective clinical nursing units to be between nine and twelve months. However, the SPNs did not consider offering an orientation programme to be a priority in the three clinical nursing units namely

community, psychiatric, and midwifery units. The findings seem not to support one of the assumptions of this study which indicates that, "SPNs might consider orientation programmes essential to facilitate mastery of the identified competencies by NQNs". Only the general SPNs (82 percent of n = 259) indicated that an orientation programme could be beneficial in the general nursing units as these units differ in the type of patients being nursed. For example, in the paediatric unit children are cared for, whereas operations are performed in the operating theatre. This study, therefore, recommends that orientation programmes should be relevant to a particular clinical nursing unit. The programme should be designed to suit the specific needs of that unit. General issues applicable to all personnel such as institutional policies also form part of a particular orientation programme. Implementation of unit orientation programmes may help to identify problems which a particular NQN might experience in the unit. During orientation this particular NQN would be able to assess the character of the work group and its job performance, and thus improve her competency.

## **7.5 IMPLICATIONS**

The findings of this study revealed various implications for the SPNs, NQNs and the nursing practices in the health services concerned.

### **7.5.1 SPNs**

- SPNs involved in this study appeared to have delineated expected competencies falling within the scope of practice of professional registered nurses (R2598) of the RSA. However, NQNs were perceived to be incompetent in some of the cognitive, affective and psychomotor competencies in the geographic areas of the RSA where this study was

psychomotor competencies in the geographic areas of the RSA where this study was conducted.

- SPNs appeared to be lacking in research knowledge. The SPNs in all four the clinical nursing units perceived research competencies to be “non-essential”. However, professional nurses need to be equipped with research skills which might help to improve clinical nursing standards.
  
- Continuing education in the form of in-service education, short courses and distance learning could be beneficial to improve SPNs perceptions of NQNs. As indicated in chapter six section 6.7, improved clinical teaching would be beneficial. A thorough in-service education emphasising aspects of clinical teaching could be recommended. This programme could consider teaching registered professional nurses the following issues:
  - orientation of student nurses in the clinical nursing unit;
  - students’ rights to learn in the clinical situation;
  - identification of learning needs by student nurses in a particular clinical unit (that is, identification of learning opportunities prevalent in a unit);
  - interpretation of clinical learning objectives of specific student nurses’ groups (relate with the learning opportunities prevalent in a unit);
  - setting of learning objectives;
  - designing an educational programme for learning; and
  - supervision of student nurses’ performance in the clinical unit.

This study therefore recommends that the identified aspects be given further consideration by

programming a course requires resources such as finance, time, space, facilities and expertise in the field, the health services which could enable professional registered nurses to follow such a course might benefit experts in clinical teaching.

### 7.5.2 NQNs

NQNs could be involved in evaluating themselves and their competencies against the competencies illustrated according to the questionnaires of the four clinical nursing units. These findings of NQNs' perceptions of the competencies could then be compared with the perceptions of SPNs obtained in this study.

In this study NQNs were perceived by the SPNs to be incompetent in performing competencies related to:

- the implementation of the nursing process;
- research;
- clinical judgement;
- administration and management of a clinical unit;
- ethics of nursing; and
- critical care.

Those competencies perceived by the SPNs to be essential, could be labelled "special" or "critical" competencies. This implies that these competencies should be taught for competency during the professional preparation of NQNs. Proficiency examination of student nurses could be based on "critical competencies".

### 7.5.3 Nursing practices

The study investigated an important aspect, namely the competencies of registered nurses which largely determine the standard of nursing care rendered to patients/clients. This study focused on the competencies of NQNs as viewed by SPNs in an effort to provide guidance to nurse educators, clinical preceptors and SPNs on the competencies that require more attention in the training of diploma student nurses in the areas of the Northern Province of the RSA (since 1994) where this study was conducted. This approach could be regarded as being original in attempting to elicit SPNs' views on the competencies NQNs should have in the practical situation at grassroots level, and in comparing these perceptions to those portrayed by experts in the literature. Such a comparison could indicate shortcomings requiring further remediation.

## 7.6 LIMITATIONS

- This study merely investigated the general perceptions of the SPNs regarding the competencies of NQNs. The actual competencies of the NQNs were not evaluated by themselves nor by the researcher. This limitation has been discussed in chapter one (section 1.10), asserting that future studies could ask the NQNs to evaluate their own competencies. Alternatively, future researchers could directly observe and evaluate NQNs' competencies. In these ways the competencies of NQNs as perceived by themselves, and as evaluated by a researcher, could be established.
  
- When the completed questionnaires had been analysed, an attempt was made to trace and interview the SPNs to establish how they categorised the NQNs' competencies as falling at level one (mastery); two (competent); three (not safe, practice and supervision needed);

at level one (mastery); two (competent); three (not safe, practice and supervision needed); and four (non nursing). However, the attempt failed due to staff unrest and strikes in the geographic areas concerned (refer to section 3.6.3 of chapter three). The inability to trace the SPNs could be regarded as limiting the usefulness of the results. However, it was decided to proceed with the study despite this limitation. The major purpose of the study, namely, to ascertain SPNs' perceptions of NQNs' competencies, could be achieved with the SPNs' responses to questionnaires.

## **7.7 RECOMMENDATIONS**

Recommendations were made throughout the descriptions of the findings. However, the following recommendations could also be considered. Other areas not involved in this study could benefit from the recommendations of this study.

- The NQNs should ideally be observed to determine whether they do in fact lack the competencies identified by the SPNs. There is a need for SPNs to provide guidance and support to NQNs in the clinical unit. NQNs should also be involved in recognising their own learning problems and suggest possible solutions. Mozingo, Thomas & Brooks (1995:121) in Knoxville, support these recommendations by indicating that SPNs should plan for increased opportunities for NQNS to practise nursing competencies in the clinical unit.
  
- Orientation programmes to be offered to NQNs should be designed to suit the specific needs of a particular clinical nursing unit. Clinical specialisation should be encouraged as

this could enhance development of NQNs' competency. It could be beneficial to have preceptors in each clinical nursing unit. These preceptors would be able to identify the essential competencies to be offered to NQNs of a particular clinical unit during orientation sessions. Annexure D suggests guidelines to develop a competency-based orientation programme for a clinical unit. Evaluations from both the SPNs and the NQNs should be considered important in further refinement of these guidelines.

- The perceived shortage of SPNs and other registered nurses in the community health areas, should be further investigated and, if possible, remedied. This would seem to be essential for the RSA to realise improved primary health care for all its citizens, as most primary health care is rendered by nurses working in the community health services.
- There is a need for professional nurses to follow clinical specialisation courses such as advanced midwifery, advanced psychiatric nursing, trauma care, oncology, intensive care, orthopaedic nursing, paediatric nursing and primary health care courses. This could improve the quality of patient care in the areas of the Northern Province, RSA, included in this study.
- The cognitive, affective and psychomotor competencies which have been perceived to be essential by the SPNs, could be considered to be activities underlying the prescribed guidelines for professional nurses' practices described in the regulation (R2598) of the RSA, should further research substantiate these findings.

their area of interest, rapidly developed competency.

- Further research should be undertaken upon the problems identified in this study. These should include:
  - clinical accompaniment by tutors and the development of competency by student nursing;
  - the expected competencies of NQNs in the psychiatric nursing unit;
  - the attitudes of SPNs towards clinical teaching;
  - the influence of NQNs' position in the unit hierarchy on role performance;
  - SPNs/NQNs' relationships in a clinical situation;
  - attitudes of registered nurses towards research;
  - essential competencies as perceived by NQNs upon entering the work setting; and
  - the effect of orientation programmes on staff on the development of competency.

## **7.8 CONCLUSIONS**

This study focused on the competencies of NQNs as viewed by SPNs with the purpose of delineating essential competencies expected of NQNs at first professional entrance.

An attempt to elicit SPNs' views on the competencies NQNs should have in the practical situation, could benefit NQNs at grassroots level. Such information could provide curriculum developers with realistic input which would assist in the delineation and refinement of the professional competencies expected of nurses trained in the comprehensive course leading to registration as a nurse (general, psychiatric, and community) and midwife. The identified

Professional competencies expected of nurses trained in the comprehensive course leading to registration as a nurse (general, psychiatric, and community) and midwife. The identified competencies could improve the quality of care and nursing standards if they could be mastered by NQNs in the health services affected by this research.

**BIBLIOGRAPHY**

1. ACKERMAN AM, PARTRIDGE KB & KALMER H. 1981. Effective integration of health education into baccalaureate nursing curriculum. Journal of nursing education, 20(2):37-43.
2. ASTEDT-KURKI P & HÄGGMAN-LAITILA A. 1992. Good nursing practice as perceived by clients: A starting point for the development of professional nursing. Journal of advance nursing, 17(10):1195-1199.
3. BENNER P. 1984. From novice to expert: Excellence and power in clinical nursing practice. California : Addison-Wesley.
4. BENNER P & BENNER RV. 1979. The new nurse's work entry: A troubled sponsorship. New York : Tiresias.
5. BEVIS EO & WATSON J. 1989. Toward a caring curriculum: A new pedagogy for nursing. New York : Author.
6. BOGGS D, BAKER B & PRICE G. 1987. Determining two levels of nursing competency. Nursing outlook, 35(1):34-37.
7. BRINK H. 1990. Teaching caring in nursing: A needs assessment. Curationis, 13(1 & 2):38-42.
8. BRINK PJ & WOOD MJ. 1989. Advanced design in nursing research. Newbury Park, CA : Sage.
9. BROWN U & JAROS G. 1990. Clinical nursing. Nursing verpleging RSA, 5(1):19-21.
10. BUCKWALTER KC. 1985. Is nursing research used in practice? In: Current issues in nursing; edited by Joanne C. McCloskey & Helen K. Grace. Boston : Blackwell Scientific, pp 110-120.

pp 110-120.

11. BURNS N & GROVE SK. 1987. The practice of nursing research: Conduct, critique and utilisation. Philadelphia : WB Saunders.
12. BUTLER FC. 1978. The concept of competency: An operational definition. Educational technology, pp 7-17.
13. CANDLIN S. 1992. Communication for nurses: Implications for nurse education. Nurse education today, 12(6):445-451.
14. CANTOR MM, SCHROEDER DM & KURTH SW. 1981. The experienced nurse and the new graduate: Do their learning needs differ? Nurse educator, 6 (6 ):17-22.
15. CHANG AM & GASKILL D. 1991. Nurses' perceptions of their problem-solving ability. Journal of advanced nursing, 16(8):813-819.
16. CHASKA NL. 1983. The nursing profession: A time to speak. New York : McGraw Hill.
17. CHIPMAN Y. 1991. Caring: Its meaning and place in the practice of nursing. Journal of nursing education, 30(4):171-175.
18. CLAYTON GM. 1983. Identification of professional competencies. In: The nursing profession: a time to speak; edited by Norma L. Chaska, New York: McGraw-Hill, pp 124-127.
19. CLAYTON GM, BROOME ME & ELLIS LA. 1989. Relationship between a preceptorship experience and role socialization of graduate nurses. Journal of nursing education, 23(2):72-73.
20. COONEY AT. 1992. An orientation program for new graduate nurses: The basis of staff development and retention. Journal of continuing education in nursing, 23(5):216-219.
21. DENNILL K, KING L, LOCK M & SWANEPOEL T. 1995. Aspects of primary health

- care. First edition. Durban : Southern.
22. DIERS D. 1986. To profess: To be a professional. Journal of nursing administration, 16(3):27.
  23. DU PREEZ J. 1990. The role of the professional nurse in the ward in the promotion of professional practice. Nursing verpleging RSA, 5(11 & 12):26-29.
  24. EHRENFELD M & ECKERLING S. 1991. Perceptions and attitudes of registered nurses to research: A comparison with a previous study. Journal of advanced nursing, 16(2):224-232.
  25. ENGELHARDT H. 1993. Hospital & nursing yearbook for Southern Africa. 33rd revised edition. Cape Town : H. Engelhardt.
  26. FEELEY N & GEREZ-LIRETTE T. 1992. Development of professional practice based on the McGill model of nursing in an ambulatory care setting. Journal of advanced nursing, 17(7):801-807.
  27. FELDER E. 1990. Baccalaureate and associate degree student nurses' cultural knowledge of and attitudes toward black American clients. Journal of nursing education, 29(6):276-281.
  28. FITZPATRICK JM, WHILE AE & ROBERTS JD. 1992. The role of the nurse in high-quality patient care: A review of the literature. Journal of advanced nursing, 17(10 ):1210-1219.
  29. GAY LR. 1987. Educational research: competencies for analysis and application. 3rd edition. London: Merrill.
  30. GIROT EA. 1993. Assessment of competency in clinical practice: A phenomenological approach. Journal of advanced nursing, 18 (1):114-119.
  31. GLEIT CJ & GRAHAM BA. 1984. Reading materials used in the preparation of nurses

- for the teaching role. Patient education and counselling, 6(1):25-28.
32. HENDERSON MS. 1982. Nursing education. London : Churchill Livingstone.
  33. HESLOP A & LATHLEAN J. 1986. Managing the ward and nursing work. In: Becoming a staff nurse; edited by Judith Lathlean and Jessica Corner, New York : 1991. Prentice Hall, pp 43-44.
  34. HOLDEN GW & KLINGNER AM. 1988. Learning from experience: Differences in how novice vs expert nurses diagnose why an infant is crying. Journal of nursing education, 27(1):23-29.
  35. HUGHES O, WADE B & PETERS M. 1991. The effects of a synthesis of nursing practice course on senior nursing students' self-concept and role perception. Journal of nursing education, 30(2):69-72.
  36. HURST K, DEAN A & TRICKEY S. 1991. The recognition and non-recognition of problem-solving stages in practice. Journal of advanced nursing, 16(11):1444-1455.
  37. IGNATAVICIUS DD. 1983. Clinical competency of new graduates: A study to measure performance. Journal of continuing education in nursing, 14(4)17-20.
  38. ITANO JK. 1989. A Comparison of the clinical judgement process in experienced registered nurses and student nurses. Journal of nursing education, 28(3):120-125.
  39. JONES GR. 1986. Socialization tactics, self-efficacy and newcomers' adjustments to organisations. Academy of management journal, 29(2):262-279.
  40. JONES JA. 1988. Clinical reasoning in nursing. Journal of advanced nursing, 13(2):185-192.
  41. JOYCE-NAGATA B, REEB R & BURCH S. 1989. Comparison of expected and evidenced baccalaureate degree competencies. Journal of nursing education, 28(7):314-320.

42. KELLY B. 1992. The professional self-concepts of nursing under-graduates and their perceptions of influential forces. Journal of nursing education, 31(3):121-124.
43. KELLY J. 1990. Management training and development. In: Nursing competence - a guide to professional development; edited by B. Kershaw, London : Hodder & Stoughton, pp 61-64.
44. KERSHAW B. 1990. Nursing competence - A guide to professional development. London : Hodder & Stoughton.
45. KIEFFER JS. 1984. Selecting technical competencies to teach for competency. Journal of nursing education, 23(5):198-202.
46. KOMORITA NI, DOEHRING KM & HIRCHERT PW. 1991. Perceptions of caring by nurse educators. Journal of nursing education, 30(1):23-29.
47. KRAMER M. 1985. Why does reality shock continue? In: Current issues in nursing; edited by Joanne C. McCloskey & Helen K. Grace, Boston : Blackwell Scientific, pp 891-903.
48. KRAMER M. 1974. Reality shock: Why nurses leave nursing. Saint Louis : CV Mosby.
49. KYRIACOS U. 1992. Developing critical thinking competencies. Curationis, 15(3):48-50.
50. LATHLEAN J & CORNER J. 1991. Becoming a staff nurse: A guide to the role of the newly registered nurse. New York : Prentice Hall.
51. LE BRECK DB. 1989. Clinical judgement. A comparison of theoretical perspectives. In: Review of research in nursing education, Volume II; edited by WL Holzemer, New York : National league for nursing, pp 33-47.
52. LEININGER MM. 1990. Transcultural nursing: A worldwide necessity to advance nursing knowledge and practice. In: Current issues in nursing, edited by Joanne C.

McCloskey & Helen K. Grace, Saint Louis : CV Mosby, pp 533-541.

53. LEWIS T. 1990. The hospital ward sister: professional gatekeeper. Journal of advanced nursing, 15(1):808-818.
54. LOUIS ME. 1980. Surprise and sense making: what newcomers experience in entering unfamiliar organizational settings. Administrative science quarterly, 25(2):226-251.
55. LOWANE LB. 1990. Student nurses ' perception of clinical learning experiences. Unpublished MA Cur dissertation, Pretoria : University of South Africa.
56. MAKHATHINI JTN. 1992. An evaluation of the problem-solving ability of diplomates from the comprehensive nursing programme. Unpublished MA Cur dissertation, Durban: University of Natal.
57. MANGOLD AM. 1991. Senior student nurses and professional nurses' perceptions of effective caring behaviours: A comparative study. Journal of nursing education, 30(3):134-139.
58. MATTHEWS A. 1982. In charge of the ward. Boston : Blackwell Scientific.
59. McCLOSKEY JM & GRACE HK. 1985. Current issues in nursing. Boston : Blackwell Scientific.
60. McCLOSKEY JM & GRACE HK. 1990. Current issues in nursing. Saint Louis : CV Mosby.
61. McGAHIE WC, MILLER GE, SAJID AW & TELDER TV. 1978. Competency based curriculum development in medical education. Geneva : WHO.
62. MILDE FK & HEIM CL. 1991. Competency to provide health education: Perception of student nurses and faculty. Journal of nursing education, 30(9):397-402.
63. MORSE W, BOTTOMS MS & WASTLICK LA. 1992. Liberal and professional undergraduate nursing education: Maintaining the connections. Journal of professional nursing,

- 8(5):282-288.
64. MOZINGO J, THOMAS S & BROOKS E. 1995. Factors associated with perceived competency levels of graduating seniors in a baccalaureate nursing program. Journal of nursing education, 34(3):115-122.
  65. MURDAUGH CL. 1980. Effects of nurses' knowledge of teaching-learning principles on knowledge of coronary care unit patients. Heart and lung, 9(6):1073-1078.
  66. PECK ML & JENNINGS S. 1989. Student perceptions of the links between nursing and the liberal arts. Journal of nursing education, 28(9):406-414.
  67. POLIT DF & HUNGLER BP. 1991. Nursing research: principles and methods. 4th edition. Philadelphia: JB Lippincott.
  68. POLIT DF & HUNGLER BP. 1993. Essentials of nursing research. Methods, appraisal and utilization. 3rd ed. Philadelphia : JB Lippincott.
  69. PRIMM PL. 1986. Entry into practice: competency statements for BSNs and ADNs. Nursing outlook, 34(3):135-137.
  70. REILLY DE & OERMANN MH. 1985. The clinical field: Its use in nursing education. Norwalk: Appleton-century-crofts.
  71. RHOSA. 1992. Memorandum to the subcommittee on nursing, Health Matters Committee (HMC) and Regional Health organisation of South Africa (RHOSA).
  72. RHOSA. 1993. Memorandum to the HMC/RHOSA Committee. RHOSA: Subcommittee on Nursing. SA. 1993.
  73. RSA. 1978. Nursing Act : Government Gazette. Cape Town : Government Printers.
  74. RSA. 1991. Personnel administration standard for nursing, Cape Town : Government Printer.
  75. SANFORD M, GENRICH S & NOWOTNY M. 1992. A study to determine the

- difference in clinical judgement abilities between BSN and non-BSN graduates. Journal of nursing education, 31(2):70-74.
76. SCHEETZ LJ. 1989. Baccalaureate nursing student preceptorship programs and the development of clinical competence. Journal of nursing education, 28(1):29-35.
77. SCHWIRIAN PM. 1978. Evaluating the performance of nurses: A multidimensional approach. Nursing research, 27(6):347-349.
78. SEAMAN CH. 1987. Research methods: principles, practice and theory for nursing. USA: Appleton & Lange.
79. SEARLE C. 1980. The ward sister. Curationis, 3(1):5-6.
80. SEARLE C. 1986. Professional practice: A South African nursing perspective. Durban: Butterworths.
81. SEARLE C. 1987. Ethos of nursing and midwifery: A general perspective. Durban : Butterworths.
82. SEARLE C & PERA S. 1992. Professional practice: A South African nursing perspective. Durban : Butterworths.
83. SHULDHAM C. 1991. Communication. In: Becoming a staff nurse; edited by Judith Lathlean & Jessica Corner, New York : Prentice Hall, pp 73-95.
84. SOUTH AFRICAN NURSING ASSOCIATION. 1991. Minutes of the committees of university nursing heads and heads of nursing colleges minutes. Pretoria : SANA.
85. SOUTH AFRICAN NURSING COUNCIL. 1975. Regulations for the course for the diploma in general nursing for registration as a general nurse. R879 of May. Pretoria : Government Printer.
86. SOUTH AFRICAN NURSING COUNCIL. 1984. Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978.

Regulation R2598 of November, Pretoria : Government Printer.

87. SOUTH AFRICAN NURSING COUNCIL. 1985. Guidelines for the course leading to registration as a nurse (general, psychiatric and community) and midwife. Regulations. (R425 of February). Pretoria : Government Printer.
88. SOUTH AFRICAN NURSING COUNCIL. 1992. Teaching guide for the programme leading to registration as a nurse (general, psychiatric and community) and midwife. Pretoria : SANC.
89. SWEENEY MA, REGAN P, O'MALLEY M & HEDSTROM B. 1980. Essential competencies for baccalaureate graduates. Journal of nursing administration, 10(10):37-44.
90. SWEENEY MA & REGAN PA. 1982. Educators, employees and new graduates define essential competencies for baccalaureate graduates. Journal of nursing administration, 12(9):36-42.
91. SWENDSEN BOSS LA. 1985. Teaching for clinical competence. Nurse educator, 10(4):8-12.
92. TROSKIE R. 1990. 'n Kritiese evaluering van die bevoegdheid van die nuutgekwalifiseerde verpleegkundige. Ongepubliseerde D Litt et Phil tesis, Pretoria : Universiteit van Suid-Afrika.
93. TROSKIE R. 1993. Critical evaluation of the newly qualified nurse's competency to practise. Curationis, 16(3):50-61.
94. VALENTINE K. 1989. Caring is more than kindness: Modelling its complexities. Journal of nursing administration, 19(11):28-35.
95. VAN DALEN DB. 1979. Understanding educational research. 4th edition. New York: McGraw-Hill Book Company, pp 127-144.

6. VAN ESS COELING H. 1990. Organizational culture: Helping new graduates adjust. Nurse educator, 15(2):26-28.
7. VANETZIAN EV & HIGGINS NG. 1990. A comparison of new graduates and evaluator appraisals of nursing programmes. Journal of nursing education, 27(6):269-275.
8. VAUGHAN B. 1980. Providing clinical care. In: Becoming a staff nurse; edited by Judith Lathlean & Jessica Corner, 1991, New York : Prentice Hall, pp 23-24.
9. VON ESSEN L & SJODEN P. 1991. Patient and staff perceptions of caring. Journal of advanced nursing, 16(11):1363-1374.
00. WINDSOR A. 1987. Nursing students' perceptions of clinical experience. Journal of nursing education, 26(4):150-154.

# **ANNEXURE A**

## **QUESTIONNAIRES**

# **QUESTIONNAIRE**

**SENIOR PROFESSIONAL NURSES IN THE  
COMMUNITY NURSING UNIT**

# SECTION ONE

## GENERAL INFORMATION

Please answer the questions, where applicable by placing a tick ✓ in the appropriate block.

1. Please state your age

--	--

2. For how many years have you been appointed as a Senior Professional Nurse?

Months

Years

3. Tick your professional qualifications

General

Midwifery

Psychiatry

Community

Education

Administration

Clinical Specialization


3/...

If you have a Clinical Specialization/s, please specify. \_\_\_\_\_

4. In which clinical area are you presently working? \_\_\_\_\_

5. Indicate your period of experience in your present unit.

months


years

6. What is your supervisory position in the chain of command?

First in charge


Second in charge

Third or lower

7. Do you presently have newly qualified nurses allocated to your department?

Yes


No

4/...

If YES, how many?

--	--

If NO, when last did you work with newly qualified nurses?

Within the last year  
More than 1 year ago  
More than 2 years ago


8. Indicate the position which the newly qualified nurses occupy in your department.

2<sup>nd</sup> or 3<sup>rd</sup> in charge  
4<sup>th</sup> or 5<sup>th</sup> in charge  
6<sup>th</sup> or lower in charge


9. How does the newly qualified nurse's position in the hierarchical structure of your unit, influence her ability to practice as a competent practitioner? Discuss briefly. \_\_\_\_\_

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10. Are you presently engaged in any studies?

Yes

No

If YES, please specify your field or course. If applicable, indicate your major subjects. \_\_\_\_\_

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---

11. Which educational programme did you complete to become a Professional Nurse?

Basic general 3 year diploma course

Four year comprehensive diploma course

Four year comprehensive degree course

Integrated basic general 3½ year course (General/midwifery; general/psychiatry)

Other

If OTHER, please specify. \_\_\_\_\_

---

## SECTION TWO

### THE COMPETENCIES OF NEWLY QUALIFIED NURSES AS VIEWED BY YOURSELF

This section consists of Part A and Part B.

Part A requires you, as a Senior Professional Nurse, to evaluate what competencies you expect newly qualified nurses to have, upon entering the work setting. (Competency implies their ability to perform/display cognitive, affective and psychomotor skills in the work setting).

Part B requires from you to indicate the competencies of newly qualified nurses in the clinical unit.

Use the following key to complete Part A of the Questionnaire :

1. **ESSENTIAL** : This competency is expected of newly qualified nurses upon entering the work setting.
2. **DESIRABLE, BUT NOT ESSENTIAL** : It would be beneficial if every newly qualified nurse could perform this competency, but it is not essential.
3. **USEFUL SHOULD NOT BE REQUIRED** : Not expected at level of experience.
4. **NON-NURSING** : This competency should not be considered part of nurse's role.

Use the following key to complete Part B of the questionnaire :

1. **MASTERY** : Able to perform competently and efficiently without supervision.
2. **COMPETENT** : Able to perform without supervision, with reasonable efficiency.
3. **NOT SAFE PRACTICE,  
SUPERVISION NEEDED** : Perform unsafely; practice and supervision is needed.
4. **NON-NURSING** : Does not think this competency should be considered part of the nurse's role.

Please complete each item by placing a tick ✓ in the appropriate block. That is, each statement will have two ticks ✓'s as the example on the following page, indicates.





















### SECTION THREE

**Please read the following statements carefully, because the key concepts differ from one statement to another.**

Indicate your answer by a tick ✓ in the appropriate column

1. For each item, indicate what deficiencies do you believe to exist in competency performance by NQNs?"

*Please turn the page for graph*

	<b>GREATEST DEFICIENCY</b>	<b>DEFICIENT</b>	<b>LESS DEFICIENT</b>	<b>NOT DEFICIENT</b>
<b>1.1 Problem solving</b>				
<b>1.2 Teaching of clients and nurses</b>				
<b>1.3 Research</b>				
<b>1.4 Clinical judgement</b>				
<b>1.5 Administrative/Management</b>				
<b>1.6 Implementation of the nursing process</b>				
<b>1.7 Adjustive/adaptive skills</b>				
<b>1.8 Interpersonal relations/communication</b>				
<b>1.9 Caring</b>				
<b>1.10 Ethical</b>				
<b>1.11 Other (please specify)</b>				

2. How do you view the following aspects as causes contributing towards incompetence of NQNs?

	VERY IMPORTANT	IMPORTANT	UNIMPORTANT	NEGLIGIBLE
2.1 Implementation of the R425 curriculum				
2.2 Clinical accompaniment				
2.3 Attitudes of newly qualified nurses				
2.4 Attitudes of Senior Professional Nurses				
2.5 Other (please specify)				





5. When did you observe newly qualified nurses to be performing nursing activities at a satisfactory level?

0 - 3 months	3 - 6 months	6 - 9 months	9 - 12 months	not yet observed
--------------	--------------	--------------	---------------	------------------

6. What do you suggest to improve competencies of newly qualified nurses in your clinical unit? Discuss briefly.

7. Would you like to add any comments to the information you have provided in this study? If so, please use the space below.

---

END

# **QUESTIONNAIRE**

**SENIOR PROFESSIONAL NURSES IN THE  
PSYCHIATRIC NURSING UNIT**

# SECTION ONE

## GENERAL INFORMATION

Please answer the questions, where applicable by placing a tick ✓ in the appropriate block.

1. Please state your age

--	--

2. For how many years have you been appointed as a Senior Professional Nurse?

Months

Years

3. Tick your professional qualifications

General

Midwifery

Psychiatry

Community

Education

Administration

Clinical Specialization


3/...

If you have a Clinical Specialization/s, please specify. \_\_\_\_\_

4. In which clinical area are you presently working? \_\_\_\_\_

5. Indicate your period of experience in your present unit.

months	<input type="text"/>	<input type="text"/>
years	<input type="text"/>	<input type="text"/>

6. What is your supervisory position in the chain of command?

First in charge	<input type="checkbox"/>
Second in charge	<input type="checkbox"/>
Third or lower	<input type="checkbox"/>

7. Do you presently have newly qualified nurses allocated to your department?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

4/...

If YES, how many?

--	--

If NO, when last did you work with newly qualified nurses?

- Within the last year
- More than 1 year ago
- More than 2 years ago


8. Indicate the position which the newly qualified nurses occupy in your department.

- 2<sup>nd</sup> or 3<sup>rd</sup> in charge
- 4<sup>th</sup> or 5<sup>th</sup> in charge
- 6<sup>th</sup> or lower in charge


9. How does the newly qualified nurse's position in the hierarchical structure of your unit, influence her ability to practice as a competent practitioner? Discuss briefly. \_\_\_\_\_

---

---

---

10. Are you presently engaged in any studies?

Yes

No

If YES, please specify your field or course. If applicable, indicate your major subjects. \_\_\_\_\_

---

---

11. Which educational programme did you complete to become a Professional Nurse?

Basic general 3 year diploma course

Four year comprehensive diploma course

Four year comprehensive degree course

Integrated basic general 3½ year course (General/midwifery; general/psychiatry)

Other

If OTHER, please specify. \_\_\_\_\_

---

## SECTION TWO

### THE COMPETENCIES OF NEWLY QUALIFIED NURSES AS VIEWED BY YOURSELF

This section consists of Part A and Part B.

Part A requires you, as a Senior Professional Nurse, to evaluate what competencies you expect newly qualified nurses to have, upon entering the work setting. (Competency implies their ability to perform/display cognitive, affective and psychomotor skills in the work setting).

Part B requires from you to indicate the competencies of newly qualified nurses in the clinical unit.

Use the following key to complete Part A of the Questionnaire :

1. **ESSENTIAL** : This competency is expected of newly qualified nurses upon entering the work setting.
2. **DESIRABLE, BUT NOT ESSENTIAL** : It would be beneficial if every newly qualified nurse could perform this competency, but it is not essential.
3. **USEFUL SHOULD NOT BE REQUIRED** : Not expected at level of experience.
4. **NON-NURSING** : This competency should not be considered part of nurse's role.

Use the following key to complete Part B of the questionnaire :

- 1. MASTERY : Able to perform competently and efficiently without supervision.
- 2. COMPETENT : Able to perform without supervision, with reasonable efficiency.
- 3. NOT SAFE PRACTICE,  
SUPERVISION NEEDED : Perform unsafely; practice and supervision is needed.
- 4. NON-NURSING : Does not think this competency should be considered part of the nurse's role.

Please complete each item by placing a tick ✓ in the appropriate block. That is, each statement will have two ticks ✓'s as the example on the following page, indicates.















COMPETENCIES WHICH NEWLY QUALIFIED  
NURSES SHOULD POSSESS

COMPETENCIES OF NEWLY  
QUALIFIED NURSES IN YOUR UNIT

PART A

PART B

ESSENTIAL	DESIRABLE BUT NOT ESSENTIAL	USEFUL SHOULD NOT BE REQUIRED	NON- NURSING	MASTERY	COMPETENT	NOT SAFE PRACTICE SUPERVISION NEEDED	NON- NURSING
-----------	-----------------------------------	--	-----------------	---------	-----------	---	-----------------

**MAINTENANCE OF SAFETY FOR  
INDIVIDUALS AND FAMILY**

1	2	3	4	1	2	3	4
---	---	---	---	---	---	---	---

62. Function in appropriate role in fire/disaster procedure

--	--	--	--	--	--	--	--

63. Check blood products for proper identification

--	--	--	--	--	--	--	--

64. Employ suicide precautions

--	--	--	--	--	--	--	--

65. Employ Medico-legal risk precautions

--	--	--	--	--	--	--	--

66. Apply physical restraints to violent patients

--	--	--	--	--	--	--	--

67. Administer and supervise oral care

--	--	--	--	--	--	--	--

68. Administer and supervise skin care

--	--	--	--	--	--	--	--

**MAINTENANCE OF NUTRITION OF A  
PATIENT**

1	2	3	4	1	2	3	4
---	---	---	---	---	---	---	---

69. Assess nutritional status of a patient

--	--	--	--	--	--	--	--

70. Feed a patient per naso gastric tube

--	--	--	--	--	--	--	--

71. Feed a helpless patient

--	--	--	--	--	--	--	--









### SECTION THREE

**Please read the following statements carefully, because the key concepts differ from one statement to another.**

Indicate you answer by a tick ✓ in the appropriate column

1. For each item, indicate what deficiencies do you believe to exist in competency performance by NQNs?"

*Please turn the page for graph*

	<b>GREATEST DEFICIENCY</b>	<b>DEFICIENT</b>	<b>LESS DEFICIENT</b>	<b>NOT DEFICIENT</b>
<b>1.1 Problem solving</b>				
<b>1.2 Teaching of clients and nurses</b>				
<b>1.3 Research</b>				
<b>1.4 Clinical judgement</b>				
<b>1.5 Administrative/Management</b>				
<b>1.6 Implementation of the nursing process</b>				
<b>1.7 Adjustive/adaptive skills</b>				
<b>1.8 Interpersonal relations/communication</b>				
<b>1.9 Caring</b>				
<b>1.10 Ethical</b>				
<b>1.11 Other (please specify)</b>				

2. How do you view the following aspects as causes contributing towards incompetence of NQNs?

	VERY IMPORTANT	IMPORTANT	UNIMPORTANT	NEGLIGIBLE
2.1 Implementation of the R425 curriculum				
2.2 Clinical accompaniment				
2.3 Attitudes of newly qualified nurses				
2.4 Attitudes of Senior Professional Nurses				
2.5 Other (please specify)				





5. When did you observe newly qualified nurses to be performing nursing activities at a satisfactory level?

0 - 3 months	3 - 6 months	6 - 9 months	9 - 12 months	not yet observed
--------------	--------------	--------------	---------------	------------------

6. What do you suggest to improve competencies of newly qualified nurses in your clinical unit? Discuss briefly.

7. Would you like to add any comments to the information you have provided in this study? If so, please use the space below.

---

END

# **QUESTIONNAIRE**

**SENIOR PROFESSIONAL NURSE IN THE  
MIDWIFERY UNIT**

# SECTION ONE

## GENERAL INFORMATION

Please answer the questions, where applicable by placing a tick ✓ in the appropriate block.

1. Please state your age

--	--

2. For how many years have you been appointed as a Senior Professional Nurse?

Months

Years

3. Tick your professional qualifications

General

Midwifery

Psychiatry

Community

Education

Administration

Clinical Specialization


3/...

If you have a Clinical Specialization/s, please specify. \_\_\_\_\_

4. In which clinical area are you presently working? \_\_\_\_\_

5. Indicate your period of experience in your present unit.

months	<input type="text"/>	<input type="text"/>
years	<input type="text"/>	<input type="text"/>

6. What is your supervisory position in the chain of command?

First in charge	<input type="checkbox"/>
Second in charge	<input type="checkbox"/>
Third or lower	<input type="checkbox"/>

7. Do you presently have newly qualified nurses allocated to your department?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

4/...

If YES, how many?

--	--

If NO, when last did you work with newly qualified nurses?

Within the last year  
More than 1 year ago  
More than 2 years ago


8. Indicate the position which the newly qualified nurses occupy in your department.

2<sup>nd</sup> or 3<sup>rd</sup> in charge  
4<sup>th</sup> or 5<sup>th</sup> in charge  
6<sup>th</sup> or lower in charge


9. How does the newly qualified nurse's position in the hierarchical structure of your unit, influence her ability to practice as a competent practitioner? Discuss briefly. \_\_\_\_\_

---

---

---

10. Are you presently engaged in any studies?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

If YES, please specify your field or course. If applicable, indicate your major subjects. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Which educational programme did you complete to become a Professional Nurse?

Basic general 3 year diploma course	<input type="checkbox"/>
Four year comprehensive diploma course	<input type="checkbox"/>
Four year comprehensive degree course	<input type="checkbox"/>
Integrated basic general 3½ year course (General/midwifery; general/psychiatry)	<input type="checkbox"/>
Other	<input type="checkbox"/>

If OTHER, please specify. \_\_\_\_\_

\_\_\_\_\_

## SECTION TWO

### THE COMPETENCIES OF NEWLY QUALIFIED NURSES AS VIEWED BY YOURSELF

This section consists of Part A and Part B.

Part A requires you, as a Senior Professional Nurse, to evaluate what competencies you expect newly qualified nurses to have, upon entering the work setting. (Competency implies their ability to perform/display cognitive, affective and psychomotor skills in the work setting).

Part B requires from you to indicate the competencies of newly qualified nurses in the clinical unit.

Use the following key to complete Part A of the Questionnaire :

1. **ESSENTIAL** : This competency is expected of newly qualified nurses upon entering the work setting.
2. **DESIRABLE, BUT NOT ESSENTIAL** : It would be beneficial if every newly qualified nurse could perform this competency, but it is not essential.
3. **USEFUL SHOULD NOT BE REQUIRED** : Not expected at level of experience.
4. **NON-NURSING** : This competency should not be considered part of nurse's role.

Use the following key to complete Part B of the questionnaire :

1. **MASTERY** : Able to perform competently and efficiently without supervision.
2. **COMPETENT** : Able to perform without supervision, with reasonable efficiency.
3. **NOT SAFE PRACTICE,  
SUPERVISION NEEDED** : Perform unsafely; practice and supervision is needed.
4. **NON-NURSING** : Does not think this competency should be considered part of the nurse's role.

Please complete each item by placing a tick ✓ in the appropriate block. That is, each statement will have two ticks ✓'s as the example on the following page, indicates.











	COMPETENCIES WHICH NEWLY QUALIFIED NURSES SHOULD POSSESS				COMPETENCIES OF NEWLY QUALIFIED NURSES IN YOUR UNIT				
	PART A				PART B				
	ESSENTIAL	DESIRABLE BUT NOT ESSENTIAL	USEFUL SHOULD NOT BE REQUIRED	NON- NURSING	MASTERY	COMPETENT	NOT SAFE PRACTICE SUPERVISION NEEDED	NON- NURSING	
50.	Support human dignity while engaging in professional practice								
51.	Respect patient's freedom of choice and right to make a decision								
52.	Inform a woman about her labour progress								
53.	Prepare patient for post partum self care								
54.	Exercise patience with demanding patients during labour								
55.	Alleviate woman's pain during labour								
56.	Practice within the scope of practice of a registered midwife								
57.	Demonstrate knowledge of ethics in nursing.								
<b>CARING AND ETHICS (CONTINUE)</b>		1	2	3	4	1	2	3	4
58.	Contribute to the growth of others by sharing knowledge and expertise								
<b>PSYCHOMOTOR SKILLS</b>		-	-	-	-	-	-	-	













### SECTION THREE

**Please read the following statements carefully, because the key concepts differ from one statement to another.**

Indicate you answer by a tick ✓ in the appropriate column

1. For each item, indicate what deficiencies do you believe to exist in competency performance by NQNs?"

*Please turn the page for graph*

	<b>GREATEST DEFICIENCY</b>	<b>DEFICIENT</b>	<b>LESS DEFICIENT</b>	<b>NOT DEFICIENT</b>
<b>1.1 Problem solving</b>				
<b>1.2 Teaching of clients and nurses</b>				
<b>1.3 Research</b>				
<b>1.4 Clinical judgement</b>				
<b>1.5 Administrative/Management</b>				
<b>1.6 Implementation of the nursing process</b>				
<b>1.7 Adjustive/adaptive skills</b>				
<b>1.8 Interpersonal relations/communication</b>				
<b>1.9 Caring</b>				
<b>1.10 Ethical</b>				
<b>1.11 Other (please specify)</b>				

2. How do you view the following aspects as causes contributing towards incompetence of NQNs?

	VERY IMPORTANT	IMPORTANT	UNIMPORTANT	NEGLIGIBLE
2.1 Implementation of the R425 curriculum				
2.2 Clinical accompaniment				
2.3 Attitudes of newly qualified nurses				
2.4 Attitudes of Senior Professional Nurses				
2.5 Other (please specify)				





5. When did you observe newly qualified nurses to be performing nursing activities at a satisfactory level?

0 - 3 months	3 - 6 months	6 - 9 months	9 - 12 months	not yet observed
--------------	--------------	--------------	---------------	------------------

6. What do you suggest to improve competencies of newly qualified nurses in your clinical unit? Discuss briefly.

7. Would you like to add any comments to the information you have provided in this study? If so, please use the space below.

---

END

# **QUESTIONNAIRE**

**SENIOR PROFESSIONAL NURSES IN THE  
GENERAL NURSING UNIT**

# SECTION ONE

## GENERAL INFORMATION

Please answer the questions, where applicable by placing a tick ✓ in the appropriate block.

1. Please state your age

--	--

2. For how many years have you been appointed as a Senior Professional Nurse?

Months

Years

3. Tick your professional qualifications

General

Midwifery

Psychiatry

Community

Education

Administration

Clinical Specialization


If you have a Clinical Specialization/s, please specify. \_\_\_\_\_

4. In which clinical area are you presently working? \_\_\_\_\_

5. Indicate your period of experience in your present unit.

months


years

6. What is your supervisory position in the chain of command?

First in charge


Second in charge

Third or lower

7. Do you presently have newly qualified nurses allocated to your department?

Yes


No

4/...

If YES, how many?

--	--

If NO, when last did you work with newly qualified nurses?

Within the last year  
More than 1 year ago  
More than 2 years ago


8. Indicate the position which the newly qualified nurses occupy in your department.

2<sup>nd</sup> or 3<sup>rd</sup> in charge  
4<sup>th</sup> or 5<sup>th</sup> in charge  
6<sup>th</sup> or lower in charge


9. How does the newly qualified nurse's position in the hierarchical structure of your unit, influence her ability to practice as a competent practitioner? Discuss briefly. \_\_\_\_\_

---

---

---

10. Are you presently engaged in any studies?

Yes

No

If YES, please specify your field or course. If applicable, indicate your major subjects. \_\_\_\_\_

---

---

11. Which educational programme did you complete to become a Professional Nurse?

Basic general 3 year diploma course

Four year comprehensive diploma course

Four year comprehensive degree course

Integrated basic general 3½ year course (General/midwifery; general/psychiatry)

Other

If OTHER, please specify. \_\_\_\_\_

---

## SECTION TWO

### THE COMPETENCIES OF NEWLY QUALIFIED NURSES AS VIEWED BY YOURSELF

This section consists of Part A and Part B.

Part A requires you, as a Senior Professional Nurse, to evaluate what competencies you expect newly qualified nurses to have, upon entering the work setting. (Competency implies their ability to perform/display cognitive, affective and psychomotor skills in the work setting).

Part B requires from you to indicate the competencies of newly qualified nurses in the clinical unit.

Use the following key to complete Part A of the Questionnaire :

1. **ESSENTIAL** : This competency is expected of newly qualified nurses upon entering the work setting.
2. **DESIRABLE, BUT NOT ESSENTIAL** : It would be beneficial if every newly qualified nurse could perform this competency, but it is not essential.
3. **USEFUL SHOULD NOT BE REQUIRED** : Not expected at level of experience.
4. **NON-NURSING** : This competency should not be considered part of nurse's role.

Use the following key to complete Part B of the questionnaire :

1. **MASTERY** : Able to perform competently and efficiently without supervision.
2. **COMPETENT** : Able to perform without supervision, with reasonable efficiency.
3. **NOT SAFE PRACTICE,  
SUPERVISION NEEDED** : Perform unsafely; practice and supervision is needed.
4. **NON-NURSING** : Does not think this competency should be considered part of the nurse's role.

**Please complete each item by placing a tick ✓ in the appropriate block. That is, each statement will have two ticks ✓'s as the example on the following page, indicates.**



















### SECTION THREE

**Please read the following statements carefully, because the key concepts differ from one statement to another.**

Indicate your answer by a tick ✓ in the appropriate column

1. For each item, indicate what deficiencies do you believe to exist in competency performance by NQNs?"

*Please turn the page for graph*

	<b>GREATEST DEFICIENCY</b>	<b>DEFICIENT</b>	<b>LESS DEFICIENT</b>	<b>NOT DEFICIENT</b>
<b>1.1 Problem solving</b>				
<b>1.2 Teaching of clients and nurses</b>				
<b>1.3 Research</b>				
<b>1.4 Clinical judgement</b>				
<b>1.5 Administrative/Management</b>				
<b>1.6 Implementation of the nursing process</b>				
<b>1.7 Adjustive/adaptive skills</b>				
<b>1.8 Interpersonal relations/communication</b>				
<b>1.9 Caring</b>				
<b>1.10 Ethical</b>				
<b>1.11 Other (please specify)</b>				

2. How do you view the following aspects as causes contributing towards incompetence of NQNs?

	<b>VERY IMPORTANT</b>	<b>IMPORTANT</b>	<b>UNIMPORTANT</b>	<b>NEGLIGIBLE</b>
<b>2.1 Implementation of the R425 curriculum</b>				
<b>2.2 Clinical accompaniment</b>				
<b>2.3 Attitudes of newly qualified nurses</b>				
<b>2.4 Attitudes of Senior Professional Nurses</b>				
<b>2.5 Other (please specify)</b>				





5. When did you observe newly qualified nurses to be performing nursing activities at a satisfactory level?

0 - 3 months	3 - 6 months	6 - 9 months	9 - 12 months	not yet observed
--------------	--------------	--------------	---------------	------------------

6. What do you suggest to improve competencies of newly qualified nurses in your clinical unit? Discuss briefly.

7. Would you like to add any comments to the information you have provided in this study? If so, please use the space below.

---

END

# **ANNEXURE B**

**COVERING LETTER FOR  
QUESTIONNAIRES**

P.O. Box 643

LETABA

0870

Dear Colleague

*Professional Nurses, actively involved in the clinical setting, it is our goal to ensure that patients receive optimum care from nurses. The attached questionnaire is designed to solicit your views concerning the competencies of newly qualified nurses, the four year integrated course, upon entering the work setting. The purpose of this research is to critically delineate the competencies (skills) expected of them within one year of employment. Newly qualified nurses in this study, therefore, refers to those who completed training during 1993 and 1994.*

*Your concern as Senior Professional Nurses is, that it appears as though newly qualified nurses are not as competent as expected in the clinical setting. I would appreciate if we could share the results of the study when completed. A copy of the thesis will be forwarded to your Head Office.*

*You are free to express your viewpoint, as I can assure you anonymity and confidentiality of your name and the health service concerned. Kindly return the completed questionnaire to the zonal supervisor of your hospital. Hoping that 30 minutes of your precious time will be enough to complete this questionnaire.*

*Thank you for your participation.*

*Yours faithfully.*

NIC BASE LOWANE

(DOCTORAL STUDENT WITH UNISA)

# **ANNEXURE C**

## **LETTERS OF PERMISSION TO DO THE SURVEY**

GAZANKULU GOVERNMENT



GAZANKULU—REGERING

MFUMO WA GAZANKULU

DEPARTMENT OF HEALTH AND SOCIAL WELFARE  
PRIVATE BAG X628  
GIYANI  
0826

94.05.26

<b>Tsalwa:</b> <b>Ref. No.</b> S.5/4/3/16	<b>Swivutliso:</b> <b>Enquiries:</b> J.V Mufamadi	<b>Riqingho</b> <b>Tel No.</b> <b>Fax No.:</b> 23151X2028
---	---	---

**ATTENTION: SENIOR/NURSING SERVICE MANAGERS**  
 ELIM, LETABA, NKHENSANI, MALAMULELE, SHILUVANA AND TINTSWALO HOSPITALS

**RESEARCH PROJECT : LOWANE L.B.**

1. The above officer is undertaking a research project for a Doctorate degree in nursing Science with UNISA.
2. She is required to distribute questionnaires to Senior professional nurses working in the above hospitals.
3. You are requested to give her the necessary assistance during the exercise.
4. Your cooperation in the above matter is highly appreciated.

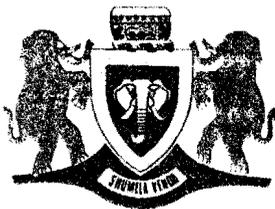
*[Signature]*  
 DIRECTOR GENERAL : HEALTH AND SOCIAL WELFARE  
 /rrm

For Information:

Mrs. L.B. Lowane

*[Signature]*

MUHASHO WA MUTAKALO  
NA  
VHULONDAVHATHU



RIHABULIKI YA VENDA  
REPUBLIC OF VENDA

DEPARTMENT OF HEALTH  
AND  
WELFARE

Li ngo:  
Ti phone: (015581) 21001/6

D si ya Thelegiramu: "MUTAKALO"  
Ti graphic Address:

N iborondaula: S 3/2/2  
R rence No. : .....

H rhudziswa: Nursing Section  
E riries: .....

Tshisagana tsha Poswo:  
Private Bag :X5009  
THOHOYANDOU  
VENDA

Riphabuliki ya Venda  
Republic of Venda

Fekisi:  
Fax No. (0159) 22274 .....

Mr . Lunic Base Lowane  
Le iba Hospital  
P. . Box 643  
LE IBA  
OE )

150 NOV 1988

RE IEST FOR PERMISSION TO UNDERTAKE A RESEARCH PROJECT.

I ereby acknowledge receipt of your request for permission to undertake a  
re arch project in our Nursing Institutions.

Th Matrons have no objection to this but request that you contact them at  
re ective hospitals to make the necessary arrangements.

Yo s faithfully

*[Signature]*  
DIRECTOR GENERAL : HEALTH AND WELFARE.

*[Signature]*  
pns.



**MMUŠO WA LEBOWA/LEBOWA-REGERINGSDIENS/GOVERNMENT SERVICE**

No. ya Tšhupetšo  
Verw. Nr./Ref. No.

DINYAKIŠISO S.V. Mokwena  
NAVRAE/ENQUIRIES:

No. ya Thelefono 0156 - 37100  
Tel. Nr. No.

Telex Nr./No.

**OFISI YA/KANTOOR VAN DIE/OFFICE OF THE**

Department of Health and  
Social Welfare  
Private Bag X04  
CHUENESPOORT  
0745

94-06-21

Mrs L.B. Lowane  
P.O. Box 643  
ETABA  
870



**PERMISSION TO UNDERTAKE A RESEARCH PROJECT**

This is to inform you that your request as stated above has been approved. You are allowed to visit our hospitals for the purpose of the study.

The department will however expect you to submit a copy of the report. Wishing you success in your project.

**DIRECTOR GENERAL  
DEPARTMENT OF HEALTH, SOCIAL WELFARE AND PENSIONS**

APPLICATION TO CARRY OUT NURSING RESEARCH

1.1. Personal details regarding researcher:

Name: ... LUNIC... BASE... LOWANE .....

Address: .. P.O. BOX.. 643.. LETABA.. 0870 .....

Employer: DEPT. OF HEALTH (GAZANKULU) official title: NURSING SERVICE MANAGE

Academic/Professional qualifications: GENERAL; MIDWIFERY, D.N.E....  
B.A.CUR.; HONOURS. B.A.CUR; MACUR.; ADMINISTRATION; COMMUNITY H.N.SCIENCE

1.2. Personal details regarding officials supervising the project.

Name: ... DR. V. J. EHLERS .....

Address: .. P. O. BOX.. 392.. PRETORIA.. 0001 .....

Rank: ..... SENIOR LECTURER .....

Station: ... UNIVERSITY OF SOUTH AFRICA .....

1.3. Details regarding the research if it is for study purposes.

Present course followed: DOCTORATE IN NURSING SCIENCE

Educational Authority: ... UNISA .....

Name of study leader: ... DR. V. J. EHLERS .....

Address of study leader: ... UNISA. P.O. BOX 392.  
PRETORIA 001 .....

2. Details regarding research project.

2. Research protocol/design attached -  YES  NO

2. Research instrument attached  YES  NO

2. Letter from the university attached  YES  NO

2. Facilities required:

2. Institutional/Extra institutional services: HOSPITALS  
.. ELIM.. MALAMULELE, NKHENSANI, LETABA;  
.. SHILYBANA... RHA... TINTSWALO .....

.....

.....

2. 2. Personnel (Specify)

SENIOR PROFESSIONAL NURSES WORKING  
IN THE HEALTH SERVICES MENTIONED IN  
ITEM 2.4.1

2. 3. Patients (Specify)

~~.....~~  
~~.....~~  
~~.....~~  
~~.....~~

2. 1. Records (Specify)

LIST OF NAMES FOR SENIOR PROFESSIONAL  
NURSES

3. Estimated time period for research:

Beginning 1993.02.01

End 1994.12.30

LUNIC BARRÉ LOWRNE

I agree to undertake the above project in accordance with the requirements mentioned in the application form.

I agree to carry out the project without incurring any expenses not budgeted for by the Department, and to bear the full responsibility for the project. Should it be necessary to deviate from any procedure or to terminate the project I shall notify the Secretary for Health and Social Welfare.

I undertake to obtain full consent from patients who are legally in a position to give this.

I agree to submit all the results of the project to the Secretary: Department of Health and Social Welfare.

I understand that the Department in granting permission for the execution of the project places itself under no obligation and will not necessarily grant permission for publication.

5. I assure that:

5.1. All information obtained will be treated confidentially.

5.2. That services will not be interrupted during the conduction of the project.

SIGNED: *Blow One* .....

DATE: 1994.05.19 .....

APPROVED BY: *[Signature]* .....

*[Signature]*  
SECRETARY: HEALTH AND SOCIAL WELFARE

DATE: 94 05 26 .....

# **ANNEXURE D**

## **GUIDELINES TO DEVELOP A COMPETENCY-BASED ORIENTATION PROGRAMME FOR A UNIT**

**ANNEXURE D****GUIDELINES TO DEVELOP A COMPETENCY-BASED  
ORIENTATION PROGRAMME FOR A UNIT****1. MISSION**

The mission of the orientation programme is to provide the desired skills and knowledge to enable a newly qualified registered nurse to perform competently in the clinical unit.

**2. COURSE OBJECTIVES**

- 2.1 To introduce the newly qualified nurse to the organisation, health personnel and work environment.
- 2.2 To enhance newly qualified nurses' competence development.
- 2.3 To orientate newly qualified nurses to specialty units (community health unit; psychiatric unit; midwifery unit; and general unit).
- 2.4 To develop an orientation manual for the future.

**3. COURSE POLICY**

- 3.1 The orientation process should address the individual's needs relative to the expectations of the specific work setting.
- 3.2 The course should follow androgogical and practically based approach.
- 3.3 A formal evaluation of the course by newly qualified nurses shall be done for programme justification.
- 3.4 Each clinical unit shall utilise specific competencies required of newly qualified nurses to perform in a safe, competent manner in the clinical unit concerned.

#### **4. TIME LINE AND LEVELS OF THE COURSE**

4.1 Course duration = 8 weeks.

4.2 The course shall consist of two levels.

##### **4.2.1 Level one - GROUP ORIENTATION SESSION**

1 week (first week of employment)

Methodology : Orientation classes.

##### **4.2.2 Level two - INDIVIDUAL UNIT ORIENTATION**

7 weeks

Methodology : Newly qualified nurse works with the preceptor.

#### **5. CRITERIA FOR PRECEPTORSHIP**

- ▶ communication skills
- ▶ leadership ability
- ▶ teaching ability
- ▶ dependability
- ▶ collaboration

#### **6. LEARNING RESOURCES**

- ▶ preceptors from each clinical unit (i.e. community health unit; psychiatric unit; midwifery unit; and general unit)
- ▶ “ideal” clinical units
- ▶ list of competencies for a particular unit
- ▶ technical equipment
- ▶ patients/clients

- ▶ clinical laboratories (demonstration rooms)
- ▶ classrooms

## **7. IMPLEMENTATION OF THE PROGRAMME**

- 7.1 One week (i.e. first week of employment) to be utilised for class sessions.
- 7.2 Second week of employment to be utilised for unit orientation outlined in the course content.
- 7.3 Third to eighth week: the newly qualified nurse interacts directly with a preceptor in her unit.
- 7.3.1 Three hours a day to be utilised for the learning of competencies (patient-centred or assimilation in the clinical laboratory).
- 7.3.2 Basic competencies should be given first priority, followed by the learning of technical or advanced competencies.
- 7.3.3 The preceptor and the newly qualified nurse should take similar work shifts, for continuity.
- 7.3.4 Delegation of work to the newly qualified nurse should be in accordance with the desired competencies.
- 7.3.5 The preceptor should organise a unit conference of one hour a week to share and deal with conflicts which may adversely affect the adjustment of a newly qualified nurse to the work environment.
- 7.3.6 During the seventh week the newly qualified nurse should be given a chance to manage a cubicle consisting of 10-12 patients (with allocated staff).
- 7.3.7 During the eighth week the newly qualified nurse should evaluate the effectiveness of the course, using an evaluation rating scale tool or an interview.

7.4 Preceptors and newcomers discuss the strengths and weaknesses of the programme.

## **8. EVALUATION METHODS**

8.1 Evaluation of the course by orientee.

8.2 Survey after six months by senior professional nurses supervising the newly qualified nurses.

8.2.1 Evaluate the following areas:

- clinical competency of newly qualified nurses
- preceptor effectiveness
- managerial support.

## 9. COURSE CONTENTS

### 9.1 Class sessions = one week

LEARNING OBJECTIVES	LEARNING RESOURCES	METHODOLOGY
Getting to know one another	Newly qualified nurses Preceptors	Preceptors facilitate self introduction Introduce oneself - personal, social, professional background, likes, future inspiration
Orientate newly qualified nurses to the course programme	Course programme List of competencies of various units	Preceptors explain the programme Preceptors discuss their roles, goals and needs for orientation with newcomers
Discuss organisational "values"	Organisational policies affecting nurses and nursing practices (both governmental and internal policies)	Preceptors apply the principle of openness, sharing values with the newcomers
Identify newcomers' learning needs	Competency checklists	Self-rating against checklists
Prioritise learning needs	List of competencies	Break-away session according to the four clinical units (community, psychiatric, midwifery and general units) Preceptors facilitate delineation of basic skills, technical skills and more complex competencies
Introduce newly qualified nurses to organisational surroundings	Clinical units Administration component Special departments i.e. X-ray, laboratory, kitroom, mortuary, and other places	Preceptors explain how they collaborate with these departments

## 9.2 Unit orientation - second week

LEARNING OBJECTIVES	LEARNING RESOURCES	METHODOLOGY
Assign newly qualified nurses to specific units	Clinical units Equipment Unit policies, objectives and unit mission Unit procedures manual Staff members Patients Unit records	Preceptors explain the unit set up, unit routines, staff members and unit rounds
Share unit "culture"	Staff members	Preceptor facilitates a unit conference
Explain the position of the newcomer in the unit hierarchy	Unit organogram Delegation schedule On-off roster	Preceptor explains the organogram
Introduce patients and their health problems (diseases)	Patients Patients' records (files)	Patient-centred learning Newly qualified nurse and preceptor identify areas in need of further consideration
Work out skill acquisition programme based on the identified needs (3rd-6th week)	Three hours per day Patients Clinical laboratory Preceptor Equipment	Demonstrations by the newcomer, preceptor guides when necessary

## REFERENCES

1. COONEY AT. 1992. An orientation program for new graduate nurse: The basis of staff development and retention. The journal of continuing education in nursing, 23(5):216-219.
2. HAMMERSTAD SM, JOHNSON SH & LAND LV. 1977. New graduate orientation programme. The journal of continuing education in nursing, 8(5):5-11.
3. O'GRADY T & O'BRIEN A. 1992. A guide to competency-based orientation. The journal of nursing staff development, 8(3):128-133.

**EVALUATION RATING SCALE**  
**OF THE ORIENTATION PROGRAMME FOR THE**  
**NEWLY QUALIFIED NURSE**

PLEASE COMMENT AND RATE HOW VALUABLE THE ORIENTATION PROGRAMME WAS IN DEVELOPING CLINICAL COMPETENCE.

(Place a tick next to your answer)

1. Comment on the length of the orientation.

Too short

Adequate

Too long

Motivate your answer if necessary .....

2. Indicate other comments/strengths/weaknesses of the programme.

2.1 Strengths:

.....  
.....  
.....

2.2 Weaknesses:

.....  
.....  
.....

2.3 Suggestions:

.....  
.....  
.....

THE ORIENTATION PROGRAMME HELPED ME TO	VERY VALU-ABLE	SOME-WHAT VALU-ABLE	OF LITTLE VALUE	OF NO VALUE
<ol style="list-style-type: none"> <li>1. become socialised into organisational culture</li> <li>2. acquire the desired unit competencies</li> <li>3. master problem-solving techniques</li> <li>4. implement the nursing process effectively</li> <li>5. use policies, procedure manual appropriately</li> <li>6. perform technical skills competently</li> <li>7. implement teaching principles satisfactorily</li> <li>8. communicate effectively with patients</li> <li>9. apply caring skills to provide basic nursing care</li> <li>10. recognise ethical implications when nursing patients</li> <li>11. maintain interpersonal relations with patients and other members in the unit</li> </ol>				

**ORIENTATION LIST OF COMPETENCIES TO BE  
MASTERED BY NEWLY QUALIFIED NURSES IN  
THE GENERAL NURSING UNITS**

COMPETENCIES	DESIRABLE	NOT DESIRABLE
<ol style="list-style-type: none"> <li>1. Formulate a nursing care plan</li> <li>2. Discriminate and synthesise information obtained from assessment</li> <li>3. Plan and organise one's work day</li> <li>4. Specify nursing intervention in order of priority</li> <li>5. Identify preventive actions to minimise patient risks</li> <li>6. Identify learning needs of nurses and patients</li> <li>7. Set objectives for teaching</li> <li>8. Use teaching strategies effectively</li> <li>9. Design educational programme for clients and nurses</li> <li>10. Produce clear and accurate reports</li> <li>11. Work with constraints e.g. shortage of staff</li> <li>12. Delegate aspects of care to peers</li> <li>13. Implement policies and procedures as needed</li> <li>14. Maintain accountability for own care</li> <li>15. Draft on-off duty roster</li> <li>16. Lead team conferences</li> <li>17. Evaluate own practice</li> <li>18. Manage conflict effectively</li> <li>19. Commit oneself to unit objectives</li> <li>20. Influence and leading others</li> <li>21. Be confident in nursing ability/practice</li> <li>22. Work under pressure</li> <li>23. Apply meaningful touch.</li> <li>24. Caring for a patient who is displaying anxiousness</li> <li>25. Support human dignity while engaging in professional practice.</li> <li>26. Respect patient's freedom of choice and decision making rights.</li> <li>27. Inform patient about their illness.</li> </ol>		

28. <b>Demonstrate knowledge of ethics of nursing</b>		
29. <b>Contribute to the growth of others by sharing knowledge and expertise.</b>		
30. <b>Recognise and Intervene in life threatening situations.</b>		
31. <b>Identify and intervene in deviations from normal behaviour.</b>		
32. <b>Function in appropriate role in fire/disaster procedures.</b>		
33. <b>Employ suicide precautions</b>		
34. <b>Employ medico-legal risk precautions</b>		
35. <b>Maintain immobilisation by tractions</b>		
36. <b>Perform gastrostomy feeding</b>		
37. <b>Perform venepuncture for I.V. infusion</b>		
38. <b>Care of intercostal underwater drainage</b>		
39. <b>Perform cardio-pulmonary resuscitation</b>		
40. <b>Prepare a patient for a special X-ray (I.V.P barium meal)</b>		
41. <b>Monitor a respirator</b>		
42. <b>Research nursing problems</b>		
43. <b>Do ward rounds with doctors</b>		
44. <b>Handle an emergency</b>		
45. <b>Pre and post operative care</b>		
46. <b>Supervision and delegation</b>		
47. <b>Communication skills.</b>		

**ORIENTATION LIST OF COMPETENCIES  
TO BE MASTERED BY  
NEWLY QUALIFIED NURSES IN THE MIDWIFERY UNIT**

COMPETENCIES	DESIRABLE	NOT DESIRABLE
1. Formulate nursing care plan for a woman in ANC and puerperium		
2. Discriminate and synthesise information obtained from assessment		
3. Specify nursing intervention in order of priority during first stage of labour		
4. Set objectives for teaching		
5. Use teaching strategies effectively		
6. Design educational programmes for the clients and nurses		
7. Produce clear and accurate reports		
8. Work with constraints e.g. time limits		
9. Delegate aspects of care to peers		
10. Implement policies and precedures as needed		
11. Evaluate own practice		
12. Manage conflict effectively		
13. Commitment to unit objectives		
14. Influence and leading others		
15. Exercise patience with demanding patients during labour		
16. Alleviate woman's pain during labour		
17. Demonstrate knowledge of ethics in nursing.		
18. Contribute to the growth of others by sharing knowledge and expertise.		
19. Be confident in nursing ability/practice		
20. Recognise and intervene in deviations from normal behaviour during pregnancy, labour and puerperium.		
21. Function in appropriate role in fire/disaster procedure		
22. Perform venepuncture for I.V. infusion.		
23. Perform cardio- pulmonary resuscitation		
24. Utilise ambubag resuscitator		

<b>26. Resuscitate a newborn baby</b>		
<b>27. Manage a cord prolapse</b>		
<b>28. Manage a woman with eclampsia</b>		
<b>29. Research Midwifery problems</b>		
<b>30. Perform a vacuum extraction</b>		
<b>31. Cutting and suturing episiotomy</b>		
<b>32. Detect fetal distress</b>		
<b>33. Seek assistance where necessary</b>		
<b>34. Conduct a delivery</b>		

**ORIENTATION LIST OF COMPETENCIES TO BE  
MASTERED BY NEWLY QUALIFIED NURSES IN  
THE COMMUNITY HEALTH NURSING UNIT**

COMPETENCIES	DESIRABLE	NOT DESIRABLE
1. Define a client's problem		
2. Formulate a nursing care plan		
3. Discriminate and synthesise information obtained from assessment		
4. Prioritise client's problems		
5. Record nursing diagnosis accurately		
6. Plan and organise one's work day		
7. Specify nursing intervention in order of priority.		
8. Demonstrate skills in effective communication		
9. Evaluate learning		
10. Organise role plays with clients		
11. Compose educational songs.		
12. Design educational programmes for the clients and nurses		
13. Implement policies and procedures as needed		
14. Maintain accountability from own care		
15. Evaluate own practice		
16. Manage conflict effectively		
17. Commitment to unit objectives		
18. Influence and leading others		
19. Apply meaningful touch		
20. Co-ordinate with other community services (church, creche and school)		
21. Demonstrate knowledge of the ethics of nursing		
22. Function in appropriate role in fire/disaster procedure		
23. Employ suicide precautions		
24. Perform venepuncture for I.V. infusion		
25. Prescribe medicines relevant to the condition		
26. Detect untowards symptoms of medication		
27. Perform episiotomy		

29.	Utilise ambubag resuscitation		
30.	Treat anaphylactic shock		
31.	Monitor a woman on pitocin drip		
32.	Resuscitate a newborn infant		
33.	Manage a cord prolapse		
34.	Manage a woman in 1st, 2nd stage of labour		
35.	Manage an emergency		
36.	Management and administration skills		
37.	Treating minor ailments		
38.	Decision making		
39.	Research Community health problems		

**ORIENTATION LIST OF COMPETENCIES TO BE  
MASTERED BY NEWLY QUALIFIED NURSES IN THE  
PSYCHIATRIC NURSING UNIT**

<b>COMPETENCIES</b>	<b>DESIRABLE</b>	<b>NOT DESIRABLE</b>
1. Assess patient's physical and psychosocial needs		
2. Define a patient's problem		
3. Discriminate and synthesise information obtained from assessment		
4. Specify nursing intervention in order of priority		
5. Identify preventive actions to minimise patient risk		
6. Evaluate learning		
7. Design educational programmes for clients		
8. Manage crisis intervention		
9. Manage stress		
10. Carry out admission and discharge of patients according to mental health act no.18 of 1973.		
11. Inform a patient about his progress		
12. Alleviate a patient's stress and anxiety		
13. Be confident in nursing ability/practice		
14. Function in appropriate role in fire/disaster procedure		
15. Check blood products for proper identification		
16. Research psychiatric nursing problems		
17. Perform a venepuncture for I.V. infusion		
18. Perform cardio-pulmonary resuscitation		
19. Prepare a patient for operation		
20. Dress wounds		
21. Collect specimen for investigation		
22. Insert an indwelling urinary catheter		
23. Manage a violent patient		
24. Medico-legal risks.		