

**A TRANSITION SUPPORT PROGRAMME TO FACILITATE THE
COMPETENCIES OF NEWLY QUALIFIED REGISTERED NURSES AT
PUBLIC HOSPITALS IN NAMIBIA**

A RESEARCH DISSERTATION SUBMITTED IN FULFILMENT OF THE
REQUIREMENTS FOR THE DEGREE OF

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BY

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ABSTRACT

Globally, competencies among newly qualified registered nurses (NQRNs) during transition have been described as a worldwide concern. Health care systems are becoming more demanding with patients and communities becoming more aware of their rights to health care. Therefore, NQRNs are expected to be competent to deliver quality and safe care. It is, therefore, important that transition support programmes are put in place to provide a baseline for the guidance and support of newly graduated nurses. The study was aimed at determining the competence of NQRNs and to develop a transition support programme to facilitate their competencies at public hospitals in Namibia. The objectives of the study were: to determine and describe the self-reported competence of newly qualified registered nurses, determine and describe the views of newly qualified registered nurses competence as rated by their unit managers, to develop a conceptual framework that informs the development of the programme, to develop the transition support programme to facilitate the competencies of newly qualified registered nurses, and to propose guidelines regarding the implementation of the programme. The study was conducted in three phases. Phase one was a situational analysis, followed by the development of a conceptual framework in phase two, and the development of the transition support programme in phase three. A quantitative approach with descriptive, analytic survey design was followed. Data were collected from the two study populations by means of questionnaires. Data were analysed using the Statistical Package for the Social Sciences software, version 24. The study findings were as follows:

In relation to professional, ethical and legal competencies (**domain 1**) of NQRNs, the different items reviewed on the NQRNs indicated that they were not completely competent in this domain. Similarly, the responses from unit managers supported these responses, with the unit managers indicating that NQRNs were not completely competent in the professional, legal and ethical domain, but rather possess basic competencies.

Findings on domain 2: Knowledge-based practice

This domain summarised the clinical competencies of NQRNs in relation to the provision of nursing care based on knowledge base practice. This study revealed that NQRNs are not completely competent in most clinical areas, but rather possess basic or adequate knowledge.

Findings on Domain 3: This domain reviewed the NQRNs competencies in management and leadership. The findings reveal that NQRNs are not completely competent, but rather possess either basic or little knowledge.

Recommendations were made to the Ministry of Health and Social Services (MoHSS), education institutions, and suggestions for further research were made based on the study findings.

LIST OF PUBLICATION(S)/CONFERENCE(S) PROCEEDINGS

Emvula, O. (2016). *Perceptions of registered nurses regarding their role of clinical teaching of student nurses at state training hospitals in Windhoek, Namibia*. Research Thesis. University of Namibia.

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LIST OF ABBREVIATIONS AND ACRONYMS

ANA: American Nurses Association

HPCNA: Health Professions Council of Namibia

ICN: International Council of Nurses

HEIs: Higher Education Institutions

IUM: International University of Management

MoHSS: Ministry of Health and Social Services

NCHE: National Council of Higher Education

NCSBN: National Council State Boards of Nursing

NQRNs: Newly qualified registered nurses

QA: Quality assurance

SANC: South African Nursing Council

UNAM: University of Namibia

WHO: World Health Organization

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DEDICATION

This study is dedicated to all newly qualified registered nurses in Namibia who endured the demanding, yet rewarding nursing journey. I hope and trust that this programme will ease your transition!!

DECLARATIONS

I, Olivia Emvula, hereby declare that “**A transition support programme to facilitate the competencies of newly qualified registered nurses at public hospitals in Namibia**”, is a true reflection of my own study and has not been submitted for any degree at any other university.

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Olivia Emvula 

Date...09/.2020...

CHAPTER 1

INTRODUCTION AND BACKGROUND OF THE STUDY

“It is such a tricky transition between education and work”.

James William Middleton

1.1. INTRODUCTION

Namibia, officially the Republic of Namibia, is a country in southern Africa. Namibia shares its borders with **Angola** in the north, **Zambia** in the northeast, **Botswana** in the east, **South Africa** in the southeast and south and the Atlantic Coast in the west. (Kimutai, 2017).

Namibia is demarcated into 14 regions, namely Zambezi, Kavango East, Kavango West, Kunene, Omusati, Ohangwena, Oshana and Oshikoto regions in the north, the Omaheke. Otjozondjupa, Erongo and Khomas regions in the central areas; and the Hardap and Kharas regions in the south (see Figure 1.1).

This study was conducted at the three intermediate hospitals in three of the regions, namely, Khomas, Oshana and Okavango East regions, because these hospitals are between the district and national level, which provides both secondary and tertiary health care. Because of the services they render, they have a broader staff establishment and are likely to employ more NQRNs. Figure 1.1 shows a map of Namibia indicating the different regions where the study was conducted.

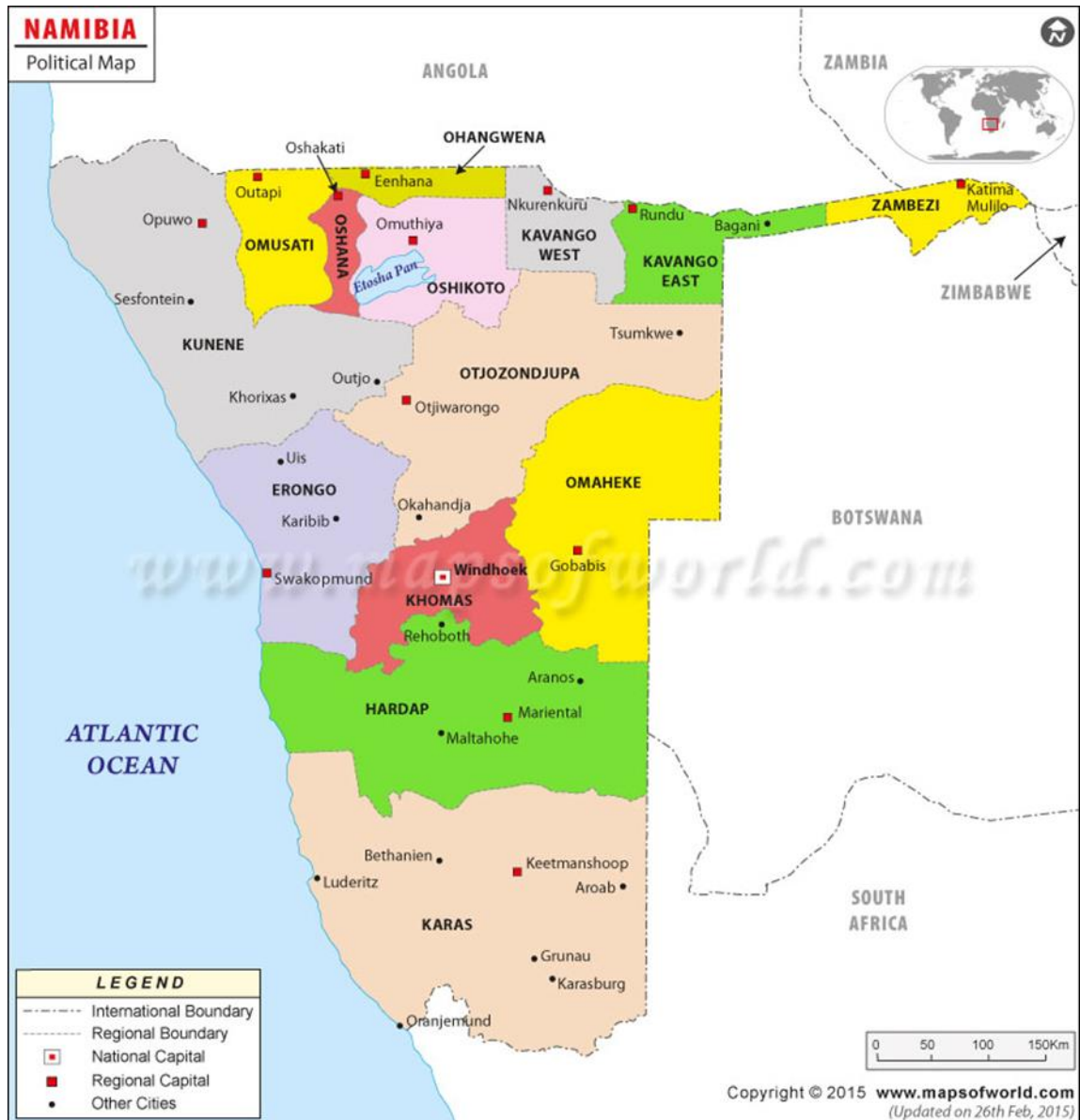


Figure 1.1: Namibian map

Source: Maps of World (2015)

Health services in Namibia were established in the 1890s and were exclusively of a curative nature, with preventative health care limited to childhood immunisations and maternal health check-ups. Before Namibia gained independence in 1990, health care was racially biased and mainly urban-centred, with the rural areas, especially in the northern

parts of the country, served by churches, mainly the Catholic and Lutheran denominations (MoHSS, 1998).

At independence, the Government made deliberate efforts to focus on primary health care and to transform the health care system from an urban-based curative service to community-based preventative service. The Government identified six key areas in line with the primary health care principles, namely preventative, curative, promotional, rehabilitative, accessible and affordable (MoHSS, 1998).

Today, the country has a well-developed health infrastructure network comprising 295 clinics, 47 health centres, 30 district hospitals, three intermediate hospitals and one national referral hospital, private hospitals and clinics (MoHSS, 2011). The public health sector is structured in a three-tier hierarchy with national, regional and district levels. Most Namibians (84%) receive their health care services from the public facilities (MoHSS, 2011).

In addition, the private sector continues to play a key role in the provision of health services in Namibia. The private sector is regulated by the Hospitals and Health Facilities Act (36 of 1994), through the provision of licences for health care delivery to complement the services of the public sector.

The mission of MoHSS in Namibia, according to its 2009-2013 strategic plan, is “to provide integrated, affordable, accessible, quality health and social welfare services that are responsive to the needs of the Namibian population” (MoHSS, 2009, p. 5). The MoHSS identified five key factors in ensuring the health of the Namibian nation. These

include access to standardised clinical services and following accepted protocols and guidelines. It also outlined health services that are designed to support existing health systems, structures and providers; access to health services that are coordinated across agencies and sectors to achieve maximum impact. In addition, health services should be based on relevant primary health care principles and services that are designed, developed and guided by the ongoing, coordinated collection, analysis and utilisation of relevant public health data (MoHSS, 2009).

The delivery of health care in Namibia is undergoing dynamic changes, as the public is becoming more aware of their right to quality health care. Therefore, there is a need to reorganise the delivery of health care. It is against this background that MoHSS acknowledges the call for efficient and quality health care delivery. Therefore, competent health workers are required to safeguard quality health care to the patients and the public.

1.2. BACKGROUND TO STUDY

The researcher, as a nurse educator, heeded the call by MoHSS to assist in addressing quality nursing care in the country. Following this call, the researcher was motivated to explore how NQRNs cope with the expectation of quality health care by focusing on the assessment of their competencies when they get employed.

The education and training of a student nurse to become a registered nurse and midwife in Namibia takes three-and-a-half years for a Diploma in General Nursing and Midwifery and a minimum of four years for a Bachelor's Degree in Nursing Science. Three

universities in Namibia offer the Bachelor's Degree in Nursing, while MoHSS, through its training centres, offered a registered nurse's diploma course, which phased out in 2019.

A student nurse usually performs clinical duties under the supervision of lecturers, clinical instructors and/or qualified registered nurses in a clinical environment. However, after completing studies, the NQRN is expected to fulfil the roles of a registered nurse within the professional, ethical and legal frameworks of the profession outlined in the Nursing Act, No.8 of 2004 and the scope of practice of a registered nurse (Republic of Namibia, 2004).

The cardinal roles of a registered nurse in Namibia include administrative, clinical, professional and educational duties. The scope of practice of a registered nurse includes the scientific application of the principles of nursing, the prevention of illness and the care of patients during illness, which include the scientifically based physical, psychological, social, educational, chemical and technological means applicable to health care practice (Nursing Act No. 8 of 2004, Government Notice, No. 206).

After completing studies, any newly qualified graduate assumes the role of a newly registered nurse, facing the expectations connected to that role and which form part of the transition to a professional role.

Transition is defined as the period during which an individual moves and adjusts to a new role to become confident and competent with various aspects of the role such as knowledge, skills and attitudes (Henderson, Cooke & Creedy, 2012).

Competence, as an expectation after transition, refers to the ability to perform as effectively and satisfactorily is expected within the new role (Medical Dictionary, 2018). It is further described as the knowledge, skills and abilities that enable a person to act effectively in a job or situation (International Council of Nurses (ICN), 2009). This definition perfectly applies to the newly qualified nurse as they are expected to, within their new role, take up new tasks and competently perform them.

Globally, competencies of NQRNs during transition have been described as a worldwide concern. NQRNs often lack the competence to efficiently execute their professional roles and responsibilities (Jonsen, Melender, & Hilli, 2012), and several reasons were given as evidence. For example, Whitehead and Holmes (2011) report that NQRNs may fail to execute their nursing functions and make clinical judgement because of lack of confidence.

They further report that the transition from a student to a newly qualified nurse comes with additional pressures (Whitehead & Holmes, 2011). For example, newly graduated nurses may experience an extensive range of emotions, such as anxiety, fear, depression, emotional exhaustion, helplessness, feeling of immense time pressures, and despair (Ebrahimi, Hassankhani, Negarandeh, Gillespie & Azizi, 2016).

Obviously, these pressures will have an impact on the NQRNs' ability to render quality nursing care, as they are still trying to integrate the theory into practice. In addition, NQRNs may possess theoretical knowledge, but often lack the organisational and clinical skills necessary to function independently as registered nurses. Therefore, NQRNs often

face challenges in effectively applying knowledge, skills and judgement in their daily practice as registered nurses.

Furthermore, it is a global concern that after completing training, NQRNs do not have the experience they are supposed to have as registered nurses, yet are expected to cope within very challenging situations, where they are required to fulfil clinical roles expected of experienced nurses. They also often face challenges in effectively applying knowledge, skills and judgement in their daily practice as registered nurses and often lack competencies to efficiently execute their professional roles and responsibilities.

Literature on NQRNs' competencies in Africa is relatively limited. However, a study conducted in South Africa, found that NQRNs lacked clinical competencies to practice as registered nurses (Dlamini et al., 2014). In addition, employers in the public and private health sectors need registered nurses who are competent in their roles and who can render quality care to patients and the communities. Therefore, the responsibilities, competencies and skills expectations of NQRNs are escalating (Sun, 2014).

A study in Namibia reported that some NQRNs were not competent in certain clinical areas (Small & Pretorius, 2015), which could be attributed to a lack of transition support programmes, especially at public hospitals, to help NQRNs cover the theory-practice gap.

Notwithstanding, the issue of NQRNs' competencies remains a global concern and the nursing profession has acknowledged the practice competency gap between the technical, cognitive and communication abilities of newly qualified nurses and the requirements of

the health care industry (Reinert, Bigelow & Kautz, 2012). The researcher believes that the competency gap can be addressed through a transition programme for NQRNs.

Most private hospitals in Namibia have transition support programmes for NQRNs. For example, at Rhino Park Private Hospital; NQRNs go through a formal transition programme for six months. During this time, NQRNs are supported to enable them to gain confidence within practice. Formal competency-based programmes are designed to close the theory-practice gap. Under such a programme, the NQRNs work under the direct supervision of an experienced registered nurse during the transition period (Alna Louw, Training officer, Rhino Park Private Hospital, personal communication, 2018).

On the other hand, at public hospitals in Namibia it is generally accepted that NQRNs are competent to start working with patients immediately after obtaining their nursing qualifications. Although NQRNs receive general orientation, there is a lack of a formal competency-based transition support programme. In addition, because of staff shortage at most public hospitals in Namibia, NQRNs do not always work under the supervision of experienced registered nurses, but rather must cope on their own.

The remoteness of some health care facilities in Namibia complicates this situation more in that NQRNs are deployed to remote public health care facilities where they confront complex situations that call for a high level of clinical judgement without the support of other health professionals. Yet, NQRNs often face challenges of effectively applying knowledge, skills and judgement in their daily practice as registered nurses, and often lack

competencies to efficiently execute their professional roles and responsibilities, which may compromise the quality of nursing care.

Professional competency is a fundamental concept in nursing. Therefore, lack of competence among NQRNs can have far-reaching consequences, not only for the nurses themselves, but also for the health care system. In addition, lack of competence might negatively affect quality improvement of patient care and public health. This may further put the NQRNs at risk of legal issues associated with lack of due care. Literature clearly indicates that NQRNs need assistance during their transition into practice to facilitate their competencies to deliver safe practice to patients and clients (Karami, Farokhzadian & Foroughameri, 2017).

1.3. PROBLEM STATEMENT

Employers generally expect the employees, in this case NQRNs, to be competent practitioners from the time of their employment. Kanyenze and Lapeyre (2012) report that Namibian employers pointed out that there is a disparity between skills required by employers and those delivered by graduates.

In Namibia, as elsewhere, employers raised concerns about graduate competence (Links, 2010). Various employers in Namibia reported that graduates often do not fully possess the type of attributes and competences essential for the workplace. For example, a report by Business Intelligence Africa (2018) revealed that 52% of employers believe that Namibian graduates are poorly or very poorly trained for the job market. According to

this study, only 6% of employers think that local graduates are well equipped for the general job market (Nakashole, 2018). This observation is echoed by the Namibian National Council for Higher Education (2011), which states that graduates are often not adequately prepared for work. Kanyenze and Lapeyre (2012) also report that Namibian employers have indicated that there is a disparity between skills required by employers and those delivered by graduates. However, these findings were too general, as no reference was made to a specific field.

The researcher, while doing clinical practice with student nurses, also heard staff at public hospitals comment that some NQRNs lack core competencies to practice as registered nurses. Although there is a general perception among employers in Namibia that graduates lack competence, the researcher could not locate a study that has investigated NQRNs' competencies in the Namibian context. Therefore, the researcher deemed it necessary to conduct a study to gain evidence-based knowledge regarding the status of NQRNs' competencies in Namibia.

As a result, the researcher noted two main gaps in literature. First, uncertainty regarding NQRNs' competencies at public hospitals in Namibia; and second, little is known regarding what could facilitate NQRNs' competencies in the workplace.

The problem is that if NQRNs lack competencies, it can compromise the quality of patient care in Namibia and elsewhere (Health Professions Council of Namibia (HPCNA), 2010). Patient safety is also at risk, hence the vision of HPCNA of protecting the public is

possibly not being realised (Amoomo, 2014). Considering the background given, the researcher was prompted to ask the following questions:

- How prepared are NQRNs to take up their role as registered nurses?
- What support do NQRNs require to facilitate their competencies during transition?

1.4. PURPOSE OF THE STUDY

The aim of the study was to determine the competencies of NQRNs and by doing so, gain evidence to develop a transition support programme that can facilitate the development of these competencies in the new graduates at public hospitals in Namibia.

1.5. OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Determine the self-reported competencies of newly qualified registered nurses at public hospitals in Namibia;
- Describe the self-reported competencies of newly qualified registered nurses at public hospitals in Namibia;
- Determine the views of unit managers at public hospitals in Namibia regarding the competencies of newly qualified registered nurses;
- Describe the views of unit managers at public hospitals in Namibia regarding the competencies of newly qualified registered nurses;

- Develop a conceptual framework to inform the development of the transition support programme;
- Develop a transition support programme to facilitate the competencies of newly qualified registered nurses at public hospitals in Namibia;
- Propose guidelines for the implementation of the transition support programme.

1.6. SIGNIFICANCE OF THE STUDY

This study strived to address the gap in research literature regarding the competencies of NQRNs at public hospitals in Namibia. The study contributed to the facilitation of competencies of NQRNs by developing a transition support programme. An assessment of the competencies of NQRNs gave a better understanding of the competency gap, which guided the development of a transition support programme. Such a programme is important in preparing NQRNs in Namibia for their professional role and in improving the quality of nursing care. Therefore, the study is in the interest of nursing practice, nursing education and patient care.

1.7. PARADIGMATIC PERSPECTIVE OF THE STUDY

Polit and Beck (2014) describe a paradigm as “a worldview, a general perspective or a way of breaking down the complexity of the real world”. Basing on the positivist paradigm, the research aimed at understanding the theory-practice gap among NQRNs in

Namibia. The study was quantitative in nature, using deductive reasoning (Polit & Beck, 2014).

This study was based on the transformative worldview, which holds that research inquiry should contain an action agenda for reform that may change the lives of the participants (Creswell, 2014). Moreover, specific issues such as empowerment needed to be addressed. Therefore, this approach enabled the researcher to ultimately empower NQRNs, who are expected to be competent immediately following graduation, by developing a transition support programme to improve their competencies.

In this study, the framework is formed based on assumptions. The latter are statements that are regarded true although they have not been empirically tested (Gray, Grove & Sutherland, 2017). In this study context, the following assumptions were made.

1.7.1. Meta-theoretical assumptions

Lor (2014) describes meta-theoretical assumptions as theories that influence research decisions throughout a study and serve as a framework within which theoretical statements are made. The following meta-theoretical assumptions were made:

- **Environment** refers to the hospital wards where NQRNs are working. It is, therefore, assumed that the transition support programme would help the NQRNs gain competencies needed to render quality and safe nursing care.

- **Health**, as per last definition of WHO, refers to the state of complete physical, mental and social well-being and not merely the absence of disease and infirmity (WHO, 2005), implying that physical, mental and social health are inseparable. The transition support programme would be an intervention to enable the NQRNs in Namibia to render comprehensive, holistic and competent, quality care to patients as defined in the concept “health”.
- **Nursing**, in this study context, refers to the tasks or care rendered by a nurse. In this regard, it refers to those nursing procedures that NQRNs must execute competently. However, the assumption is that in reality NQRNs might face challenges in executing these tasks.
- **Persons** in this study refer to the unit managers, NQRNs and the patients. The NQRNs are transitioning from students to experienced registered nurses. It is assumed, as previously elaborated on, that NQRNs need support to demonstrate acceptable performance according to their scope of practice. It is also assumed that they lack core competencies to practice as registered nurses. Thus, the researcher assumed that while in transition, NQRNs needed support to facilitate their competencies in executing their roles and responsibilities.

In this regard, the following assumptions apply:

1.7.2. Ontological assumptions

Ontological assumptions refer to the inquiry about the realities as constructed by individuals (Polit & Beck, 2017). Thus, the research question that needs to be answered is: “What is the nature of reality as perceived by the research participants in various situations?” There is, however, no single reality, but multiple realities an individual constructs from their own perception and interpretation of a given phenomenon.

In this study context, there are NQRNs who are in transition to gain experience as registered nurses without the necessary support programme (Edmonds & Kennedy, 2013). The reality is that NQRNs may possess theoretical knowledge accrued during their study, but they may lack the core competencies in nursing practice. It is also true that NQRNs need to be supported to improve their competencies for them to deliver quality nursing care. It is for this reason that a situational analysis was done to answer the research questions regarding the NQRNs’ competencies.

1.7.3. Epistemological assumptions

Epistemology refers to the way the researcher, as an inquirer, interacts with those being researched and the findings which would result from this interaction process, and the relationship between the inquirer and the participants (Yilmaz, 2013). In the context of this study, the researcher, as a nurse lecturer at one of the Namibian academic institutions that train student nurses, is, therefore, concerned about the clinical competence and readiness of NQRNs.

1.7.4. Axiological assumptions

Axiological assumptions refer to the role of values in the inquiry on hand (Polit & Beck, 2017). It further addresses the values that are closely related to ethical considerations of a study. In this study context, the researcher abided by the ethical code and principles of the University of Namibia (UNAM) and MoHSS.

The values of the study refer to the development of a transition support programme to facilitate the competencies of NQRNs, which could add value to nursing practice. Therefore, the knowledge acquired on the NQRNs' competencies informed the researcher on the support they required and enabled the researcher to develop the transition support programme.

1.7.5. Methodological assumptions

Methodological assumptions are ways of knowing about the reality of the research inquiry (Malinga, Gordon, Jewitt & Lindborg, 2016). Methodological assumptions describe the research process and right methods undertaken to conduct a research project. Regarding this study, a quantitative research process was deemed most appropriate. The full methodology of the study is described in Chapter 3.

1.8. THEORETICAL BASIS OF THE STUDY

This study used different theories and frameworks to guide the development of the transition support programme, such as:

- The generic competency framework of registered nurses/accoucheurs in Namibia (HPCNA, 2018).
- The programme logic model (Knowlton & Phillips, 2013).
- Humanistic-existential philosophical approach (Khatib, Sarem, & Hamidi, 2013).
- Knowles' adult learning theory (Knowles, 1984).
- Bloom's taxonomy of learning (Cook, 2013).
- Nicholls & Nicholls Cyclical Curriculum Model (Nicholls & Nicholls, 1978).

The above will be briefly discussed below.

- **The generic competency framework of registered nurses/accoucheurs in Namibia**

The study tools, as well as the content of the transition support programme, were based on the Namibian competency framework for registered nurses and midwives/accoucheurs.

- **The programme logic model**

This model informed the researcher on the design of the programme. The components of the model guided the researcher on the steps to follow in programme development.

- **Humanistic-existential approach**

The researcher developed the programme within the philosophy of humanistic-existentialism. The humanistic-existential approach focuses on the learner as first a human being, and then considered a learner. Therefore, first, the researcher based this programme upon the awareness of the dignity and rights of NQRNs as unique human beings with each person on a path of self-actualisation. Second, the researcher was cognisant that NQRNs'

feelings and aspirations should be respected with attention given to the emotional side of learning, leading to the development of positive self-concept and self-esteem, which in turn develops self-efficacy.

- **Knowles' adult learning theory**

This theory represents adult learning principles and was, therefore, deemed appropriate to guide the implementation of the envisaged transition support programme.

- **Bloom's taxonomy of learning**

To ensure clinical excellence, the Bloom's taxonomy of learning domains were applied in developing the content of the transition support programme. This taxonomy was deemed appropriate as NQRNs are expected to possess different levels of cognitive, affective and psychomotor skills to deliver quality and safe nursing care.

- **Nicholls & Nicholls cyclical curriculum model**

The steps in this model were adopted to guide the researcher in the implementation of the transition support programme.

1.9. DEFINITION OF KEY CONCEPTS

The following definitions apply to concepts in this study:

- **Accoucheur** means a male midwife as described in the Namibia Nursing Act No. 8 of 2004. Namibia training includes midwifery in the undergraduate programme, therefore, all Namibia-trained NQRNs have midwifery as a qualification.
- **Competencies** refer to the effective application of knowledge, skills and judgement demonstrated by someone in daily practice or job performance (ICN,

2009). In this study, it refers to the capability of NQRNs to adequately perform those duties directly related to patient care. However, this study only focused on professional, legal, ethical, clinical, provision of care, and management and leadership competencies of NQRNs.

- **Facilitate** means to make something easy or better (American Heritage, 2014). In this study context, it refers to the actions in the transition support programme that could be performed to enhance the competencies of NQRNs.
- **Framework** indicates the structure that supports or encloses something (Medical Dictionary, 2018). In this study, it refers to the schematic presentation of concepts, which would guide the implementation of the transition support programme.
- **Programme:** this is a specified sequence of courses and other educational experiences that lead to specified outcomes. Certificates or degrees are awarded at the completion of all courses and other requirements in a programme (WHO, 2016). According to this study, programme refers to a set of planned activities proposed to facilitate the competencies of NQRNs.
- **Registered nurse** refers to a person registered as such in terms of section 20, or regarded to be so registered in terms of section 64 of the Namibian Nursing Act, No. 8 of 2004 (Republic of Namibia, 2004). This study focuses on NQRNs with more than six months, but less than two years' experience as registered nurses.
- **Transition** is defined as a period during which an individual moves and adjusts to a new role to become confident and competent with various aspects of the role such as knowledge, skills and attitudes (Henderson et al., 2012). The concept in

this study refers to the process NQRNs undergo between the six months and two years after graduation.

- **Unit managers** are those registered nurses who oversee the patient wards where NQRNs are working. They are responsible for the management of patient care, all nursing staff in the unit, and the resources related to health care delivery in the unit (Armstrong, Rispel & Penn-Kekana, 2015). In the context of this study, the nursing unit managers are senior nurses registered with HPCNA and employed as unit managers in charge of various departments in the hospital.

These concepts are extensively elaborated on in Chapter 2 under literature review.

A quantitative approach with descriptive, analytic survey design was followed. Data were collected from the two study populations by means of questionnaires. The study was a multi-phased study conducted in three phases. In phase one, a situational analysis was done, followed by the development of a conceptual framework in phase two, and the development of the transition support programme and guidelines on the implementation of the transition support programme was presented in phase three. Next is an outline of the study.

1.10. **OUTLINE OF THE STUDY**

The study comprises the following chapters:

Chapter 1: Introduction and background of the study, which focuses on the introduction and background of the study, the problem statement, aims and objectives, the

paradigmatic perspective, significance of the study and definition of key concepts used in the study.

Chapter 2: Literature review indicates the main topics related to NQRNs' competencies at global, regional and national levels. The chapter also gives a brief overview of the conceptual framework and the theoretical perspectives guiding the study.

Chapter 3: Research methodology outlines the research design, population, sample and sampling method and data collection procedures. Data analysis and ethical considerations are also presented in this chapter.

Chapter 4: Presentation of research findings. This chapter presents the data obtained during the situational analysis for phase 1.

Chapter 5: Discussion of study findings

Chapter 6: Development of the conceptual framework of the study. In this chapter, the researcher developed a conceptual framework to guide the development of the transition support programme.

Chapter 7: Development of the transition support programme. Chapter 7 details the development of a transition support programme for facilitating the competencies of NQRNs

Chapter 8: Conclusions, recommendations and limitations of the study

In this chapter, recommendations, conclusions and limitation of the study are discussed. The application of the transition support programme to facilitate the competencies of

NQRNs is elicited. In addition, the researcher recommends areas of further research and makes concluding remarks on the study.

1.11. **SUMMARY**

This chapter discussed the introduction and background to the problem, and the research aim and objectives. It also outlined the assumptions that guided the researcher. A detailed review on related literature follows in Chapter 2. The theoretical framework was briefly mentioned, followed by the operational definitions applicable to the study. The chapter outline was also presented.

CHAPTER 2

LITERATURE REVIEW

“Literature adds to reality; it does not simply describe it.” C. S. Lewis

2.1. INTRODUCTION

An overview of the study was provided in the previous chapter (Chapter 1), where the problem, research questions and objectives were highlighted. The lack of competencies among NQRNs seems to be a phenomenon of global concern, and Namibia is no exception. In this chapter, relevant literature on competencies of NQRNs globally and nationally is discussed.

Through literature review, the researcher enriched her knowledge of the subject area by following a systematic and explicit approach to the identification of different existing competency frameworks (Brink, Van der Walt & Van Rensburg, 2018), to reveal the gaps in the literature pertaining to NQRNs’ competencies in Namibia. The literature further gave the researcher a clear understanding of the nature and meaning of the research problem (De Vos, Strydom, Fouche and Delpont, 2016) discussed in Chapter 1 of the study.

2.2. CLARIFICATION OF RELATED CONCEPTS

Though the key concepts were defined in Chapter 1, it is imperative to clarify the *key concepts* within the context of the study and to point out the differences between the related concepts that form the basis of this study and that are sometimes used interchangeably, although there are differences in meaning. These concepts are: *competencies, competence, and competent*.

Competency

Competency relates to the expected level of performance of the registered nurse and includes knowledge, skills, abilities and clinical judgement (American Nurses Association (ANA), 2013). In other words, “competency” is a measure of registered nurse competence, which indicates how well the nurse works and the type of professionals they are (Daniels & Jooste, 2018). In other words, a nurse with the necessary competencies can be regarded as competent in their role.

The *competencies* of NQRNs are important in health care, as they relate to professional standards, patient safety and the quality of nursing care. Nurses need to have specific *competencies* to meet the standards of nursing practice. This implies that the nurses should perform their duties according to set standards, which are measured and regarded as competencies (Daniels & Jooste, 2018).

According to Daniels and Jooste (2018), *competencies* reflect professional recognition and the ability of the nurse to deliver a specified professional service, using cognitive,

affective and psychomotor skills effectively. It is also referred to as the state of having knowledge, judgement, skills, experience and motivation to adequately address the demands of one's professional responsibilities (Armstrong & Barton, 2013).

Searle et al. (2009) view *competencies* in nursing as the comprehensiveness of a nurse's knowledge and ability to perform skills in a proficient and effective manner. In other words, *competencies* can be regarded as the outcomes and expectations of clinical training and experience. The latter, therefore, requires registered nurses to continually enhance their knowledge, skills and intellectual abilities (Quinn & Hughes, 2013) to enable them to solve problems and make sound judgements in clinical practice.

Literature further reaffirms that adequate nursing *competencies* are evident in changing and improving patient care. Moreover, most employers expect NQRNs to be prepared to perform a wide range of functions and have the skills to provide safe care. However, employers are often concerned that new graduates cannot competently perform basic clinical tasks or that their education and work competencies are disconnected, which can result in negligence that compromises patient safety (Denolle, Fan & Shearer, 2015).

Moreover, the standard of professional practice and conduct of all categories of all nurses and midwives or accoucheurs in Namibia are set to be improved continuously (Nursing Act, No. 8 of 2004), hence the focus of the researcher on a transition support programme that might facilitate the *competencies* of NQRNs in Namibia.

Competence

Competence, on the other hand, refers to cognitive and psychomotor skills, attitudes and the ability of nurses to perform their duties effectively (Scanlon, 2017). NQRN training is designed such that they attain these skills which are the main domains of learning in nursing.

Following is a description of the different domains that are key in nursing practice, namely:

- **Knowledge (cognitive skills)**, which imply that NQRNs should demonstrate the knowledge acquired during their training by acting intellectually in all activities, such as thought, recall, decision making, and drawing conclusions. In this domain, the NQRNs use previous experiences, prior knowledge, and perceptions to give meaning to new information or to modify previous thinking. The nurses also use their cognitive abilities when giving information to the patient and family about the disease process, prevention, and medication regimen, etc. (Mogotlane, Mokoena, Chauke, & Joung, 2018).

In addition, the NQRNs should be able to use their cognitive abilities to process information, ask questions and make decisions. Most importantly, they must be able to use information to solve clinical problems by creating new approaches (Mogotlane et al. 2018).

- **Attitudes and behaviours (affective skills)**

These skills are very crucial for NQRNs, as they revolve around attitudes, characteristics and values. For example, nurses should show interest in their patients and the communities

they serve. Moreover, NQRNs should demonstrate the ability to act consistently, according to the nursing values and philosophy, and commitment to ethical practice. They should conform to the ethical, professional and legal standards of the profession (Mogotlane et al., 2018).

- **Psychomotor skills**

Psychomotor skills refer to those technical skills that are performed in rendering nursing care, such as taking blood pressure, performing head-to-toe assessments, putting in intravenous lines, and administering intramuscular injections. Nursing is a practice-oriented profession, therefore, the acquisition of skills forms an important part of nursing practice.

Becoming competent in essential nursing skills is fundamental to safe, effective nursing practice, however, it requires training, commitment and practice. It is, therefore, assumed that NQRNs have acquired these skills during their training, as competence is measured by adherence to basic principles of safe technique, correct sequencing, accuracy, precision and efficiency.

Being *competent* means to have the ability to perform skills in an efficient and effective manner (Ragg, 2011). However, being competent is a legal requirement for nursing practice; hence employees expect NQRNs to be competent in the execution of nursing duties and to deliver quality nursing care. Therefore, it can be concluded that competence

is one of the fundamental aspects of professional practice as it covers the three domains of being competent and proficient (Ragg, 2011).

2.3. COMPETENCY FRAMEWORKS FOR REGISTERED NURSES

Different nursing boards/councils and associations across the world have competency frameworks that describe different competencies with their specific set of behavioural indicators and measurement criteria for registered nurses. Similarly, different other nursing organisations have published frameworks to provide direction for the assessment of competencies of registered nurses. These competencies are mainly spread across domains that highlight essential activities required of the registered nurse. Examples of these organisations are the Canadian Council of Registered Nurse Regulators (2012), Code of Professional Conduct for Registered Nurses Midwives in Brunei Darussalam (Nursing Board of Brunei, 2013), and the South African Nursing Council (2005).

Next is a brief description of some of the competency frameworks.

2.3.1. International Council of Nurses framework

ICN's framework of competency identifies specific dimensions of registered nurses' competencies expected from the newly qualified professional nurse on entry into employment (ICN, 2009). The framework groups the competencies under three headings, namely: professional, ethical and legal practice, care provision and management, and professional, personal and quality development. These competencies are for registered nurses working in specialist clinical roles (ICN, 2009).

2.3.2. Singapore Nursing Board

According to the Singapore Nursing Board, registered nurses use evidence-based nursing knowledge and judgement to assess health needs, provide nursing care, educate clients and support individuals to manage their health. Registered nurses are accountable for their scope of practice and may practice in a variety of clinical contexts depending on their educational preparation and clinical experience (Singapore Nursing Board, 2018). They present a set of broad guidelines that outline the requisite qualities, attributes and skills for registered nurses. These competencies are additional to standard of practice for nurses and midwives and set the basis for registered nurses to maintain their competence and to acquire additional competencies to deliver safe patient and client care (Nurses and Midwives Act, Cap 209, Singapore, 2018).

In addition, the Nursing Council of Hong Kong (2012) describes the role of the nurse as evolving, as the mode of delivery of health care services has undergone major changes both locally and internationally over the past decades. In line with international trends, the Nursing Council of Hong Kong (2012) further stipulates competencies that provide life-long holistic care, promote health, enhance the quality of life and enable human development. The scope of core-competencies required of a registered nurse comprises the following five competence areas, namely professional, legal and ethical nursing practice competence area, health promotion and health education competence area, management and leadership competence area, research competence area and personal effectiveness and professional development.

2.3.3. Nursing Council of New Zealand

The Nursing Council of New Zealand (2012) presents its understanding of competencies within four domains for the registered nurse's scope of practice. The evidence of safety to practice as a registered nurse is demonstrated when the registered nurse meets the competencies within the following domains: professional responsibility, management of nursing care, interpersonal relationships, interprofessional health care and quality improvement.

Registered nurses apply nursing knowledge and multi-faceted nursing judgement to assess health needs and provide nursing care. They practice independently and in collaboration with other health professionals. They provide comprehensive assessments to develop, implement, and evaluate an integrated plan of health care, and provide interventions that require substantial scientific and professional knowledge, skills and clinical decision making. This occurs in a range of settings in partnership with individuals, families and communities (Nursing Council of New Zealand, 2012).

According to the Nursing Council of New Zealand (2012), registered nurses may also practice in a variety of clinical contexts depending on their educational preparation and practice experience. In addition, registered nurses may use this expertise to manage, teach, evaluate and research nursing practice. However, registered nurses remain accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards (Nursing Council of New Zealand, 2012).

In summary, the global view on competencies, therefore, reveals the following very important concepts related to competencies:

- Competencies in nursing are based on the professional standards registered nurses base their practice on;
- Competencies are also a combination of attributes enabling performance of a range of professional tasks according to the appropriate standards;
- Competencies incorporate knowledge, abilities, skills and attitudes that are portrayed in competent performance of the registered nurse;
- Competency frameworks specify the level of achievement expected and the tasks and contexts of professional practice (National Council State Boards of Nursing (NCSBN), 2018).

2.3.4. African view on registered nurses' competency frameworks

In recognition of the global view on competencies for registered nurses, it is also important to know how the competency concept is referred to in an African context, though specific literature is limited.

2.3.4.1. The South African Nursing Council Competency Framework

In terms of the South African Nursing Council (SANC), there is a need for skilled professionals with highly developed critical thinking, analytical, and problem-solving skills that will be able to use evidence-based practice in nursing care (SANC, 2005).

In addition, SANC (2005) identifies core competency domains for advanced nurse practitioners such as professional, ethical, legal practice, care provision and management, personal development and quality of care, management and leadership and research. SANC, as a regulatory body, is authorised by the Nursing Act (Act No. 33 of 2005) to develop and maintain the scope of practice, professional standards and competencies through section 3(e), which stipulates that the objects of the council are, among others, to maintain professional conduct and practice standards for practitioners and to uphold and maintain professional and ethical standards within nursing (SANC, 2005). Sections 4(1)(i) and (iv) of the Nursing Act require that the council determine the scope of practice of nurses and the requirements for any nurse to remain competent in the manner prescribed (SANC, 2005).

The purpose of a nursing competency framework is to identify competencies expected of a generalist nurse and a specialist nurse at the point of entry into professional practice. This framework focuses on nursing competencies that address three concepts. The first concept addresses professional ethical practice, which contains the legal framework, ethical practice and accountability. The second concept refers to clinical practice. This concept consists of competencies for care provision and for care management. Quality of practice is the third concept (Makie, 2017).

2.3.4.2. The Zambian Nursing Council Regulatory Framework

The Zambian Competency Framework, on the other hand, emphasizes the registered nurse practice, management and leadership, and research for improved quality care. This

framework outlines three competency domains, namely: principles of care provision, leadership and management and quality improvement (Zambian Nurses and Midwives Act No. 31 of 1997).

2.3.4.3. Overview of the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia

HPCNA (2018) outlines the key domains of competencies in which registered nurses should practice. It further stipulates the key functions or roles which registered nurses should fulfil. In addition, the conceptual framework illustrates that the registered nurse and midwife/accoucheurs practice according to the applicable laws and policies of Namibia, and the Nursing Council to ensure quality of care and safe health care as the cornerstone or centrepiece of the framework.

Registered nurses and midwives/accoucheurs in Namibia practice according to Act, 8 of 2004 (Republic of Namibia, 2004); Regulations No 143; 13; 178 and 206, (Republic of Namibia, 2014.); and the Patient Charter of Namibia (MoHSS, 2016). They are accountable for their scope of practice and may practice in a variety of clinical contexts. In addition to the above standards of practice, core competencies need to be developed to define the minimum level of performance of registered nurses and midwives/ accoucheurs and it is set at the entry to practice level. These competencies also describe the required qualities, attributes and skills for registered nurses and midwives/ accoucheurs to practice in Namibia.

2.4. PURPOSE OF THE NAMIBIAN GENERIC COMPETENCY

FRAMEWORK

By establishing and applying core-competencies in the profession, the Nursing Council of Namibia sets the foundation for registered nurses and midwives/accoucheurs to maintain their competence and to acquire additional competencies or advanced clinical skills to enable them to deliver safe patient/client care in response to changing healthcare needs. The purpose of the development and use of core-competencies can be highlighted as follows:

- To enlighten registered nurses on the minimum competencies required for safe practice;
- Guide pre-registration nursing curriculum development and review.
- Monitor the competency development and assessment of newly graduated registered nurses,
- Assess the competencies of internationally qualified nurses seeking employment in Namibia.
- Evaluate nurses seeking re-registration.
- Judge nurses involved in professional disciplinary cases (HPCNA, 2018).

To ensure adherence to competency standards and indicators, and to demonstrate accountability for one's development and status as a professional registered nurse, the following competencies should be attained. See Table 2.1 below:

Table 2.1: Registered Nurse Competency Standards and Indications (Namibia)

Domain 1: Professional, Ethical and Legal Practice, Accountability	
Competency standards	Competency indicators
Professional Practice	<ul style="list-style-type: none"> ✓ Ensures own physical, cognitive, psychological and emotional fitness to practice and delivers safe care ✓ Supports, collaborate and co-operates with team members and other healthcare professionals ✓ Respects the values, customs, spiritual beliefs and practices of individuals and groups ✓ Recognises own beliefs and values and how these may influence care giving
Ethical Practice	<ul style="list-style-type: none"> ✓ Practices in a manner that conforms to the Namibian Scope of Practice ✓ Engages in effective ethical decision-making with respect to own professional responsibilities or where ethical issues affect the broader health care team ✓ Acts in an advocacy role to protect human rights and questions violation of client in accordance with jurisdictional and cope of practice for nurses ✓ Respects the client’s right to privacy and dignity ✓ Challenges behaviour and health care practice that could compromise client safety, privacy or dignity

<p>Legal Practice</p>	<ul style="list-style-type: none"> ✓ Practices in accordance with professional, relevant Namibian legislation and regulations ✓ Practices in accordance with jurisdictional and local policies and procedural guidelines ✓ Recognises and acts upon breaches of law relating to the professional role and conduct of a registered nurse and midwives/accoucheurs ✓ Obtains informed consent to respect the rights of patients ✓ Maintains clear and legible documentation and records
<p>Accountability</p>	<ul style="list-style-type: none"> ✓ Accepts accountability for own professional judgement, actions, outcomes of care and continued competence in accordance with scope of practice, increased responsibility, legislative acts and regulations ✓ Recognises the limits of scope of practice and own competence ✓ Seeks guidance from appropriate others when encountering situations beyond own knowledge

Domain 2: Knowledge-based practice	
Health Education	<ul style="list-style-type: none"> ✓ Maintains own health and personal fitness for work ✓ Cooperates with nurses, other health professionals and community groups in activities to reduce illness and promote healthy lifestyles and environments ✓ Incorporates into practice a perspective that takes account of the multiple determinants of health ✓ Plans, develops and implements needs-based programmes to promote health
Assessment	<ul style="list-style-type: none"> ✓ Gathers accurate and relevant objective and subjective data required for practice in speciality practice area through systematic Health and Nursing Assessment ✓ Organises, synthesizes, analyses and interprets data from different sources to derive nursing diagnoses and determine a care plan ✓ Shares and documents findings accurately, completely and timely to comply with Nursing Practice Standards and institutional policies
Planning	<ul style="list-style-type: none"> ✓ Formulates a comprehensive care plan according to patient needs

	<ul style="list-style-type: none"> ✓ Applies critical thinking and clinical reasoning skills underpinned by knowledge to plan care ✓ Prioritises care in collaboration with other members of the health care team based on urgency ✓ Maintains a current, accurate care plan and related records
Implementation	<ul style="list-style-type: none"> ✓ Implements a range of procedures, treatments and interventions that fall within the scope of practice for the registered nurse and are in accordance with nursing and best practice ✓ Documents interventions and client responses accurately and in a timely manner ✓ Responds appropriately and in time to unexpected or rapidly changing situations ✓ Responds immediately and appropriately to emergency/disaster procedures
Evaluation	<ul style="list-style-type: none"> ✓ Monitors and documents progress towards expected outcomes accurately and completely ✓ Evaluates progress towards planned outcomes in consultation with clients, families and health team members

	<ul style="list-style-type: none"> ✓ Uses evaluation data to modify the care plan
Therapeutic communication and relationships	<ul style="list-style-type: none"> ✓ Initiates, develops and discontinues therapeutic relationships through the use of appropriate communication and interpersonal skills ✓ Maintains a relationship that respects the boundary between clients and self ✓ Listens to others without bias, respects the point of view of others and promotes the expression of diverse opinions and perspectives ✓ Communicates clear, consistent and accurate information verbally or in writing, that falls within professional responsibility and maintains confidence in care ✓ Interacts in a manner that is respectful and culturally appropriate to the clients and family from diverse cultural backgrounds ✓ Communicates and shares relevant information including views of client and families with other health team members involved in providing services
Critical Thinking and Education	<ul style="list-style-type: none"> ✓ Identifies problems/issues in nursing practice that may be investigated through formal/informal research*

	<ul style="list-style-type: none"> ✓ Uses best available evidence, nursing expertise and respect for the values and beliefs of individuals in the provision of nursing care ✓ Demonstrates analytical skills in accessing and evaluating health information and research evidence ✓ Supports and contributes to nursing and health care research ✓ Participates in quality improvement activities
Professional Development	<ul style="list-style-type: none"> ✓ Undertakes regular self-evaluation of own nursing practice by engaging in reflection, critical examination and evaluation and seeking peer review ✓ Assumes responsibility for lifelong learning, own professional development and maintenance of competence ✓ Participates in unilateral and multidisciplinary teaching and learning activities ✓ Takes steps to remedy deficits in skills and/or personal knowledge
Quality improvement	<ul style="list-style-type: none"> ✓ Promotes dissemination, use, monitoring and review of Nursing Practice Standards and best practice guidelines

	<ul style="list-style-type: none"> ✓ Participates in developing and adapting Nursing Practice Standards to the health care environment ✓ Uses appropriate assessment tools to identify actual and potential risks to safety and security, takes appropriate actions and reports concerns where necessary to relevant authority ✓ Ensures safe and proper storage, administration and recording of therapeutic substances ✓ Complies with infection-prevention procedures and challenges breaches in other practitioners' practices
Research	<ul style="list-style-type: none"> ✓ Use evidence to inform nursing practice.
Domain 3: Leadership and Management	
Leadership	<ul style="list-style-type: none"> ✓ Adapts leadership style and approaches to different situations ✓ Contributes to team leadership by reinforcing goals to promote respect and confidence amongst the team ✓ Articulates own leadership contributions and supports expectations of other team members ✓ Leads in the development, review and modification of institutional practice policies, procedures and protocols

Management	<ul style="list-style-type: none"> ✓ Advocates for and acts within span of control to create a positive working environment ✓ Confronts conflict in a non-judgemental fashion ✓ Prioritises workload and manages time effectively ✓ Acts as role model for students and within the care team
Delegation	<ul style="list-style-type: none"> ✓ Maintains accountability and responsibility when delegating aspects of care to others ✓ Delegates activities to others, according to ability, level of preparation, proficiency and Scope of Practice ✓ Accepts delegated activities in line with personal level of proficiency and legal scope of practice
Supervision	<ul style="list-style-type: none"> ✓ Supervises staff effectively ✓ Uses a range of supportive strategies such as precepting and mentoring when supervising and/or monitoring delegated care
Domain 4: Enhancement of the Profession	

<p>Enhancement of the Profession</p>	<ul style="list-style-type: none"> ✓ Promotes dissemination, use, monitoring and review of Nursing Practice Standards and best practice guidelines ✓ Promotes and maintains a positive image of nursing ✓ Acts as an effective role model within the care team ✓ Acts as a resource for students, other members of the health and the public ✓ Values research in contributing to developments in nursing and uses findings to improve standards of care
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Looking at the aim of the competency framework, it is imperative to ensure that NQRNs acquire the necessary competencies to render safe nursing care.

2.5. SYNOPSIS OF COMPETENCY FRAMEWORKS ACROSS THE GLOBE

The review of literature revealed that most, if not all, nursing boards across the globe have frameworks that stipulate the required competencies for their registered nurses to practice. However, there are variations in the different competency domains, the conclusion is that there are universal core competencies applicable to all registered nurses. A comprehensive literature review revealed the following differences and similarities among different nursing boards, as illustrated in Table 2.2 below.

Table 2.2: Differences and similarities between different competency domains across the globe

DOMAIN	Namibia	ICN	UK	Australia	Philippine s	Singapore	Brunei	Zambia
Accountability	✓	✓						
Legal practice	✓	✓			✓	✓	✓	
Ethical practice	✓	✓			✓	✓	✓	
Professional practice			✓	✓		✓	✓	
Principles of care provision	✓	✓						✓
Health promotion/Education	✓	✓			✓			
Assessment	✓	✓						
Planning	✓	✓						
Implementation	✓	✓						
Evaluation	✓	✓						

DOMAIN	Namibia	ICN	UK	Australia	Philippine s	Singapore	Brunei	Zambia
Therapeutic communication, interpersonal relationships	✓	✓	✓		✓			
Leadership and management	✓	✓	✓			✓	✓	✓
Safe environment	✓	✓			✓			
Interprofessional health care	✓	✓						
Delegation and supervision	✓	✓						
Enhancement of the profession	✓	✓						
Quality improvement	✓	✓			✓			✓

DOMAIN	Namibia	ICN	UK	Australia	Philippine s	Singapore	Brunei	Zambia
Continuing Professional Education/Dev	✓	✓			✓	✓	✓	
Critical thinking & education				✓			✓	
Provision and coordination of care			✓	✓		✓		
Collaboration & therapeutic practice				✓	✓			
Research					✓		✓	
Record management					✓			

Despite the variations within the different frameworks, as depicted in Table 2.2, there are common domains that can be identified which are outlined as follows:

2.5.1. Domain 1: Professional, Ethical and Legal Practice, Accountability

This domain refers to different aspects pertaining to the required competency and most of the frameworks consider it as very essential.

2.5.1.1. Professional competencies

Professionalism or professional competence is considered enormously important in the nursing career and refers to the professional attributes of the person who practices the profession. It further implies that a nurse must fulfil all expected norms and expectations of professional practice. However, newly qualified nurses should be socialised professionally for them to become competent and to display all the characteristics of professionalism (Mellor & Gregoric, 2016).

According to WHO (2016), upon graduation, nurses should be able to demonstrate professional competency. This implies the application of professional standards in patient care that ensures the rights of and obligation to patients. The WHO (2016) further suggests that nurses should be able to identify professional nursing roles and responsibilities, including the recognition of independent roles of various members of the health team. Therefore, nurses should uphold the professional standards of practice and promote the positive image of nursing.

Similarly, the ICN (2009) supports HPCNA's notion that registered nurses should portray professional attitude and behaviour, while acting as role models. Similarly, Armstrong and Barton (2013) agree that professionals are expected to behave in a professional way, because their behaviour informs people whether one is reputable, competent and acting ethically with integrity.

As a caring profession, nursing should recognise caring as central in a therapeutic interpersonal relationship between the registered nurse and the patient. This relationship is referred to as a carative process, which concerns human activity (Watson, 2008). It is also a humanistic, altruistic value system whereby registered nurses use their scientific and technological knowledge to provide a caring service to patients in the form of nursing care. To be a caring registered nurse, one needs to adopt the values of the profession. Hence, the following are values and attitudes that registered nurses should portray in the execution of their professional duties and roles:

Competence

Competence within the framework of HPCNA (2010) implies that registered nurses should be accountable for their own professional judgement, actions, and outcomes of care and should show continued competence in accordance with their scope of practice. They should also demonstrate increased responsibility and adherence to legislative acts and regulations. Therefore, NQRNs should recognise the limits of their scope of practice and their own competence. They should seek guidance from appropriate others when they encounter situations beyond their own knowledge (HPCNA, 2018).

Competence further implies that registered nurses must be able to understand an individual's health and social needs and possess the expertise, clinical and technical knowledge to deliver effective care and treatment based on research and evidence (Cummings & Bennett, 2012). They should further demonstrate an understanding of the parameters of own roles and competence and, if not sure, should consult other nurse practitioners when nursing care requires expertise beyond their own competence (Booyens, Jooste & Sibiya, 2015).

Compassion

Compassion implies that registered nurses should cultivate a humane, perceptive, compassionate approach to providing care always (Searle, 2011). It also refers to “the sensitivity shown in order to understand another person's suffering, combined with a willingness to help and to promote the wellbeing of that person, in order to find a solution to their situation” (Perez-Bret, Altisent & Rocafort, 2016).

Compassion is viewed as more than an individual demonstrating empathy and kindness, but it is valued on the moral, emotional and organisational environment within which that individual learns their caring skills (Curtis & Burns, 2015). Compassion is how care is given through relationships based on empathy, respect and dignity - it can also be described as intelligent kindness, and is central to how people perceive their care (Cummings & Bennett, 2012).

Conscience

Conscience is a state of moral awareness, which the registered nurses must have about what is right or wrong. In other words, conscience implies that as a registered nurse one

is able to judge their moral actions and how they feel guilty about bad things that they have done or things they feel responsible for (Cleary & Lees, 2019).

Confidence

Confidence is the aspect of fostering a trust relationship between nurses and patients. However, it takes confidence in personal skills and knowledge to act with commitment (Cleary & Lees, 2019). Therefore, registered nurses should ensure confidence in experiences, education and skills which will ensure that they continually put their best foot forward.

Commitment

Professional commitment is more than a job obligation, but striving for continuous improvement, constantly looking at things and exploring ways of doing them differently. Therefore, upholding and staying committed to the professional values of nursing is vital. Registered nurses should continue improving not only their clinical skills, but also the interpersonal, the caring, the logical thinking, the problem-solving, and the analytical skills. Figure 2.1 illustrates the professional values and attitudes as described by Cleary and Lease (2019).



Figure 2.1: Professional values and attitudes (Source: Berman & Snyder, 2012)

2.5.1.2. Ethical and legal competencies

Ethics refer to standards of right and wrong, and prescribe what humans ought to do in terms of rights, obligations, and benefits to society (Armstrong et al., 2017). Ethical competence implies formalised and agreed upon standards and rules that guide the ethical conduct of a profession (Booyens et al., 2015). In this regard, nurses should adhere to the professional code of ethics and have a responsibility towards society, supporting the notion that nurses should develop and maintain ethical conduct.

The WHO (2016) concurs that all nurses/midwives should be able to apply the nursing code of ethics as well as professional guidelines to clinical practice. Furthermore, nurses should be competent in implementing a plan of care within the legal, ethical and regulatory framework of the nursing profession. In addition, WHO (2016) also indicates that all

nurses/midwives should be able to uphold and support ethical and legal standards of nursing, thus advocate for, and protect patients from unfair and discriminatory practices.

Similarly, ICN (2009) agrees that registered nurses should be able to take responsibility for own acts and omissions, while protecting the rights and safety of patients. In addition, ICN (2009) maintains that registered nurses should always portray professional attitude and behaviour, act as role models and show respect to other team members. In this connection, registered nurses should be competent and skilful to meet the complex patient needs.

HPCNA (2010) states that health professionals should have moral and ethical duties to others and to society. Therefore, registered nurses should adhere to ethical values and standards such as respect for persons, non-maleficence, beneficence, autonomy, justice, human rights, veracity, confidence, compassion, including professional competence (HPCNA, 2010).

However, it is reported that in nursing practice, nurses face many ethical situations daily (Holt & Convey, 2012). To practice ethically, registered nurses need certain skills, such as ethical decision-making skills, critical-thinking skills and problem-solving skills.

Ethical decision making

Decision making is based on the scientific process of assessment, diagnosis, planning, implementation and evaluation (Nibbelink & Brewer, 2018). Therefore, NQRNs must be able to identify a problem, assess possible solutions to the problem, weigh possible solutions considering the consequences and finally decide on the best solutions.

Ethical decision making is viewed as a process that can be used in addressing any ethical dilemma in health care and registered nurses are required to adhere to ethical principles during ethical decision-making (Sari, Baysal, Celik & Eser, 2018). Decision-making further implies following one's mind about an issue or situation (Berman & Snyder, 2012). In this case, ethical decision making requires a review of different options, eliminating those with an unethical viewpoint and then choosing the best ethical alternative.

Duchscher (2009) states that NQRNs often lack decision-making skills. Moreover, Ulrich et al. (2010) report that challenges associated with ethical decision making may increase because of the complexity of patient care. Therefore, ethics is fundamental to nursing practice (Silva, Marins, Nobre, Frazão & Santa Ros, 2014).

National and international literature reported incompetence, as a common phenomenon among NQRNs. For instance, Small and Pretorius (2015) report lack of clinical competence among NQRNs at private hospitals in Windhoek, Namibia. Similarly, Nghiwete (2017) concurs that new graduates' competencies in Namibia should be addressed as the public and professional organisations expect nurses to be competent upon completing their training. However, Benner, Sutphen, Leonard and Day (2010) posit that a NQRN acquires competence after two years in practice.

2.5.1.3. Knowledge-based practice

This domain is based on the achievement of positive client health outcomes. This implies that the registered nurse must have a broad scientific knowledge base of health sciences in the provision of health care. Provision of care refers to the clinical competencies a nurse must possess to render nursing care. Therefore, clinical competence entails a combination

of skills, knowledge, attitudes and abilities that each nurse should possess to perform actions related to patient care in order to promote, maintain and restore the health of patients. In other words, a clinical-competent nurse is one who can integrate psychomotor, affective and cognitive skills in rendering nursing care (Fukada, 2018).

Similarly, public and professional organisations expect nurses to be competent upon completing their training. However, national and international literature reports incompetence among NQRNs. Benner et al. (2010) observe that a NQRN acquires competence after approximately two years of practice. The latter further confirms the notion that experienced nurses tend to view NQRNs as incompetent during the first two years of practice. Spector et al. (2015) concur with Benner et al. (2010) regarding unrealistic expectations. These authors suggest the need for a one-year transition model for NQRNs to reduce medical errors and improve patient care.

On the contrary, HPCNA expects all registered nurses to be skilful in all three domains for them to deliver competent care, namely: cognitive, affective and psychomotor skills. These expected competencies are outlined in the Scope of Practice of Registered Nurses (Republic of Namibia, 2014), which outlines nurses' functions that involve competence. The scope of practice of a registered nurse in Namibia includes the scientific application of the principles of nursing and health care related to the prevention of illness and the care of patients during illness. These principles include the scientifically based physical, psychological, social, educational, chemical and technological means applicable to health care practice (Republic of Namibia, 2014).

Correspondingly, the ICN (2009) states that registered nurses should be able to formulate a comprehensive care plan with identified care outcomes based on nursing diagnoses, findings from a nursing and health assessment, inputs from other health team members, and nursing practice standards. Furthermore, registered nurses should be able to implement a range of procedures, treatments and interventions that fall within the scope of practice for the registered nurse and are in accordance with nursing and best practice standards (ICN, 2009). Moreover, to be clinically competent, registered nurses should be able to assess the health situation, plan patient care effectively, and implement nursing actions to achieve quality nursing care outcomes.

2.5.1.4. Management and leadership competencies

Management and leadership competencies are viewed as the achievement of the nursing unit objectives by means of the application of management activities of planning, organising, directing and controlling (Jooste, 2017). Management competencies are regarded as more than just frontline activities and include supervision and administration (Ragg, 2011). Management of health care further incorporates the application of the processes of planning, organising, controlling and evaluation (Jooste, 2017). Therefore, it is crucial for NQRNs, as future nurse managers, to possess these competencies.

Registered nurses should, as part of their roles, contribute towards the achievement of the organisational goals through the managerial functions of planning, organising, directing and controlling (Jooste, 2017). As leaders, on the other hand, they should be able to influence others to accomplish positive patient-care outcomes with passion, integrity and curiosity (Bennis & Nanus, 2007).

From the summary of the competencies above, one can conclude that not all nurses would automatically have those competencies and that in many instances these competencies should be facilitated for the registered nurses to become effective managers and good leaders. Therefore, as observed by Bennis and Nanus (2007) that good leaders are made and not born, NQRNs need to be facilitated to develop into good leaders.

2.6. BEST PRACTICES TO FACILITATE NEWLY QUALIFIED REGISTERED NURSES' COMPETENCIES

Literature was reviewed to identify best practices regarding the facilitation of NQRNs' competencies. It was discovered that NQRNs are very aware of the importance of their role as professional registered nurses who need to uphold their professional values accordingly (Chang & Daly, 2012). However, it seems NQRNs are not fully competent, as the transition period from newly qualified to experienced nurse is often described as a complete reality shock (Duscher, 2009). It is further described as a time when new graduates are questioning everything from their ability to whether they made the right career choice, and whether they will ever be like the nurses they are now working with on their new ward (Chang & Daly, 2012; Hofler & Thomas, 2016; Kaihlanen, Lakanmaa & Salminen, 2013).

Due to the complex nature of the NQRNs' transition, it was reported that support should be a major factor in ensuring a smooth competency-based transition period. Following are some of the strategies described in literature, which can be employed to support NQRNs' competencies.

Preceptorship

A preceptor programme has been shown to be very effective in facilitating NQRNs' competencies. It was further reported that preceptor programmes have been found to help ensure more positive patient care outcomes in the first six months of transitioning to a registered nurse and help not only to reduce culture shock, but also to integrate and link theory with practice (Chang & Daly, 2012; Hofler & Thomas, 2016; Kaihlanen et al. 2013).

The authors further confirmed the need for preceptor programmes to support the NQRNs by allowing them to work closely with an experienced nurse to develop their confidence, competence and gradually gain more autonomy in patient care (Chang & Daly, 2012; Hofler & Thomas, 2016; Kaihlanen et al., 2013).

Supportive environment

Literature further confirms the need for a supportive environment in ensuring a successful transition, as it gives the newly registered nurses opportunities to develop their clinical and patient-management skills, and enable them to see the effective outcomes of their work in practice, thereby encouraging further confidence in their ability. Moreover, being part of a supportive environment also allows the NQRNs to feel comfortable raising any issues or concerns during their transition period, allowing any potential problems to be identified and managed early – essential in reducing anxiety and stress (Chang & Daly, 2012).

Orientation programmes

Other strategies and factors that have been found to facilitate a positive transition from newly qualified to experienced registered nurse include orientation programmes with

realistic goals, timely provision of constructive feedback, appropriate guidance from senior staff and continuing staff development opportunities (Chang & Daly, 2012).

Transition support programmes, if incorporated into orientation programmes, would be ideal due to the various benefits they can offer NQRNs. For instance, Spector et al. (2015) observe that NQRNs who were in established transition support programmes had fewer negative safety practices and had higher competence levels compared to those in hospitals with limited transition support programmes.

Similarly, Stacey and Hardy (2011) observe that transition support programmes produce increased confidence and competency, improved patient care, increased job satisfaction and result in reduced attrition rates. In addition, Baxter (2010) posits that a supportive environment is crucial because the transition of NQRNs has been seen as a time of stress, role adjustment, interpersonal conflict, and reality shock.

However, Zinsmeister and Schafer (2009) postulate that the successful transition of the newly qualified nurse into the nursing workforce is largely dependent on the amount and quality of support that the NQRNs receive during the transition period.

Supernumerary status

Another strategy of organisational support is that of having supernumerary status, in which NQRNs work alongside a peer or mentor for them to learn what is expected of them, while giving them time to familiarise with policies, documentation and the team, though still allowing them to carry out nursing duties (Tavengwa, 2011).

Both preceptorship and supernumerary nursing programmes were reported to have benefits in addressing accountability issues for NQRNs (Ripley & Hoad, 2011). Moreover, it was found that preceptorship and supernumerary status allow increasing NQRNs' confidence regarding their competence and help them to take responsibility for the care they provide (Twibell et al., 2012).

In summary, the researcher also shares the same view with the authors, but decided to rather focus more on a competency-based transition support programme, which emphasizes NQRNs' ability to perform skills necessary in a new work setting. The purpose of this proposed programme is to enhance and facilitate these competencies of NQRNs.

2.7. REVIEW OF TRANSITION SUPPORT PROGRAMMES

The researcher reviewed different transition support programmes to gain in-depth knowledge on how best to facilitate the competencies of NQRNs in Namibia. Next is an overview of some of these programmes.

2.7.1. Global view

Globally, graduate transition support programmes have been developed to facilitate effective transition from a newly qualified to experienced registered nurse within the clinical environment.

Transition support programmes seem to be ideal because of the various benefits they offer NQRNs. For instance, Spector et al. (2015) observe that NQRNs who were in established transition support programmes had fewer negative safety practices and had higher competence levels compared to those in hospitals with limited transition support programmes.

Similarly, Stacey and Hardy (2011) report that transition support programmes resulted in increased confidence and competency, improved patient care, increased job satisfaction and a reduction in attrition rates. In addition, Baxter (2010) posit that a supportive environment is crucial because the transition of NQRNs has been recognised as a time of stress, role adjustment, interpersonal conflict, and reality shock.

However, Paget and Britten (2020) postulate that the successful transition of the newly qualified nurse into the nursing workforce is largely dependent on the amount and quality of support that the NQRN receives during the transition period.

In Australia, for example, at the Victoria Health and Human Services, nursing and midwifery graduate transition to practice programme guidelines were developed in 2018 to provide a safe and positive environment with a range of supporting resources that help graduates to develop skills and confidence in their professional roles as part of a high-quality and sustainable workforce (Britt et al., 2013).

This programme focused on key areas that would ensure a smooth transition for NQRNs, such as leadership, preceptorship and mentoring, and peer support. In addition, the programme emphasized that patients have a right to receive safe and high-quality care. Thus, it was acknowledged that best clinical practice is the goal of every health service.

The Association of Registered Nurses of Newfoundland and Labrador (2007) developed a similar programme grounded in a competency-based assessment model and linked with ongoing continuing education programmes. Accordingly, all new graduate nurses and experienced nurses in transition require comprehensive nursing orientation with clearly defined time frames, goals and expectations. Such a programme was further based on an effective orientation programme, which includes a quality clinical preceptorship followed by a mentorship programme that supports the registered nurse beyond the formal orientation. Opportunities are presented throughout the orientation period to strengthen the new nurses' critical thinking, clinical judgement and organisational management skills. In other words, supporting these skills to ensure a smooth transition for the NQRNs.

Similarly, the Royal Melbourne Hospital's graduate nurse programme supports graduate nurses in the clinical area and provides opportunities to consolidate both theoretical and clinical skills. The programme supports graduates transitioning from student to registered nurses in a friendly and stimulating working environment. Thus, the programme begins with a structured orientation and induction programme.

The orientation comprises different activities, workshops and lectures to help one feel more relaxed and confident about beginning a role as a registered nurse. Therefore, the programme can be viewed as a transition support programme for NQRNs.

Following the workshops and lectures, NQRNs begin their first rotation alongside an assigned preceptor to provide guidance and to transfer clinical skills. NQRNs are also, throughout the year, given paid professional study days. These days aim at providing

NQRNs with up-to-date knowledge to assist them with clinical and professional development.

2.7.2. Newly qualified registered nurse transition support programmes in Africa

Limited literature exists on transition support programmes in Africa. Most programmes are mainly on induction and orientation of NQRNs, which are not the same as transition support programme. Hence, these programmes merely aim at preparing NQRNs for the job, while transition support programmes are mostly competency based.

2.7.3. Newly qualified registered nurse transition support programmes in Namibia

As previously alluded to, there are no standardised transition support programmes for NQRNs at public hospitals in Namibia. Therefore, each hospital provides support to NQRNs differently. However, the researcher discovered that private hospitals have formal competency-based programmes for newly qualified registered nurses. These programmes aim at helping NQRNs integrate theory into practice to enhance nursing service delivery.

2.8. SUMMARY

This chapter reviewed literature related to the study topic focusing on registered nurses' generic competencies and transition support programmes, including competency frameworks across the globe. The literature review revealed the importance of transition support programmes in the facilitation of NQRNs' competencies during the transition period. It is against this background that the researcher developed a transition support programme for NQRNs at public hospitals in Namibia. Chapter 3 discusses the research methods, data collection, and ethical aspect underpinning the study.

CHAPTER 3

RESEARCH DESIGN AND METHODS

“Research is an organized method of trying to find out what you are going to do after you cannot do what you are doing now”. Charles. F. Kettering

3.1. INTRODUCTION

Following the literature review in the previous chapter, this chapter focuses on the research approach, research design, sampling, data collection and data analysis to clearly show how the researcher conducted the multi-phase study. Measures to ensure validity and reliability of the design and research findings, and ethical considerations of the study are also discussed in this chapter.

3.2. RESEARCH DESIGN

Gray et al. (2017) define research design as the structure within which the study is implemented. In this study, the researcher chose a quantitative approach with a non-experimental, descriptive, research design in collecting and analysing the data. Quantitative research is conducted to describe new situations, events, or concepts, but also to provide strong evidence regarding the research problem investigated (Brink et al., 2018). The quantitative research design was deemed applicable to achieve the objectives of the study, namely to determine, describe, analyse and discuss the competence of NQRNs so as to develop a transition support programme for facilitating their

competencies. This design was also found suitable because quantitative researchers use deductive reasoning to generate ideas that are tested in the real world (Polit & Beck, 2017).

Quantitative design

Gray et al. (2017) further refer to a quantitative research design as a formal objective and systematic process to describe and test the relationship and to examine the cause and effect of interaction among variables. In this study, a quantitative, exploratory and descriptive design was selected to address the first two objectives of the study to determine and describe the views of NQRNs at public hospitals regarding their self-reported competence (**Objective 1**) and to determine and describe the views of unit managers at public hospitals regarding newly qualified registered nurses competence (**Objective 2**).

Exploratory research design

Exploratory designs are used to explore research questions about an unknown phenomenon, such as the status of NQRNs' competence in this study. The exploratory part of the design focused on providing a basic understanding on the topic under study with the aim of understanding it fully (Polit & Beck, 2017). The approach is appropriate to this study as the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018) is relatively new, which incited the researcher to explore this area. Moreover, no study of this nature in Namibia could be located.

Descriptive design

A descriptive design was used to expand theory, determine current problems in practice and identify what others in similar situations are doing (Gray et al., 2017). The authors further state that a descriptive design helps to identify problems in current practice with the view to improve practice outcomes. The purpose of the descriptive research is also to explore and describe real-life situations, as it provides information of the events as they occur, specifically the competence of the NQRNs.

3.3. SCOPE OF THE STUDY

This study intended to determine the self-rated competence of newly qualified registered nurses, as well as NQRNs competence as viewed by their unit managers at intermediate, tertiary, training hospitals which render specialized health care. The study participants comprised 103 newly qualified registered nurses, and their 48 unit managers. The researcher collected the data and collected the completed questionnaires between January and May 2019.

3.4. REASONING STRATEGIES

The reasoning approach was based on processing and organising ideas to reach conclusions. To achieve the purpose of this study, the following reasoning strategies were used, namely: deductive reasoning and synthesis.

Deductive reasoning is the process of moving from general to specific evidence (Polit & Beck, 2017). In this study, deductive reasoning helped the researcher move from the general idea, which existed in the literature regarding NQRNs competence, to the context

in Namibia. This approach ultimately provided the basis for developing the transition support programme based on empirical findings on NQRNs' competence.

Following the deductive reasoning process, facts and ideas obtained through data collection, analysis and literature review were synthesized to get a complete picture of NQRNs' competence during transition. This process enabled the researcher to develop the transition support programme based on empirical evidence.

3.5. PHASES OF THE STUDY

The study was conducted following three phases, as illustrated in Figure 3.1.

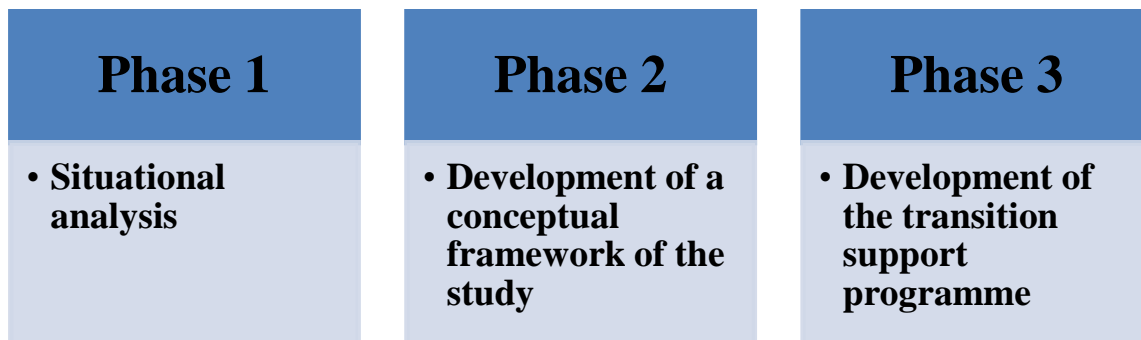


Figure 3.1: Phases of the study

3.5.1. Phase 1: Situational analysis

The aim of this phase was to gather baseline data on the competence of NQRNs during transition to experienced registered nurses. Thus, this information guided the researcher in developing the programme based on the theory-practice gap among NQRNs. The study was based on the Generic Competency Framework of Registered Nurses in Namibia (HPCNA, 2018). Prior to the collection of data, a survey was conducted to obtain non-experimental information about the competency level of NQRNs at public hospitals in Namibia. A clarified, standardised and quality survey is required for research (Fincham & Draugalis, 2013). Thus, a situational analysis was carried out as the researcher found it appropriate to employ a survey technique (Polit & Beck, 2017).

The objectives of phase 1 were to:

- Determine the self-reported competence of NQRNs at public hospitals;
- Describe the self-reported competence of NQRNs at public hospitals;
- Determine the views of unit managers at public hospitals regarding the competence of NQRNs;
- Describe the views of unit managers at public hospitals regarding the competence of NQRNs

POPULATION

Creswell (2016) defines a population as the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned. **Phase 1** comprised of two populations, namely NQRNs and unit managers.

- ❖ **NQRNs:** According to data obtained from the nursing services data information at respective hospitals, at the time of the study, 121 NQRNs registered within six months of practice were employed at Oshakati, Rundu, Katutura and Windhoek Central hospitals in three regions of Namibia, namely Khomas, Oshana and Kavango East.
- ❖ **Unit Managers:** To eliminate bias and subjectivity, a second population comprising 54 unit managers at the above-mentioned hospitals were included in the study. Following is a brief description of the two populations.
- ❖ **Newly qualified registered nurses (n=121)**

NQRNs are those respondents referred to in the first population and who are in their first year of professional practice as registered nurses. They were newly registered with HPCNA after obtaining nursing qualifications at academic institutions and

were licenced to start practising nursing in Namibia. These registered nurses are new to nursing professional practice as well as to the expectations of a registered nurse and might lack experience and, therefore, might find it difficult to draw on experience to make decisions (Benner, 1982). Because of lack of experience, NQRNs might lack confidence and are often insecure. This population totalled 121 NQRNs as indicated in Table 3.1. below. Table 3.1 below outlines the response rate from population 1 of the study.

Table 3.1: Response rate from study population 1: newly qualified registered nurses

Hospital	Total NQRNs	Responses	Percentage
A	38	33	86.8
B	24	20	83.0
C	34	30	88.0
D	25	20	80.0
Total	121	103	85.0

The second population comprised of unit managers.

❖ **Unit managers(n=54)**

The second population, as previously indicated, comprised of 54 nurse unit managers, who are senior registered nurses, who oversee all aspects of managing a unit within a health care facility. Their duties range from supervising nursing staff to monitoring patient care. Nurse unit managers also handle all supervisory duties for the unit, overseeing NQRNs and enrolled nurses and support staff. They set work schedules, delegate assignments, assign tasks and evaluate employee job performance. They also discipline employees who fail to fulfil their job requirements or provide inadequate patient care.

Nurse unit managers often mentor less experienced nurses, offering clinical and career advice, hence, the reason they were included in the study. Unit managers set, monitor and evaluate goals and standards for the unit, and may hold regular staff meetings in which they give directions or discuss areas for improvement. Table 3.2 below is a depiction of the response rate from the second study population.

Table 3.2: Response rate from study population 2: unit managers

Hospital	Total Unit Managers	Responses	Percentage
A	15	14	80.0
B	12	11	75.0
C	14	12	78.5
D	13	11	76.9
TOTAL	54	48	88.8

SAMPLING AND SAMPLE

A sampling method is a procedure for selecting sample members from a population (Brink et al., 2018). A sample, according to Brink et al. (2018), is a part or a fraction of a whole or a subset of a large set, selected by the researcher to participate in a research study. For this study, no sampling was done, as the target population was relatively small. Therefore, all 54 (n=54) unit managers working at Katutura, Windhoek Central and Rundu and Oshakati hospitals and all NQRNs employed between 2017 and 2018 (n=121) were included in the study (refer to Table 3.1 & 3.2). However, the researcher used the following inclusion criteria to determine eligible participants in the study, namely:

- Participants from both samples should be registered with HPCNA as registered nurses and midwives.
- Participants (population 1): Only NQRNs employed between 2017 and 2018, with more than six months, but less than two years' experience as registered nurses.
- Participants (population 2): unit managers with two and more years of experience as unit managers to ensure vast and rich information on supervising NQRNs.

DATA COLLECTION

Gray et al. (2017) explain data collection as the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypothesis of the study. There are many ways to collect data depending on the type of research and type of data to be collected. The researcher approached the data collection as described below:

RESEARCH METHODS

The study was based on the Generic Competency Framework of Registered Nurses in Namibia (HPCNA, 2018). Prior to the collection of data, a survey was conducted to obtain non-experimental information about the competency level of NQRNs in public hospitals in Namibia. A clarified, standardised and quality survey is required for research (Fincham & Draugalis, 2013). The clarification on what is required to measure the level of NQRNs' competency was extracted from the survey. Thus, a situation analysis was done. Since the research adopted an extensive analysis approach, employing survey technique was found suitable (Polit & Beck, 2017).

RESEARCH INSTRUMENTS

The research instrument used was a self-administered questionnaire with a 4-point Likert scale (Gray et al., 2017; Moule & Heck, 2014). Two types of structured questionnaires were administered based on the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018).

Questionnaires were viewed as ideal tools for this study as, according to Brink et al. (2018), participants feel a greater sense of anonymity, and are more likely to provide honest answers.

The questionnaire for the NQRNs consisted of four sections (Annexure 9). Section 1 comprised of the socio-demographic data of the participants; Section 2 covered questions related to professional, ethical and legal competencies; Section 3 comprised of questions related to NQRNs on the provision of care competencies, while Section 4 contained the management and leadership competencies.

Participants were expected to rate their own competence on a scale of 1-4, where one denoted little knowledge, and four represented complete competence.

The questionnaire for the unit managers (Annexure 10) consisted of three sections comprising both open and closed-ended questions to allow respondents the opportunity to elaborate or specify. Section one was based on the respondents' demographic information, while section two comprised of questions related to unit managers' opinions on NQRNs' competence, while section three was based on support rendered to NQRNs to facilitate their competencies.

VALIDITY AND RELIABILITY

To ensure consistency of the research instrument and that the research would produce required results, the questionnaire was checked for validity and reliability.

Validity

Validity can be regarded as utility. In other words, validity is the extent to which differences found with a measuring instrument reflect true differences among those being tested (Kothari et al., 2012). Gray et al. (2017) refer to validity in terms of whether the instrument measures the actual concept in the question. The data collection instrument was found valid, as it ensured the following different types of validity:

Content validity is the extent to which a measuring instrument provides adequate coverage of the topic under study (Heale & Twycross, 2015). Content validity also refers to how accurately an assessment or measurement tool answers the research question. It is, therefore, concerned with whether the measurement instrument and the items it contains are representative of the content domain that the researcher intends to measure (LoBiondo-Wood, Haber, Cameron & Singh, 2017).

In this study, content validity was ensured through an extensive literature review on the topic of competencies and synopsis of previous studies. Items in the questionnaire were assessed against existing competency frameworks to determine whether they measured what they intended to measure to achieve the aim of the study. Research experts, also in the nursing profession, also evaluated the questionnaires for readability, clarity and comprehensiveness. The researcher ensured that all the questions in the questionnaire applied to the focus of the study.

Construct Validity

Construct validity refers to the extent to which a test measures a theoretical construct, attribute, or trait measure (LoBiondo-Wood et al., 2017).

Therefore, a pilot test was conducted to validate the data collection instrument. The instrument was also examined by the study supervisors and the statistician, who helped with data analysis to determine whether it is a valid tool to determine NQRNs competence. The research expert further evaluated the tools to determine whether each of the measuring items matched the different competency domains.

Reliability

Reliability of the instrument was ensured, as it measured the competence of NQRNs (LoBiondo-Wood et al., 2017). According to Pandey and Pandey (2016), reliability is the degree of consistency or accuracy that the instrument measures an attribute. Reliability is also used to indicate the extent to which the different items, measures, or assessments, are consistent with one another and the extent to which each measure is free from measurement error.

In this study, the acceptable range for Cronbach's alpha test of reliability was 0.70 or above and, therefore, regarded acceptable (Bolarinwa, 2015) The items were also found to be reliable, because a standardised score of 0.70 and above was obtained. Table 3.3 illustrates the outcome of the Cronbach's alpha of reliability test.

Table 3.3: Level of Cronbach’s alpha reliability test

Domains	Cronbach's alpha based on standardised items		Number of items
Professional, legal and ethical competencies	NQRNs	0.798	4
	Unit	0.916	
	Managers		
Knowledge-based practice	NQRNs	0.957	33
	Unit	0.981	
	Managers		
Management and leadership	NQRNs	0.910	9

Cronbach’s alpha of 0.70–0.95 is considered reliable (Bolarinwa, 2015). All domains in the instrument achieved scales with Cronbach’s alpha (α) higher than 0.70, thus considered reliable as outlined in Table 3.3.

PILOT TESTING

The researcher conducted a pilot test prior to the main study. It aimed at investigating and detecting possible flaws in its methodology (Brink et al., 2018). The main reasons for conducting the pilot testing were to identify any problems with the research instruments; determine whether the questions were clear and understandable to the participants; detect possible errors in the methodology; and to make the necessary changes based on the outcome of the testing (Brink et al., 2018).

In this study, the pilot testing was conducted with NQRNs and senior registered nurses at the Katutura Intermediate Hospital to determine the consistency and stability of the questions and whether the questions were clear and understandable. The population of the pilot testing comprised of four NQRNs, as well as four unit managers, who were not included in the main study. After the pilot testing, the researcher adjusted the instrument according to the outcome of the testing. For example, the researcher noticed that some questions based on different competency items needed simplifying to ensure that participants understand the questions clearly. Some questions were also rearranged in logical order.

Field preparation

Firstly, the researcher met with the hospital management team, and potential participants to explain the study. The aim of this meeting was to discuss the aims, objectives and envisaged significance of the study. Thereafter, time was also allocated for potential participants and managers to express their concerns. Concerns were mainly expressed in the context of anonymity and confidentiality, which were clarified by the researcher by referring to the ethical considerations of the study. Emphasis was placed on the protection of participants' identity and voluntary participation. An information sheet was given to each potential participant to complement the information offered. The information contained the description of the study, including the study aim, objectives, ethical issues on confidentiality and anonymity, benefits and significance of the study, and contact details of the researcher.

Data collection procedure

Prior to data collection, permission was obtained from the Executive Director of Ministry of Health and Social Services (MOHSS) and the Medical Superintendents at respective hospitals. After permission was granted, a meeting was arranged with the management teams at different hospitals to explain the study and the presence of the researcher in their areas of supervision. After the researcher introduced herself and the purpose of the study, permission was obtained from participants to take part in the study. In this study, the researcher used questionnaires to collect data from the participants. After giving participants consent forms to sign as proof that they understood and agreed to willingly participate in the research, the researcher explained the instructions on how to complete the questionnaires. The participants were informed not to write their names on the questionnaires to ensure anonymity. Participants were given envelopes to safeguard the questionnaires and to ensure confidentiality. Participants were allowed to complete the questionnaires at their convenience, either at home or at work. The researcher personally distributed the questionnaires and collected the sealed envelopes with questionnaires from the respective wards.

Of the 54 unit managers recruited for the study, only 48 completed and returned their questionnaires, representing a response rate of 88.8%. On the other hand, 121 NQRNs were recruited, but 103 questionnaires were received back, representing a response rate of 85%.

Data Analysis

To ascertain the competency level of NQRNs, an exploratory and descriptive analysis was thus required. The analysis was done using Statistical Package for the Social Sciences (SPSS- Version24) with the assistance of a statistician. Descriptive analysis included

percentages, means, medians, ranges, standard deviations, and variances as appropriate for all variables. Data were presented in the form of graphs, tables and pie charts.

To draw a conclusion on the relationship between the competency level and NQRNs' demographics, inferential statistics were thus required. A Spearman Rho non-parametric correlation analysis was carried out to interpret the demographic statistics' relationship with NQRNs' competence. The Spearman Rho non-parametric coefficient was used to measure if an association or relationship exist between NQRNs demographics and their competence (Corder & Foreman, 2014).

According to Makie (2017), inferential statistics are used to draw conclusions about the reliability and generalisability of the findings and allowed the researcher to gather from the data the relationship between NQRNs' competence and their demographics. A significant level ($\alpha=0.05$) was considered where a correlation coefficient (p) less than 0.05 indicated that the correlation was statistically significant and vice versa. That is, $p < 0.05$ = statistically significant relationship, while $p > 0.05$ = not statistically significant relationship.

In this study, regarding the interpretation of the correlation between NQRNs' demographics and their competency level, the correlation coefficient ranges were 0–1 for a positive relationship and -1-0 for a negative relationship. The study findings are discussed in Chapter 4.

RESEARCH ETHICS

Ethics refer to principles of morality, particularly those dealing with issues of the right and wrong of an action. It also refers to rules of conduct for members of any profession (Pandey & Pandey, 2016). Ethics in research are very important because they promote important moral and social issues, such as responsibility, human rights, compliance with the law, public health and safety (David & Resnik, 2015). This study adhered to ethical principles to ensure the safety and wellbeing of participants (Taylor et al., 2014).

Permission to conduct the study (Annexure 1-7)

Prior to conducting the study, permission was obtained from the Post-Graduate Research Committee at UNAM (SON/460/2019), the Executive Director of the Ministry of Health and Social Services Research Committee. Medical superintendents at the public hospitals, unit managers, and individuals participating in the study were also approached for permission. (Refer to Annexures 1, 2, 3, 4, 5, 6 &7, respectively).

Autonomy (Annexure 8)

Autonomy refers to the ability or power to make decisions for yourself (Cambridge Dictionary, 2019). This implies that individuals have the right to decide whether to participate in a study (Brink et al., 2018). In this study, the participants were neither forced nor intimidated in any manner to take part, but they did so voluntarily. In addition, those who agreed to take part in the study were not promised any rewards. Furthermore, the participants were not subjected to any physical or psychological discomfort, because the content of the questionnaires was not sensitive. Participants were free to withdraw at any time during the study if they did not wish to continue (**Annexure 8**).

Anonymity and confidentiality (Annexure 8)

The right to confidentiality and anonymity means that the participants have the right to privacy (Akaranga & Makau, 2016). The anonymity of the participants was protected through the absence of any link between recorded data and specific respondents and no names were recorded anywhere in the survey findings. To ensure autonomy of each participant, all individual were informed of their rights and participants then had the right to part take in the study or not to and made informed decisions.

The results were also reported in frequencies and percentages, hence not able to indicate any subject specifically. Participants were assured that their information would be treated with strictest confidentiality and privacy. Therefore, the study documents were kept under lock and key. No unauthorized person had access to the information.

Beneficence and non-maleficence (Annexure 8)

Beneficence and non-maleficence refer to doing good and avoiding harm or inflicting as little harm as possible (Akaranga & Makau, 2016). This type of harm can be caused by asking embarrassing questions or forcing participants to discuss sensitive topics that they are not comfortable with. The researcher assured participants that their participation could not harm them in any way and that the questionnaires did not contain sensitive questions.

Principle of justice

Regarding justice, Akaranga and Makau (2016) state that justice in research entails ensuring that the participants are selected fairly and the burdens and benefits of the study are distributed equally. Justice implies that research participants must be treated fairly (Burns, Grove & Gray, 2015). In this study, the research participants were treated with

utmost dignity and respect. Participants were not selected as all in the target population could participate in the study.

3.5.2. Phase 2: Development of a conceptual framework of the study

Objective: To develop a conceptual framework for facilitating the competencies of newly qualified registered nurses at public hospitals in Namibia.

A conceptual framework can be defined as “the abstract, logical structure of meaning that guides the development of the study and enables the researcher to link the findings to the existing body of knowledge” (Burns et al., 2015). Hence, the researcher of the study used the components of the programme logic model to guide the development of the transition support programme. The conceptual framework is discussed in detail in Chapter 6 of this study.

3.5.3. Phase 3: Development of transition support programme

Phase 3 addressed objective three of the study, namely to develop a transition support programme to facilitate the competencies of NQRNs. The empirical findings of phase 1, as conceptualised in phase 2, form the basis for the development of the transition support programme.

The programme was developed to address the competency gaps, as identified in the situational analysis (Phase 1) and based on the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018). The adult learning theory, Bloom’s taxonomy of learning and humanistic existentialist philosophy were incorporated into the development of the programme. A detailed description of the

programme development phase, as well as the guidelines for the implementation of the programme follow in Chapter 7.

3.6. SUMMARY

Chapter 1 and 2 presented the overview of the study, as well as the literature review. In this chapter, the researcher presented the research design and the methodology of the study. The chapter further described the data collection instruments and reliability and validity thereof. Data collection procedures, data analysis and research ethical principles were also discussed. The next chapter will present the findings of phase 1.

CHAPTER 4

PRESENTATION OF RESULTS OF THE SITUATIONAL ANALYSIS

(PHASE 1).

“Regardless of the brilliance of your analysis or the importance of your insights, you need to be able to communicate your findings successfully to others” Albert Einstein

4.1. INTRODUCTION

The previous chapter discussed the methodology and related aspects used in this study. This chapter will present the data collected in phase one (situational analysis). The findings relate to objectives 1 and 2 of the study, namely to determine and describe the self-reported competence of NQRNs at public hospitals, and to determine and describe the competence of NQRNs as reported by unit managers at public hospitals in Namibia.

4.2. RESPONSES ON DATA COLLECTION

As discussed previously in 3.3, data in phase one (situational analysis) were collected from two populations, namely NQRNs and unit managers. The researcher used structured questionnaires to gain insight into the competence of NQRNs. In addition, 54 questionnaires were distributed to the unit managers, and 88.8% (n=48) were received back (Table 3.2). Similarly, 103 questionnaires were received back from 121 NQRNs representing a response rate of 85.1%. A response rate is the percentage of questionnaires that participants returned to the researcher (Creswell, 2014). According to Creswell (2014), a response rate of 60% is considered as good and 70% as very good. For this study,

the researcher was able to obtain information that could be generalised to the population, which the researcher deemed to be adequate for data analysis (Creswell, 2014).

The findings of phase 1 are discussed as follows:

4.2.1. Questionnaire 1 to NQRNs (Annexure 9) with sections 1 and 2

4.2.2. Questionnaire 2 to unit managers (Annexure 10) with sections 1, 2 and 3

The sections of each questionnaire will be discussed separately.

4.2.3. Questionnaire 1: NQRNS

The following section discussed the responses provided by NQRNs to each of the questions in the questionnaire.

4.2.3.1. SECTION 1: Demographic data of NQRNS [Item 1-7]

The demographic data comprised of the following: gender, experience, qualification obtained, institution of training, and the unit of practice.

- **Item 1.1: Gender (n=103)**

The number of valid returned questionnaires for NQRNs is n=103, of which 91(n=88.3%) are female and 11.7% (n=12) are male, as presented in Table 4.1.

Table 4.1: Gender of respondents (n=103)

Gender	Frequency	Percent	Valid Percent	Cumulative Percent
Male	12	11.7	11.7	11.7
Female	91	88.3	88.3	100.0
Total	103	100.0	100.0	

- **Item 1.2: Years of experience as registered nurse (n=103)**

In terms of years of experience, 81.6% (n=84) of the population had 6-12 months' experience, while 6.8% (n=7) of the NQRNs had 13–17 months' experience and finally, 11.7% (n=12) had 18–23 months' experience (see Table 4.2 below).

Table 4.2: Years of experience as registered nurse (n=103)

	Frequency(n)	Percent	Valid Percent	Cumulative Percent
Valid 6-12 months	84	81.6	81.6	81.6
13-17 months	7	6.8	6.8	88.3
18-23 months	12	11.7	11.7	100.0
Total	103	100.0	100.0	

- **Item 1.3: Training institution attended (n=103)**

In Namibia, there are four major training institutions for nursing. These institutions are: UNAM, the International University of Management (IUM), Welwitchia Health Training Centre and MoHSS. Among these institutions, most respondents (49.02% (n=51)) received their training from UNAM, while the rest were trained at other institutions, as indicated in Figure 4.1, IUM 28.43% (n=29), Welwitchia 20.59% (n=21) and MoHSS 1.96 % (n=2).

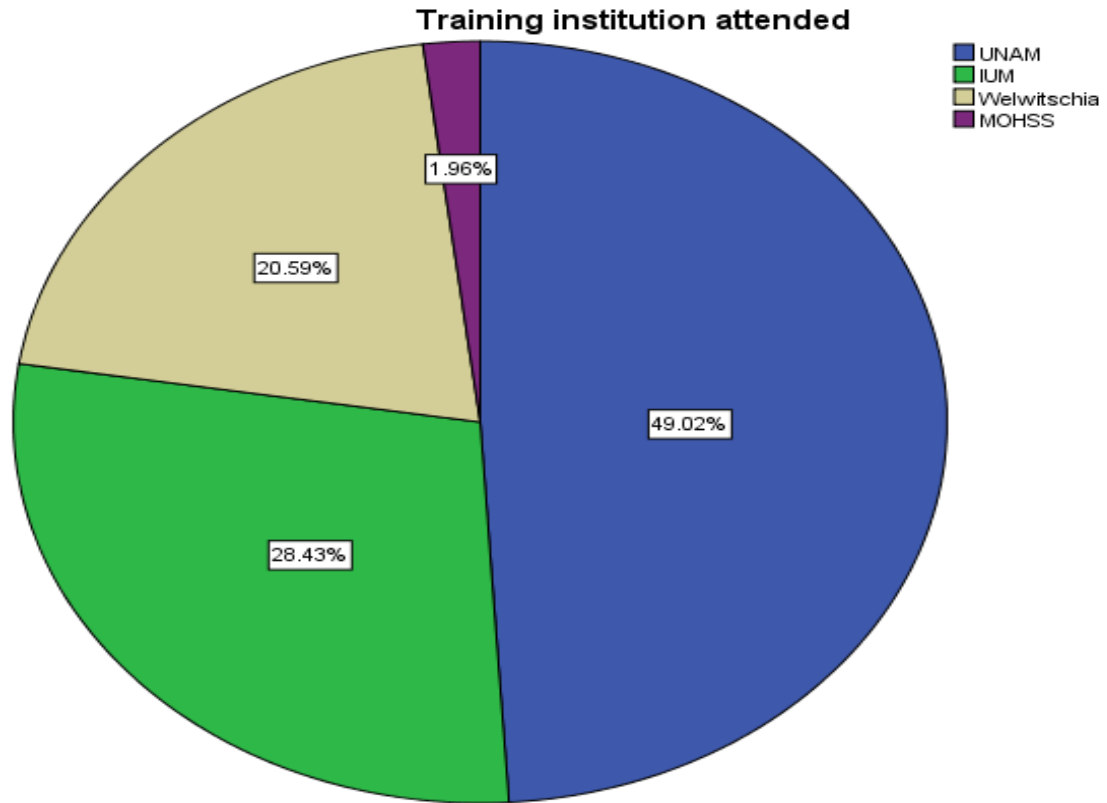


Figure 4.1: Responses according to training institutions

Source: Research data

- **Item 1.4: Nursing qualification (n=103)**

In this item, respondents were required to indicate whether they hold a degree or diploma. As indicated in Table 4.3, 95.1% (n= 98) NQRNs hold a degree while 4.9% (n=5) are diploma holders.

Table 4.3: Nursing qualification (n=103)

	Frequency (n)	Percent	Valid Percent	Cumulative Percent
Valid Diploma	5	4.9	4.9	4.9
Degree	98	95.1	95.1	100.0
Total	103	100.0	100.0	

- **Item 1.5: Previous nursing training (n=103)**

As previous training might influence the level of competency, item 1.5 in the questionnaire required candidates to reflect on possible previous training as enrolled nurses. From the 103 respondents, 85.4% (n=88) indicated that they had no previous training as enrolled nurses, while 14.6% (n=15) indicated that they underwent previous training (Table 4.4).

Table 4.4: Previous training as an enrolled nurse (n=103)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	15	14.6	14.6	14.6
No	88	85.4	85.4	100.0
Total	103	100.0	100.0	

- **Item 1.6: Unit/ward of practice (n=103)**

In terms of the ward of practice at the time of data collection, the following, as depicted in Figure 4.2, were evident: the majority of respondents 30.1% (n=31) were assigned to the medical wards, followed by the surgical and other unidentified wards 16.5% (n=17) each, while the gynaecology ward 0.97% (n=1) and paediatric ward 2.9% (n=3) were least represented.

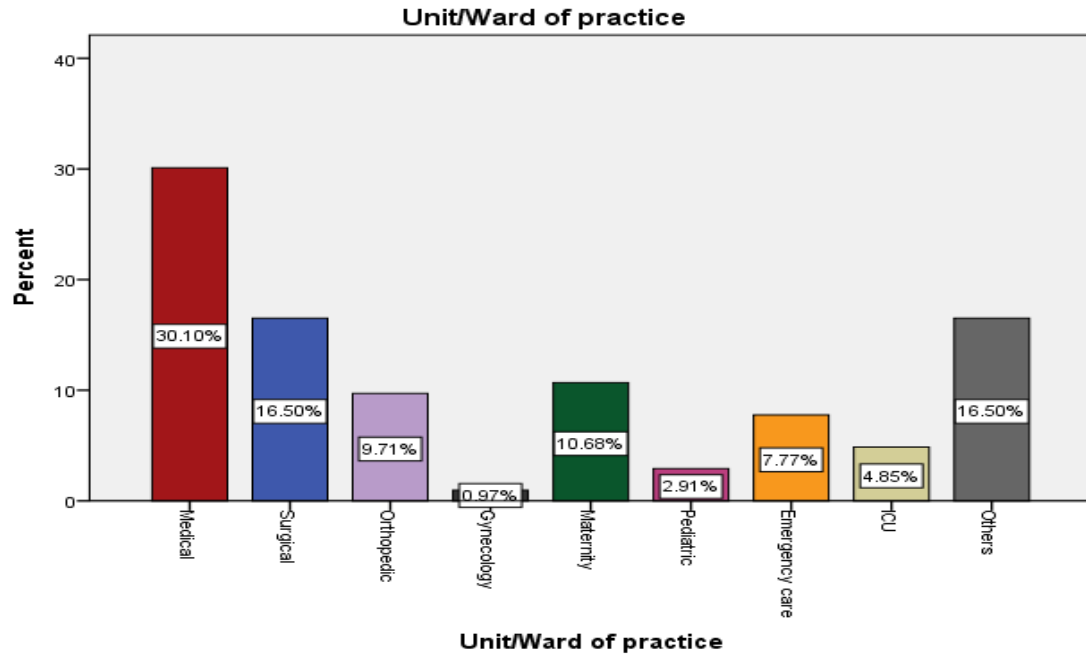


Figure 4.2: Unit/ward of practice

Source: Research data

- **Item 1.7: Unit/ward experience (n=103)**

In a follow up on the wards of practice, respondents had to indicate (Item 1.7) their length of experience. The results are laid out in Table 4.5. The length of experience of the NQRNs in the wards they indicated seemed short. Ninety-three nurses (90.3%) had 6-12 months’ experience, seven nurses (6.8%) had 18-23 months experience and three nurses (2.9%) indicated that they had 13-17 months’ experience.

Table 4.5: Unit /ward experience (n=103)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 6-12 months	93	90.3	90.3	90.3
13-17 months	3	2.9	2.9	93.2
18-23 months	7	6.8	6.8	100.0
Total	103	100.0	100.0	

4.2.3.2. SECTION 2: Self-rated competence of newly qualified registered nurses

Section 2 of the questionnaire consisted of questions on the domains of competencies, which will also guide the following discussion. Domain 1 on professional, legal and ethical competencies consisted of four questions (items 1.1-1.4). Domain 2 concentrated on knowledge-based practice in five sub-sections and contained 33 questions. Domain 3 addressed the final domain of competencies in nine questions (item 3.1-3.9). The discussion on each domain follows the sequence of the numbering of each item on the questionnaire.

4.2.3.2.1. Domain 1: Professional, legal and ethical competencies

Domain 1 measured the professional, legal and ethical competencies of NQRNs in four items, which are discussed below. For this domain all 103 respondents completed the items.

- **Item 1.1: Ensuring physical safety of patients (n=103)**

In terms of ensuring the safety of patients, only 43.7% (n=45) of NQRNs indicated that they were completely competent, while 40.8% (n=42) responded that they only had adequate knowledge. One percent (n=1) of the participants indicated that they had little knowledge, while 14.6% (n=15) only had basic knowledge.

- **Item 1.2: Practising in a manner that conforms to a registered nurse's job description (n=103)**

Regarding practising in a manner that conforms to their job description, only 26.7% (n=28) of the NQRNs said they were completely competent to perform efficiently and confidently without supervision, while 50.5% (n=52) responded that they had adequate knowledge and skills to perform without supervision. NQRNs who had only basic

knowledge and skills and still needed supervision represented 21.8% (n=22) of the respondents. Only 1% (n=1) of the respondents reflected little knowledge skills and the need for supervision and guidance.

- **Item 1.3: Recognising medical legal hazards (n=103)**

In relation to recognising medical legal hazards, only 45.6% (n=47) of the NQRNs said they were completely competent, while 44.7% (n=46) responded that they had adequate knowledge, while 8.7% (n=9) felt they only had basic knowledge. One percent (n=1) of the respondents felt they had little knowledge and needed guidance and supervision.

- **Item 1.4: Maintaining clear and legible documentation (n=103)**

This item required self-rating on the maintenance of clear and legible documentation. Forty-five (43.7%) NQRNs said they were completely competent, while 44.7% (n=46) responded that they had adequate knowledge. In addition, 10.7% (n= 12) of the NQRNs indicated that they had basic knowledge, whereas 1% (n=1) indicated that they had little knowledge and needed guidance and supervision.

Spearman Correlation presentation with demographic statistics of NQRN

A correlational analysis was conducted between NQRNs demographic characteristics and different competency items. It is worth noting that only some variables were used to determine the correlations. The data sets are all ordinal data except data on demography (no correlation test was carried out). Hence, a spearman rho is suitable to determine the correlation of non-parametric statistics. The correlation coefficient ranges between (0 – 1) for a positive relationship and (-1 - 0) for a negative relationship. Next is an interpretation of the values for the correlation coefficient.

Very weak positive correlation = 0.01 – 0.199

Weak positive correlation = 0.20 – 0.399

Moderate positive correlation = 0.40 – 0.599

Strong positive correlation = 0.60 – 0.799

Very strong positive correlation = 0.80 – 1.000

Since correlation coefficient is used to measure how strong a correlation is between two variables. The research adopted a rule of thumb acceptable correlation coefficient of p-value at 0.05. However, a correlation coefficient of 0.01 level (2 tailed) was also considered in case of some level of significance.

Correlational analysis between domain 1 and NQRNs demographics (n=103)

Regarding demographic characteristics, the respondents differed in two aspects which required analysis, namely qualification and previous experience in nursing. Correlational statistics were applied in this regard, and the results are depicted in Table 4.6.

As seen in Table 4.6 below, a weak relationship exists between the NQRNs' demographics and competency items in domain 1. It implies there are significant values, but a weakness of the correlation between the NQRN's demographics and competencies in domain 1.

Table 4.6: Spearman Correlation presentation of domain 1 with demographic statistics of NQRN (n=103)

Significant correlated Items	Correlation Coefficient	Statistical Significance	Relationship outcome
1. Correlation between nursing qualification and ensuring physical safety of patient.	-0.240*	0.015	weak
2. Correlation between previous training as an enrolled nurse and ensuring physical safety of patients.	-0.205*	0.037	weak
3. Correlation between nursing qualification and recognising medical legal hazards.	-0.236*	0.017	weak

***Correlation is significant at 0.05 level**

The following table presents the NQRNs responses on domain 1.

Table 4.7: Summary responses: Domain 1(NQRNs)

Competency Item	N	%	Little Knowledge %	Basic Knowledge %	Adequate Knowledge %	Completely competent %
Ensuring Physical safety of patients	103	100	1.0	14.6	40.8	43.7
How to practice in a manner that conforms to my job description	103	100	1.0	21.8	50.5	26.7
Recognizing medical legal hazards	103	100	1.0	8.7	44.7	45.6
Maintaining clear and legible documentation and records	103	100	1.0	11.7	43.7	43.7

In summary, the NQRNs indicated to possess either basic or adequate professional, legal and ethical competencies, but little or not completely competent in this domain. The findings however revealed that no significant relationship exist between NQRNs demographic characteristics and their competence.

4.2.3.2.2. Domain 2: Provision of care competencies

The following section comprised of 33 items that addressed the provision of care competencies through questions on knowledge-based practice. The question items in domain 2 were sub-divided into (2.1) assessment, (2.2) planning, (2.3) implementation, (2.4) provision of care and (2.5) evaluation. The discussion that follows was in the same sequence.

Sub-division: Assessment (2.1)

Item 2.1.1: Gathering accurate and relevant objective and subjective data (n=103)

In relation to the above, 33% (n=34) of the NQRNs answered that they were completely competent to gather data, while 57.3% (n=59) indicated that they only had adequate knowledge. In addition, 8.7% (n=9) responded that they had basic knowledge with 1.0% (n=1) indicating that they had little knowledge and needed guidance and supervision.

Item 2.1.2: Organising and interpreting patient data (n=103)

Of the 103 responses received, 29.1% (n=30) of the NQRNs answered that they were completely competent, 58.3% (n=60) indicated that only had adequate knowledge, and 12.6% (n=13) responded that they had basic knowledge.

Item 2.1.3: Making correct nursing diagnosis (n=103)

Pertaining to making correct nursing diagnosis, 30.0% (n=31) of the NQRNs answered that they were completely competent to do so, while 49% (n=50) indicated they only had adequate knowledge. In addition, 20% (n=21) responded that they had basic knowledge, with 1% (n=1) indicating that they had little knowledge and, therefore, needed supervision and guidance in making correct nursing diagnoses.

Subdivision: Planning 2.2

Item 2.2.1: Formulation of a comprehensive nursing care plan according to patient needs (n=103)

Following the making of a correct nursing diagnosis was the drafting of a nursing care plan. Of the 103 respondents, 41.7% (n=43) NQRNs indicated they were completely competent, while 47% (n=48) indicated that they had adequate knowledge in drafting a nursing care plan. Only 12% (n=12) felt their knowledge of this was basic.

Item 2.2.2: Prioritising nursing care plan based on urgency (n=103)

Regarding prioritising a nursing care plan based on urgency, 36% (n=37) of the NQRNs said they were completely competent in doing so, while 51.4% (n=53) indicated they only had adequate knowledge. On the other hand, 11% (n=11) responded that they had basic knowledge, with 2% (n=2) indicating they had little knowledge.

Subdivision: Implementation (2.3)

Item 2.3.1: Performing nursing procedures according to patient needs (n=103)

In terms of performing nursing procedures according to patient needs, 42.7% (n=44) of the NQRNs indicated that they were completely competent and 49% (n=50) only had adequate knowledge. Additionally, 8% (n=8) had basic knowledge in doing nursing procedures that speak to the needs of patients. NQRNs with little knowledge represented 1% (n=1) of the respondents.

Item 2.3.2: Documenting nursing intervention accurately and timely (n=103)

For this item, 42.7% (n=44) of the NQRNs said they were completely competent, while 54% (n=56) indicated that they only had adequate knowledge in documenting nursing interventions. On the other hand, 2% (n=2) responded that they had basic knowledge with 1% (n=1) indicating that they had little knowledge on documenting nursing interventions accurately and on time.

Subdivision: Provision of care (2.4)

Item 2.4.1: Recognising possible cardiac arrest (n=103)

This item required the NQRNs to indicate whether they were able to recognise a possible cardiac arrest. From all the responses, only 15% (n=15) answered they were completely competent, while 38% (n=39) deemed they had adequate knowledge. The researcher recorded with concern that 45% (n=46) had basic knowledge and 3% (n=3) little knowledge, requiring supervision and guidance.

Item 2.4.2: Performing cardiopulmonary resuscitation correctly (n=103)

Following the previous item on the recognition of a cardiac arrest, this item required the NQRNs to indicate whether they regarded themselves completely competent in performing cardiopulmonary resuscitation (CPR) correctly. Only 22% (n=23) indicated that they were completely competent, while 28% (n= 29) indicated that they had adequate knowledge. A high percentage, 47% (n=48), responded that they had basic knowledge while 3% (n=3) indicated that they had little knowledge.

Item 2.4.3: Recognising possible emergency situations (n=103)

In this item, 30% (n=31) of the NQRNs responded that they were completely competent in recognising possible emergency situations, while 44% (n=45) indicated that they only had adequate knowledge. On the other hand, 25% (n=26) responded that they had basic knowledge with 1% (n=1) indicating they had little knowledge, and thus needed supervision and guidance.

Item 2.4.4: Recognising anaphylactic shock (n=103)

Recognising anaphylactic shock is a key competency that every NQRN should possess. Only 21% (n=22) indicated that they could recognise anaphylactic shock without guidance and supervision, whereas 46% (n=47) considered themselves to have adequate knowledge. Thirty-one percent (n=32) indicated that they had basic knowledge, while 2% (n=2) had little knowledge and, therefore, would not be able to recognise anaphylaxis without assistance.

Item 2.4.5: Calculations of dosages of emergency drugs (n=103)

Regarding calculating dosages of emergency drugs, 39% (n=40) of the NQRNs said they were completely competent, while 46% (n=47) indicated that they only had adequate knowledge. On the other hand, 13.6% (n=14) responded that they had basic knowledge with 2% (n=2) indicating they had little knowledge.

Item 2.4.6: Administering of different emergency drugs (n=103)

In this item, NQRNs were expected to indicate their competency in administering different emergency drugs after the dosage was calculated. Thirty-one percent (n=32) indicated that they were completely competent in doing so, while 48.5% (n=50) indicated that they only had adequate knowledge. On the other hand, 19.4% (n=20) responded that they had basic knowledge with 1% (n=1) indicating they had little knowledge.

Item 2.4.7: Admission of patients correctly (n=103)

Asked whether they felt competent to admit patients correctly, a majority of the NQRNs, 61.1% (n=63), answered they were completely competent, while 34% (n=35) indicated that they had adequate knowledge. Three percent (n=3) of the NQRNs responded that they had basic knowledge with 2% (n=2) indicating that they had little knowledge.

Item 2.4.8: Discharge of patients correctly (n=102)

On whether they could discharge patients correctly, 63% (n=64) of the NQRNs answered they are completely competent, while 30% (n=31) indicated that they only had adequate knowledge. Those who doubted their competency (5% (n=5)) responded that they had

basic knowledge, with 1% (n=1) indicating that they had little knowledge on discharging patients. One participant (1%) did respond to this question.

Item 2.4.9: Provision of safe environments for patients (n=102)

Providing a safe environment for patients is a competency expected of every NQRN. Sixty percent NQRNs (n=61) indicated that they were completely competent, while 35.2% (n=36) indicated that they only had adequate knowledge. Four percent (n=4) regarded themselves as having basic knowledge, while 1% (n=1) indicated they had little knowledge. One participant (1%) did respond to this question.

Item 2.4.10: Performing accurate intake and output recording (n=102)

In relation to the above item on intake and output, 62.2% (n=61) of the NQRNs indicated that they were completely competent, while 37% (n=35) indicated that they had adequate knowledge on recording of intake and output. In addition, 4% (n=4) responded that they had basic knowledge, with 1% (n=1) indicating they had little knowledge, while one participant (1%) did not provide an answer.

Item 2.4.11: Insertion of nasogastric tube (n=103)

Regarding the insertion of a nasogastric tube, 33% (n=34) of the NQRNs answered they were completely competent, while 40% (n=41) indicated that they have adequate knowledge on how to insert a nasogastric tube. On the other hand, 22% (n=23) responded that they had basic knowledge, with 5% (n=5) indicating that they had little knowledge.

Item 2.4.12: Performing of gastric aspiration (n=101)

In relation to performing gastric aspiration, 19.4 % (n=20) of the NQRNs responded that they were completely competent in doing so, NQRNs had adequate knowledge 43.7% (n=45), while 23.3 % (n=23) responded that they had basic knowledge, with 10.7% (n=11) indicating they had little knowledge, and, therefore, required supervision and guidance. Two participants (2%) did not provide responses.

Item 2.4.13: Insertion of female catheter (n=103)

On the insertion of a female catheter, 62.1% (n=64) of the NQRNs responded that they were completely competent, while 33% (n=34) indicated that they only had adequate knowledge. A few (2.9% (n=3) responded that they had basic knowledge, with 1.9% (n=2) indicating that they had little knowledge.

Item 2.4.14: Insertion of male catheter (n=103)

In terms of inserting a male catheter, 43.7% (n=45) of the NQRNs answered they were completely competent, while 31.1% (n=32) indicated that they had adequate knowledge. In addition, 16.5% (n=17) responded they had basic knowledge, with 8.7% (n=9) indicating that they had little knowledge on the procedure.

Item 2.4.15: Drawing of blood specimen (n=103)

On whether they regarded themselves competent in drawing blood, 68 % (n=70) of the NQRNs answered they were completely competent, while 27% (n=28) indicated that they had adequate knowledge. On the other hand, 3.9% (n=4) responded that they had basic knowledge, with 1.0 % (n=1) indicating that they had little knowledge.

Item 2.4.16: Stoma care (n=101)

On stoma care, 25.2% (n=26) of the NQRNs regarded themselves completely competent, while 31.1% (n=32) indicated that they had adequate knowledge. NQRNs with basic and little knowledge were 27.2% (n=28) and 12.6% (n=13), respectively. Two participants (2%) did not indicate their competencies on this item.

Item 2.4.17: Administering oxygen therapy (n=101)

Regarding the administering of oxygen therapy, 68.0% (n=70) of the NQRNs felt completely competent, while 21.4% (n=22) indicated that they only had adequate knowledge. On the other hand, 4.9% (n=5) responded that they had basic knowledge, with 2.9% (n=3) indicating that they had little knowledge on the administration of oxygen therapy. One participant (1%) did not answer this question.

Item 2.4.18: Interpreting of the medicine prescription chart (n=103)

In relation to the above, 68% (n=70) of the NQRNs indicated that they were completely competent in interpreting a medicine prescription, while 26.2% (n=27) indicated that they only had adequate knowledge. Additionally, 5.8% (n=6) responded that they had basic knowledge.

Item 2.4.19: Preparing of patient for operation (n=99)

In terms of preparing patients for operation, 68% (n=70) of the NQRNs answered they were completely competent, 20.3% (n=21) indicated that they had adequate knowledge, while 3.9% (n=4) said they had basic knowledge. Four participants (4%) did not indicate whether they are able to prepare a patient for operation.

Item 2.4.20: Caring for patient after operation (n=103)

Sixty-five percent (n=67) of the respondents indicated that they were completely competent to care for a patient after operation. Those with adequate knowledge represented 30.1% (n=31), while 3.9% (n=4) only had basic knowledge. Only one participant (1%) indicated little knowledge in caring for a patient post-operatively.

Item 2.4.21: Performing aseptic wound care (n=102)

Regarding wound care, 60.2% (n=61) of the NQRNs answered they were completely competent, while 33% (n=34) indicated that they had adequate knowledge on caring for wounds aseptically. On the other hand, 4.9% (n=5) responded that they had basic knowledge, with 1% indicating that they had little knowledge. One participant (1%) did not indicate their response.

Item 2.4.22: Understanding infection control principles (n=102)

On understanding infection control principles, 49.5% (n=50) of NQRNs answered they were completely competent in understanding infection control, while 46.0% (n=45) indicated that they had adequate knowledge. A minority of 5.8% (n=6) responded that they had basic knowledge. One participant (1%) did not answer the question.

Item 2.4.23: Administering intravenous fluids and medications (n=103)

Regarding administering intravenous fluids and medications, 68% (n=70) of NQRNs responded that they were completely competent, while 25.2% (n=26) indicated that they had adequate knowledge. The remaining 5.8% (n=6) responded that they had basic

knowledge about the administration of intravenous fluids and medication and one participant (1%) indicated little knowledge.

Subdivision: Evaluation (2.5)

Item 2.5.1: Monitoring and documenting patient progress accurately and completely (n=103)

On monitoring and documenting patient progress accurately and completely, 62.1% (n=64) of NQRNs answered they were completely competent in doing so, while 33% (n=34) indicated that they had adequate knowledge. In addition, 3.9% (n=4) responded that they had basic knowledge with only 1% (n=1) indicating that they had little knowledge.

Item 2.5.2: Evaluate patient progress in relation to nursing care plan (n=103)

In terms of the evaluation of patient progress in relation to nursing care plan, 47.6% (n=49) responded that they were completely competent, while almost the same number (45.6% (n=47)) answered they had adequate knowledge. A low 4.9 % (n=5) had basic knowledge, whereas 1.9% (n=2) indicated that they had little knowledge and should be guided and supervised to execute this task.

Item 2.5.3: Uses evaluation data to modify the nursing care plan (n=101)

Lastly, on using evaluation data to modify the nursing care plan, 34% (n=34) of NQRNs said they were completely competent, while the highest number 49.0 % (n=51) indicated that they have adequate knowledge. On the other hand, 14.5 % (n=15) responded that they

had basic knowledge with 1% (n=1) indicating that they had little knowledge. Two participants (2%) did not provide answers on this item.

As in domain 1, the NQRNs shared the same views of not being completely competent in most competency items on provision of care, but possess either basic or adequate competencies.

The following table presents a summary of the responses of NQRNs on domain 2.

Table 4.8: Summary of responses on domain 2 (NQRNs)

Competency Item	n	%	Little Knowledge %	Basic Knowledge %	Adequate Knowledge %	Completely competent %
How to gather accurate and relevant objective and subjective data	103	100	1.0	8.7	57.3	33.0
Organizing and interpreting patient data	103	100	0	12.6	58.3	29.1
Making correct nursing diagnosis	103	100	1.0	19.4	47.6	32.0
Formulation of a comprehensive nursing care plan according to patient needs	103	100	0	11.7	45.6	42.7
Prioritizing nursing care plan based on urgency	103	100	1.9	10.7	52.4	35.0
Performing nursing procedures according to patient needs	102	99.0	1.0	7.8	48.0	43.1
Documenting nursing intervention accurately and in timely manner	103	100	1.0	3.9	52.4	42.7

Recognizing possible cardiac arrest	103	100	4.9	43.7	36.9	14.6
Performing Cardiopulmonary Resuscitation (CPR) correctly	103	100	5.8	45.6	27.2	21.4
Recognizing possible emergency situations	103	100	3.9	24.3	42.7	29.1
Recognizing of anaphylactic shock	102	99.0	3.9	30.0	45.1	20.6
	n	%	Little Knowledge %	Basic Knowledge %	Adequate Knowledge %	Completely competent %
Calculations of dosages of emergency drugs	103	100	1.9	15.5	44.7	37.9
Administering of different emergency drugs	103	100	1.0	18.4	50.5	30.1
Admission of patients correctly	103	100	1.9	2.9	33.0	62.1
Discharge of patients correctly	102	99.0	1.0	4.9	29.4	64.7
Provision of safe environments for patients	103	100	1.0	3.9	36.3	58.8
Performing accurate intake & output recording	102	99.0	0	3.9	36.3	59.8
Insertion of nasogastric tube	103	100	7.8	21.4	38.8	32.0
Performing of gastric aspiration	103	100	10.9	23.8	44.6	20.8
Insertion of female catheter	103	100	1.9	2.9	33.0	62.1
Insertion of male catheter	103	100	8.8	15.7	31.4	44.1

	N	%	Little Knowledge %	Basic Knowledge %	Adequate Knowledge %	Completely competent %
Drawing of blood specimen	102	99.0	0	3.9	27.5	68.6
Stoma care	101	98.1	12.9	27.7	33.7	25.7
Administering oxygen therapy	100	97.1	0	5.0	22.0	73.0
Interpretation of medicine prescription chart	103	100	0	5.8	26.2	68.0
Preparation of patient for operation	103	100	0	3.9	28.2	68.0
Caring of patient after operation	102	99.0	0	3.9	30.4	65.7
Performing aseptic wound care	102	99.0	1.0	4.9	33.3	60.8
Understanding infection control principles	103	100	0	5.8	44.7	49.5
Administering intravenous fluids and medications	101	98.1	0	5.9	25.7	68.3
Monitoring and documenting patient progress accurately and completely	103	100	1.0	3.9	33.0	62.1
Evaluate patient progress in relation to nursing care plan	103	100	1.9	4.9	45.6	47.6
Uses evaluation data to modify the nursing care plan	103	100	1.0	15.5	49.5	34.0

Correlation analysis between domain 2 and NQRNs' demographics

A correlational analysis was conducted between demographic variables and items on skills and knowledge related to specific nursing care, as indicated in Table 4.9.

Table 4.9: Spearman Correlation analysis between domain 2 and demographics of NQRNs

Significant correlated items	N=	Correlation Coefficient	Statistical Significance	Relationship Outcome
1. Correlation between nursing qualification and:				
• How to gather accurate and relevant objective and subjective data	103	-0.217*	0.027	Negative & weak
• Prioritising nursing care plan based on urgency	103	-0.207*	0.036	Negative & weak
• Nursing qualification & performing of gastric aspiration	101	-0.223*	0.025	Negative & weak
• Nursing qualification & stoma care	101	-0.306**	0.002	Negative & weak
• Nursing qualification & recognising possible cardiac arrest	103	-0.273**	0.005	Negative & weak
2. Correlation between years of experience and:				
• Recognising possible cardiac arrest	103	0.216*	0.028	Positive & weak
• Stoma care	101	0.199*	0.046	Positive & weak
• Administering intravenous fluids and medications	103	0.222*	0.026	Positive & weak

3. Correlation between gender and:				
• Recognising possible emergency situations	103	0.204*	0.039	Positive & weak
• Calculations of dosages of emergency drugs	103	0.195*	0.049	Positive & very weak
• Admission of patients correctly	103	0.236*	0.016	Positive & weak
• Discharge of patients correctly	102	0.195*	0.050	Positive & very weak
• Performing accurate intake & output recording	102	0.200*	0.044	Positive & weak
• Insertion of nasogastric tube	103	0.251*	0.010	Positive & weak
• Stoma care	101	0.224*	0.025	Positive & weak
• Administering oxygen therapy	101	0.253*	0.011	Positive & weak
• Preparation of patient for operation	99	0.247*	0.012	Positive & weak
• Caring of patient after operation	103	0.209*	0.035	Positive & weak
• Performing aseptic wound care	102	0.197*	0.048	Positive & very weak
• Understanding infection control principles	102	0.258**	0.009	Positive & weak
4. Correlation between unit/ward experience and:				

• Discharge of patients correctly	102	-0.213*	0.032	Negative & weak
• Provision of safe environment for patients	102	-0.223*	0.024	Negative & weak
5. Correlation between training institution and:				
• Administering oxygen therapy	100	-0.210*	0.037	Negative & weak
6. Correlation between previous training as enrolled nurse and:				
• Uses evaluation data to modify the nursing care plan	101	0.210*	0.034	Positive & weak

***Correlation is significant at the 0.05 level (2-tailed)**

Regarding domain 2 significance level and correlation between NQRNs' competencies and demographic representation, there are mostly weak relationship outcomes, as seen in Table 4.9. Although, there are some significantly correlated items where $\alpha=0.05$ and cases where $\alpha=0.01$, a weak or very weak (positive or negative) relationship does not provide strong argument to determine a relationship (Table 4.9). The following table (Table 4.10) is a summary of the responses on Domain 3.

Table 4.10: Summary of responses of Domain 3 (NQRN)

Competency Item	n	%	Little Knowledge %	Basic Knowledge %	Adequate Knowledge %	Completely competent %
Identify priority nursing duties	103	100	1.9	8.7	52.4	36.9
Planning nursing care according to patient needs	103	100	1.0	7.8	49.5	41.7
Delegation of nursing care duties	103	100	0	5.8	43.7	50.5
Scheduling off duties based on the workload	103	100	1.0	11.7	43.7	43.7
Complete nursing duties on time	103	100	0	10.8	40.2	49.0
Communication of clear and accurate information	103	100	0	12.6	44.7	42.7
Managing staff conflict in the ward	103	100	7.8	37.9	38.8	15.5
Assisting patients to make informed decisions	103	100	1.9	20.4	43.7	34.0
Supervision of junior nurses and subordinates	103	100	1.9	12.6	50.5	35.0
Competency Item	N	%	Little Knowledge %	Basic Knowledge %	Adequate Knowledge %	Completely competent %
Identify priority nursing duties	103	100	1.9	8.7	52.4	36.9
Planning nursing care according to patient needs	103	100	1.0	7.8	49.5	41.7
Delegation of nursing care duties	103	100	0	5.8	43.7	50.5

Scheduling off duties based on the workload	103	100	1.0	11.7	43.7	43.7
Complete nursing duties on time	103	100	0	10.8	40.2	49.0
Communication of clear and accurate information	103	100	0	12.6	44.7	42.7
Managing staff conflict in the ward	103	100	7.8	37.9	38.8	15.5
Assisting patients to make informed decisions	103	100	1.9	20.4	43.7	34.0
Supervision of junior nurses and subordinates	103	100	1.9	12.6	50.5	35.0

4.2.3.2.3. Domain 3: Management and leadership competencies (n=103)

Domain 3 consists of nine items measuring the respondents' competency levels in terms of management and leadership. All 103 participants responded to these items.

Item 3.1: Identify priority nursing duties (n=103)

In terms of the identification of nursing duty priorities, 35.9% (n=37) NQRNs responded that they were completely competent, while 52.4% (n=54) indicated that they had adequate knowledge. Respondents with basic knowledge represented 9.7% (n=10), while 1.9% (n=2) responded that they had little knowledge.

Item 3.2: Planning nursing care according to patient needs (n=103)

Regarding planning nursing care according to patient needs, 41.7% (n=43) NQRNs regarded themselves as completely competent, 49.5% (n=51) indicated that they had adequate knowledge, with 7.8% (n=8) indicating they had basic knowledge. Only 1% (n=1) indicated that they had little knowledge.

Item 3.3: Delegation of nursing care duties (n=103)

In terms of delegation of nursing care duties based on the workload of nurses, 52% (n=54) NQRNs responded that they were completely competent, while 43.7% (n=45) indicated that they only had adequate knowledge. Respondents who indicated that they possessed basic knowledge were 3.8% (n=4). No respondents regarded themselves as having little knowledge.

Item 3.4: Scheduling off duties based on the workload (n=103)

Regarding scheduling off duties based on the workload in the unit, 43.7% (n=45) of the NQRNs responded that they were completely competent, with the same number 43.7% (n=45) indicating that they had adequate knowledge. Those who indicated that they had

basic knowledge were 11.7% (n=12), with only 1% (n=1) indicating that they had little knowledge.

Item 3.5: Completion of nursing duties on time (n=103)

NQRNs had to indicate whether they were competent to complete nursing duties on time. Those who regarded themselves completely competent were 48.5% (n=50), while 39.8% (n=41) said they had adequate knowledge. Only 12.0% (n=12) responded that they had basic knowledge, and none regarded themselves as having little knowledge.

Item 3.6: Communication of clear and accurate information (n=103)

In terms of clear communication and accurate information, those with complete competence were 42.7% (n=44) with almost the same number possessing adequate knowledge at 44.7% (n=46). The NQRNs with only adequate knowledge represented 12.6% (n=13) of the respondents. None of the participants reflected little knowledge.

Item 3.7: Managing staff conflict in the unit (n=103)

A small percentage of 15.5% (n=16) of the NQRNs regarded themselves as completely competent to manage staff conflict in the unit. NQRNs with adequate knowledge and basic knowledge were very close at 38.8% (n=40) and 37.9% (n=39), respectively. Only 7.8% (n=8) indicated they had little knowledge and needed guidance and supervision.

Item 3.8: Assisting patients to make informed decisions (n=103)

In terms of assisting patients to make informed decisions, 34.0% (n=35) of the NQRNs responded that they were completely competent, while 43.7% (n=45) indicated that they

had only adequate knowledge. Those who indicated that they possessed basic knowledge were 20.4%, (n=21), with only 1.9% (n=2) indicating that they had little knowledge.

Item 3.9: Supervision of junior nurses and subordinates (n=103)

On the final item on whether the NQRNs regarded themselves competent in supervising junior nurses, 35% (n=36) responded that they were completely competent, 50.5% (n=52) had adequate knowledge, whereas 12.6% (n=13) and 1.9% (n=2) indicated basic and little knowledge, respectively.

In summary, the researcher concluded that NQRNs views of their competencies on domain 3 (management and leadership) are not different from those on domains 1&2. Therefore, the researcher draw the conclusion based on the findings that a transitional support programme could be the answer to enhance the competence of NQRNs.

Correlation analysis between domain 3 and demographics of NQRNs (n=103)

As mentioned previously, Domain 3 of this study focused on managerial and leadership skills. Statistical analysis was conducted to determine whether there was any association between certain demographic variables and the ratings indicated on this specific domain by the respondents. The variables were Qualification, Gender, and Years of experience. From the results, as indicated in Table 4.11, there was not significant evidence of any association or relationship.

Table 4.11: Spearman Correlation analysis between domain 3 and demographics of NQRNs (n=103)

Significantly correlated items	Correlation Coefficient	Statistical Significance	N=	Relationship outcome
1. Correlation between nursing qualification and:				
• Identify priority nursing duties	-0.197*	0.046	103	Negative & very weak
• Delegation of nursing care duties based on the workload	-0.218*	0.027	103	Negative & weak
• Scheduling off duties based on the workload	-0.242*	0.014	103	Negative & weak
• Assisting patients to make informed decisions	-0.212*	0.032	103	Negative & weak
• Supervision of junior nurses and subordinates	-0.280**	0.004	103	Negative & weak
2. Correlation between gender and:				
• Assisting patients to make informed decisions	0.251*	0.011	103	Positive & weak
3. Correlation between years of experience and:				
• Supervision of junior nurses and subordinates	0.198*	0.045	103	Positive & very weak

****Correlation is significant at the 0.01 level (2-tailed)**

***Correlation is significant at the 0.05 level (2-tailed)**

In summary, the findings indicated that there is no significant relationship or association between NQRNs' management and leadership competencies and their biographical data. Following is a table summarizing the responses on domain 3.

The study focused on two populations, namely, NQRNs and unit managers. The analysis of the questionnaires from NQRNs was discussed in the previous section. The following discussion is on the questionnaires received from unit managers. Fifty-four questionnaires were distributed to unit managers from which 89% (n=48) were collected.

4.2.3.3. SECTION 1: Demographic data of unit managers

The following section gives an insight into the demographic information of the unit managers. The items are numbered as in the questionnaire.

Item 1.1: Years of experience as unit manager (n=48)

The years of experience were grouped as follows: 2-5 years, 6-10 years, 11-15 years and 16–20 years, and 21 years and above. See Table 4.12 below.

Table 4.12: Years of experience as unit manager (n=48)

Years	Frequency	Percentage
2-5 years	9	18.8
6-10 years	11	22.9
11-15 years	6	12.5
16-20 years	5	10.4
21 years and above	17	35.4
Total	48	100.0

Item 1.2: Clinical unit/ward (n=48)

According to the responses, as per Figure 4.2 (page 88), most of the unit managers were stationed in the medical and surgical wards, with 22.9% (n=11) each representation of the population (see Table 4.13 below), followed by orthopaedic ward and others of which 4.2% (n=2) represented ICU and emergency. Eight of the respondents (16.7%) did not specify the wards where they worked.

Table 4.13: Clinical unit/ward (n=48)

Clinical unit/ward		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Medical	11	22.9	22.9	22.9
	Surgical	11	22.9	22.9	45.8
	Orthopaedic	5	10.4	10.4	56.3
	Gynaecology	1	2.1	2.1	58.3
	Maternity	4	8.3	8.3	66.7
	Paediatric	4	8.3	8.3	75.0
	Emergency care	2	4.2	4.2	79.2
	ICU	2	4.2	4.2	83.3
	Others	8	16.7	16.7	100.0
	Total	48	100.0	100.0	

Item 1.3: Highest nursing qualification (n=48)

In terms of the unit managers' qualification, as indicated in Table 4.14, 52% (n=25) possess nursing diploma and 22.9% (n=11) of the managers have nursing degrees.

Twenty-five percent (n=12) have a post-graduate diploma. None of the unit managers has a master's or doctoral qualification.

Table 4.14: Highest nursing qualification (n=48)

Qualification	Frequency	Per cent
Nursing diploma	25	52.1
Nursing degree	11	22.9
Post graduate diploma	12	25.0
Master's degree	0	0
Doctoral degree	0	0
Total	48	100.0

4.2.3.4. SECTION 2: Responses of unit managers on NQRNs' competence

Section 2 of the questionnaire to unit managers is aligned to a similar section in the questionnaire to NQRNs. The researcher aimed to determine whether there was correlation between NQRNs' self-assessment and unit managers' assessment of the NQRNs.

Data collected from unit managers were meant to provide managerial insight into NQRNs' competencies under the supervision of the unit managers.

4.2.3.4.1. Domain 1: Professional, legal and ethical competencies

Item 1.1: Ensuring safety for patients (n=48)

In terms of ensuring safety for patients, 6.2% (n=3) of unit managers believed NQRNs were completely competent, while 14.6% (n=7) responded that NQRNs had adequate knowledge, but the majority 60.4% (n=29) felt NQRNs only had basic knowledge, with 18.8% (n=9) saying NQRNs had little knowledge.

Item 1.2: Practising in a manner that conforms to their job description (n=48)

On whether NQRNs can practice in a manner that conforms to their job description, only a small percentage of 4.2% (n=9) of the unit managers responded that they could, while 14.6% (n=7) replied NQRNs had adequate knowledge. The other 22.9% (n=11) indicated that NQRNs had little knowledge, while the majority 43.8% (n=21) felt that NQRNs only had basic knowledge in this competency.

Item 1.3: Recognising medical legal hazards (n=48)

Despite recognising that a medical legal hazards is a crucial competency NQRNs should possess, only a small percentage (4.2% (n=2)) of unit managers believed the NQRNs were completely competent in doing so. Those that indicated that NQRNs had adequate knowledge represented 14.6% (n=7), while 29.2% (n=14) pointed out that NQRNs had little knowledge. However, a majority 52.1% (n=25) indicated that NQRNs had basic knowledge.

Item 1.4: Maintaining clear and legible documentation and records (n=48)

This item required the unit managers to indicate whether NQRNs can maintain clear and legible documentation and records. Only 4.2% (n=2) of the unit managers responded that NQRNs were completely competent in doing so, 12.5% (n=6) responded that NQRNs only had adequate knowledge and the majority 62.5% (n=30) believed NQRNs had only basic knowledge, while 20.8% (n=10) indicated that they had little knowledge.

4.2.3.4.2. Responses on domain 2: provision of care competencies (n=48)

This section comprised of the same items in the NQRNs questionnaire. The difference is that these are the assessments of NQRNs' competencies by the unit managers.

Subdivision: Assessment (2.1)

Item 2.1.1: Gathering accurate and relevant objective and subjective data (n=47)

In this item, unit managers were required to indicate whether NQRNs were able to gather accurate and relevant objective and subjective data. Of the 48 unit managers, 2.1% (n=1) pointed out that NQRNs were completely competent, while 14.9% (n=7) indicated that NQRNs had adequate knowledge. In addition, a majority 55.2% (n=26) responded NQRNs had basic knowledge, while 27.7% (n=13) believed NQRNs had little knowledge, thus needed supervision and guidance, while one participant (2.1%) did not provide a response as illustrated in Table 4.15.

Table 4.15: How to gather accurate and relevant objective and subjective data

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	13	27.1	27.7	27.7
	Basic knowledge	26	54.2	55.3	83.0
	Adequate knowledge	7	14.6	14.9	97.9
	Completely competent	1	2.1	2.1	100.0
	Total	47	97.9	100.0	
Missing	System	1	2.1		
Total		48	100.0		

Item 2.1.2: Organising and interpreting patient data (n=48)

Only a small number (4.2% (n=2) of unit managers pointed out that NQRNs were completely competent in organising and interpreting patient data, while 12.5% (n=6) indicated that NQRNs had adequate knowledge. A majority 52.1% (n=25) responded that NQRNs had basic knowledge, while 31.3% (n=15) indicated that NQRNs had little knowledge. See Table 4.16.

Table 4.16: Organising and interpreting patient data (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	15	31.3	31.3	31.3
	Basic knowledge	25	52.1	52.1	83.3
	Adequate knowledge	6	12.5	12.5	95.8
	Completely competent	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

Item 2.1.3: Making correct nursing diagnosis (n=46)

This item required unit managers to rate NQRNs on making a correct diagnosis. Only 6.3% (n=3) unit managers pointed out that NQRNs were completely competent in doing so, while 12.5% (n=6) indicated that they had adequate knowledge. In addition, 45.8% (n=22) answered NQRNs had basic knowledge, while 31.3% (n=15) indicated that they had little knowledge. Two participants (4.2%) did not respond to this question as shown in Table 4.17.

Table 4.17: Making correct nursing diagnosis (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	15	31.3	32.6	32.6
	Basic knowledge	22	45.8	47.8	80.4
	Adequate knowledge	6	12.5	13.0	93.5
	Completely competent	3	6.3	6.5	100.0
	Total	46	95.8	100.0	
Missing	System	2	4.2		
Total		48	100.0		

Subdivision: Planning (2.2)

Item 2.2.1: Formulation of a comprehensive nursing care plan according to patient needs (n=45)

Following making a correct nursing diagnosis, unit managers were expected to indicate NQRNs' competencies in formulating a comprehensive nursing care plan according to

patient needs. The researcher has documented with concern that only a minimum number 8.3% (n=4) of unit managers answered that NQRNs were completely competent, while 16.7% (n=8) indicated they had adequate knowledge. The remaining 41.7% (n=20) responded that NQRNs had basic knowledge, while 27.1% (n=13) indicated that NQRNs had little knowledge. Three of the unit managers (6.3%) did not provide answers on this item as shown in Table 4.18.

Table 4.18: Formulation of a comprehensive nursing care plan according to patient needs (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	13	27.1	28.9	28.9
	Basic knowledge	20	41.7	44.4	73.3
	Adequate knowledge	8	16.7	17.8	91.1
	Completely competent	4	8.3	8.9	100.0
	Total	45	93.8	100.0	
Missing	System	3	6.3		
Total		48	100.0		

Item 2.2.2: Prioritising nursing care plan based on urgency (n=47)

With reference to prioritising nursing care plan based on urgency, 6.3% (n=3) of the unit managers pointed out that NQRNs were completely competent in this skill, while 8.3% (n=4) indicated that NQRNs they had adequate knowledge. More than half (52.1% (n=25) the unit managers answered NQRNs had basic knowledge and 31.3% (n=15) indicated that NQRNs had little knowledge, while one participant (2.1%) did not indicate their opinion. Refer to Table 4.19.

Table 4.19: Prioritising nursing care plan based on urgency

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	15	31.3	31.9	31.9
	Basic knowledge	25	52.1	53.2	85.1
	Adequate knowledge	4	8.3	8.5	93.6
	Completely competent	3	6.3	6.4	100.0
	Total	47	97.9	100.0	
Missing	System	1	2.1		
Total		48	100.0		

Subdivision: Implementation (2.3)

Item 2.3.1: Performing nursing procedures according to patient needs (n=48)

Responding to a question on NQRNs' competencies on performing nursing procedures according to patient needs, 4.2% (n=2) unit managers pointed out that NQRNs were completely competent, while 20.8% (n=10) indicated that they had adequate knowledge. The other 47.9% (n=23) responded that NQRNs had basic knowledge and 27.1% (n=13) believed NQRNs had little knowledge. See Table 4.20 below.

Table 4.20: Performing nursing procedures according to patient needs

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	13	27.1	27.1	27.1
Basic knowledge	23	47.9	47.9	75.0
Adequate knowledge	10	20.8	20.8	95.8
Completely competent	2	4.2	4.2	100.0
Total	48	100.0	100.0	

Item 2.3.2: Documenting nursing intervention accurately and in a timely manner (n=48)

For this item, only 4.2% (n=2) of the unit managers felt NQRNs were completely competent in documenting nursing intervention accurately and in a timely manner, with 10.4% (n=5) indicating that they had adequate knowledge. The majority, 64.6% (n=31)

responded NQRNs had basic knowledge. In addition, 20.8% (n=10) believed NQRNs had little knowledge (Table 4.21).

Table 4.21: Documenting nursing interventions accurately and in timely manner (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	10	20.8	20.8	20.8
Basic knowledge	31	64.6	64.6	85.4
Adequate knowledge	5	10.4	10.4	95.8
Completely competent	2	4.2	4.2	100.0
Total	48	100.0	100.0	

Subdivision: Provision of care (2.4)

Item 2.4.1: Recognising possible cardiac arrest (n=47)

This item required unit managers to indicate whether NQRNs could recognise possible cardiac arrest. In this regard, a meagre 2.1% (n=1) unit managers pointed out that NQRNs were completely competent; while 10.4% (n=5) indicated that they had adequate knowledge. The other, 47.9% (n=23) responded they had basic knowledge, and 37.5% (n=18) felt that NQRNs had little knowledge and one participant (2.1%) did not provide an answer (Table 4.22).

Table 4.22: Recognising possible cardiac arrest (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	18	37.5	38.3	38.3
	Basic knowledge	23	47.9	48.9	87.2
	Adequate knowledge	5	10.4	10.6	97.9
	Completely competent	1	2.1	2.1	100.0
	Total	47	97.9	100.0	
Missing	system	1	2.1		
Total		48	100.0		

Item 2.4.2: Performing cardiopulmonary resuscitation correctly (n=48)

After giving their opinion on whether NQRNs could recognise a cardiac arrest, unit managers had to indicate whether the NQRNs could perform cardiopulmonary resuscitation. As with the previous items, only a minimal number of 4.2% (n=2) unit managers said NQRNs were completely competent in doing so. Similarly, a small number (2.1% (n=2)) responded NQRNs had adequate knowledge, while 33.3% (n=16) responded they had basic knowledge, with the majority 60.4% (n=29) indicating that NQRNs had little knowledge, thus needed supervision and guidance (Table 4.23).

Table 4.23: Performing cardiopulmonary resuscitation correctly (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	29	60.4	60.4	60.4
	Basic knowledge	16	33.3	33.3	93.8
	Adequate knowledge	1	2.1	2.1	95.8
	Completely competent	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

Item 2.4.3: Recognising possible emergency situations (n=48)

When asked whether NQRNs were able to recognise possible emergency situations, only 6.3%(n=3) unit managers responded that NQRNs were completely competent and could do so efficiently and confidently without supervision, 8.3% (n=4) indicated that they had adequate knowledge, 52.1% (n=25) responded that NQRNs had basic knowledge, and 33.3% (n=16) indicated that NQRNs had little knowledge (Table 4.24).

Table 4.24: Recognising possible emergency situations (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	16	33.3	33.3	33.3
Basic knowledge	25	52.1	52.1	85.4
Adequate knowledge	4	8.3	8.3	93.8
Completely competent	3	6.3	6.3	100.0
Total	48	100.0	100.0	

Item 24.4: Recognising anaphylactic shock (n=48)

On this item, only 4.2% (2) unit managers pointed out that NQRNs were completely competent and could recognise anaphylactic shock, while 12.5% (n=6) indicated that they had adequate knowledge. Nineteen unit managers (39.6%) responded NQRNs had basic knowledge, but still needed supervision, while most of them (43.8% (n=21)) believed that NQRNs had little knowledge to recognise anaphylactic shock (Table 4.25).

Table 4.25: Recognising of anaphylactic shock (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	21	43.8	43.8	43.8
Basic knowledge	19	39.6	39.6	83.3
Adequate knowledge	6	12.5	12.5	95.8
Completely competent	2	4.2	4.2	100.0
Total	48	100.0	100.0	

Item 2.4.5: Calculation of dosages of emergency drugs (n=45)

Calculation of dosages of emergency drugs is a key competency of registered nurses. Based on this item, only 6.3% (n=3) unit managers pointed out that NQRNs were completely competent in calculating the dosages of emergency drugs confidently without supervision, but 22.9% (n=11) indicated that they had adequate knowledge and could do so without supervision. However, 29.2% (n=14) answered NQRNs had basic knowledge, but still need supervision, while most of them (35.4% (n=17)) stated that NQRNs had little knowledge and needed supervision and guidance. Three unit managers (6.3%) did not provided responses (Table 4.26).

Table 4.26: Calculation of dosages of emergency drugs (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	17	35.4	37.8	37.8
	Basic knowledge	14	29.2	31.1	68.9
	Adequate knowledge	11	22.9	24.4	93.3
	Completely competent	3	6.3	6.7	100.0
	Total	45	93.8	100.0	
Missing	system	3	6.3		
Total		48	100.0		

Item 2.4.6: Administering of different emergency drugs (n=47)

Only 4.2% (n=2) unit managers pointed out that NQRNs were completely competent in administering different emergency drugs and could do so efficiently and confidently without supervision. The other 20.8% (n=10) indicated that they had adequate knowledge and could administer emergency drugs without supervision. However, most unit managers (41.7% (n=20)) indicated that NQRNs had basic knowledge and needed to be supervised when administering different emergency drugs, while 31.3% (n=15) stated that NQRNs had little knowledge and needed guidance and supervision when administering emergency drugs. One participant (2.1%) did not answer this question (Table 4.27).

Table 4.27: Administering of different emergency drugs (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	15	31.3	31.9	31.9
	Basic knowledge	20	41.7	42.6	74.5
	Adequate knowledge	10	20.8	21.3	95.7
	Completely competent	2	4.2	4.3	100.0
	Total	47	97.9	100.0	
Missing	system	1	2.1		
Total		48	100.0		

Item 2.4.7: Admission of patients correctly (n=48)

Regarding the admission of patients, 14.6% (n=7) unit managers pointed out that NQRNs were completely competent and could admit patients efficiently without supervision, while 29.2% (n=14) indicated that they had adequate knowledge, thus did not need supervision. Half of the respondents (50% (n=24)) responded that they had basic knowledge, but needed supervision and 2.1% (n=1) believed NQRNs had little knowledge (Table 4.28).

Table 4.28: Admission of patients correctly (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	1	2.1	2.2	2.2
	Basic knowledge	24	50.0	52.2	54.3
	Adequate knowledge	14	29.2	30.4	84.8
	Completely competent	7	14.6	15.2	100.0
	Total	46	95.8	100.0	
Missing	system	2	4.2		
Total		48	100.0		

Item 2.4.8: Discharge of patients correctly (n=45)

According to the responses from unit managers, 12.5% (6) indicated that NQRNs were completely competent and could discharge a patient efficiently without supervision, while 27.1% (n=13) indicated NQRNs had adequate knowledge and could do so without supervision. However, 47.9% (n=23) responded that NQRNs had basic knowledge and needed supervision, while 6.3% (n=3) said NQRNs had little knowledge, thus needed guidance and supervision, while three managers (6.3%) did not reflect their opinion (Table 4.29).

Table 4.29: Discharge of patients correctly (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	3	6.3	6.7	6.7
	Basic knowledge	23	47.9	51.1	57.8
	Adequate knowledge	13	27.1	28.9	86.7
	Completely competent	6	12.5	13.3	100.0
	Total	45	93.8	100.0	
Missing	system	3	6.3		
Total		48	100.0		

Item 2.4.9: Provision of safe environments for patients (n=48)

On this item, 14.6. % (n=7) of the unit were managers pointed out that NQRNs completely competent, 25.0% (n=12) answered that NQRNs had adequate knowledge, 43.8% (n=21)

responded that NQRNs had basic knowledge, while 16.7% (n=8) believed that NQRNs had little knowledge (Table 4.30)

Table 4.30: Provision of safe environment for patients (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	8	16.7	16.7	16.7
Basic knowledge	21	43.8	43.8	60.4
Adequate knowledge	12	25.0	25.0	85.4
Completely competent	7	14.6	14.6	100.0
Total	48	100.0	100.0	

Item 2.4.10: Performing accurate intake and output recording (n=47)

Unit managers were further required to indicate whether NQRNs were competent in recording intake and output accurately. Only 10.4% (n=5) pointed out that NQRNs were completely competent and could record patients' intake and output without supervision, while 22.9% (n=11) indicated that NQRNs had adequate knowledge and did not need supervision. However, 47.9% (n=23) responded that NQRNs had basic knowledge and skills, but needed supervision when performing these procedures, while 16.7% (n=8) stated that NQRNs had little knowledge and should always be guided and supervised and one manager (2.1%) did not respond to this item (Table 4.31).

Table 4.31: Performing accurate intake and output recording (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	8	16.7	17.0	17.0
	Basic knowledge	23	47.9	48.9	66.0
	Adequate knowledge	11	22.9	23.4	89.4
	Completely competent	5	10.4	10.6	100.0
	Total	47	97.9	100.0	
Missing	system	1	2.1		
Total		48	100.0		

Item 2.4.11: Insertion of nasogastric tube (n=47)

Asked whether NQRNs could insert a nasogastric tube confidently, 10.4% (n=5) of the unit managers answered that NQRNs were completely competent in doing so, while an equal number (10.4% (n=5) indicated that they had adequate knowledge and could do so without being supervised. However, 27.1% (n=13) responded that NQRNs had basic

knowledge and needed to be supervised, while a majority 50.0% (n=24) pointed out that NQRNs had little knowledge and one (2.1%) did not respond to this item (Table 4.32).

Table 4.32: Insertion of nasogastric tube (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	24	50.0	51.1	51.1
	Basic knowledge	13	27.1	27.7	78.7
	Adequate knowledge	5	10.4	10.6	89.4
	Completely competent	5	10.4	10.6	100.0
	Total	47	97.9	100.0	
Missing	System	1	2.1		
Total		48	100.0		

Item 2.4.12: Performing of gastric aspiration (n=47)

In relation to performing gastric aspiration, only 6.3% (n=3) unit managers pointed out that NQRNs were completely competent, while 12.5% (n=6) indicated that they had adequate knowledge and, therefore, could do so without supervision. On the other hand, 35.4% (n=17) responded that NQRNs had basic knowledge, while 43.8% (n=21) stated that NQRNs had little knowledge, thus in need of guidance and supervision. One participants (2.1%) did not indicate their opinion on this item (Table 4.33).

Table 4.33: Performing of gastric aspiration (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	21	43.8	44.7	44.7
	Basic knowledge	17	35.4	36.2	80.9
	Adequate knowledge	6	12.5	12.8	93.6
	Completely competent	3	6.3	6.4	100.0
	Total	47	97.9	100.0	
Missing	System	1	2.1		
Total		48	100.0		

Item 2.4.13: Insertion of a female catheter (n=48)

On the insertion of a female catheter, 16.7% (n=8) unit managers answered that NQRNs were completely competent, while 12.5% (n=6) indicated that NQRNs had adequate knowledge. Most unit managers (47.9% (n=23) responded NQRNs had basic knowledge, while 22.9% (n=11) stated NQRNs had little knowledge and, therefore, required supervision and guidance (Table 4.34).

Table 4.34: Insertion of female catheter (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	11	22.9	22.9	22.9
	Basic knowledge	23	47.9	47.9	70.8
	Adequate knowledge	6	12.5	12.5	83.3
	Completely competent	8	16.7	16.7	100.0
	Total	48	100.0	100.0	

Item 2.4.14: Insertion of male catheter (n=45)

On this item, 8.3% (n=4) unit managers pointed out that NQRNs were completely competent and could insert a male catheter confidently and without supervision, while 12.5% (n=6) indicated that they had adequate knowledge and could do so without supervision. The other 39.6% (n=19) responded they had basic knowledge and 33.3% (n=16) stated that NQRNs had little knowledge and, therefore, required guidance and supervision, while three unit managers (6.3%) did not provide answers (Table 4.35).

Table 4.35: Insertion of male catheter (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	16	33.3	35.6	35.6
	Basic knowledge	19	39.6	42.2	77.8
	Adequate knowledge	6	12.5	13.3	91.1
	Completely competent	4	8.3	8.9	100.0
	Total	45	93.8	100.0	
	Missing	system	3	6.3	
Total		48	100.0		

Item 2.4.15: Drawing of blood specimen (n=47)

On whether NQRNs were capable of drawing a blood specimen, 16.7% (n=8) unit managers pointed out that NQRNs were completely competent, 33.3% (n=16) indicated that they had adequate knowledge, while 35.4. % (n=17) responded NQRNs had basic knowledge and 12.5% (n=6) answered that NQRNs had little knowledge and one unit manager (2.1%) did not indicate any response (Table 4.36).

Table 4.36: Drawing of blood specimen (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	6	12.5	12.8	12.8
	Basic knowledge	17	35.4	36.2	48.9
	Adequate knowledge	16	33.3	34.0	83.0
	Completely competent	8	16.7	17.0	100.0
	Total	47	97.9	100.0	
Missing	System	1	2.1		
Total		48	100.0		

Item 2.4.16.: Stoma care (n=46)

Regarding stoma care, only 10.4% (n=23) unit managers considered NQRNs completely competent in stoma care, while 16.7% (n=8) indicated that they had adequate knowledge and could do so without supervision, while 33.3% (n=15) responded they had basic knowledge and 35.4% (n=16) believed that NQRNs had little knowledge, thus in need of

guidance and supervision. Two unit managers (4.2%) did not provide responses (Table 4.37).

Table 4.37: Stoma care (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	17	35.4	37.0	37.0
	Basic knowledge	16	33.3	34.8	71.7
	Adequate knowledge	8	16.7	17.4	89.1
	Completely competent	5	10.4	10.9	100.0
	Total	46	95.8	100.0	
Missing	System	2	4.2		
Total		48	100.0		

Item 2.4.17: Administering oxygen therapy (n=48)

Regarding administration of oxygen therapy, 22.9% (n=11) of the unit managers pointed out that NQRNs were completely competent, 27.1. % (n=13) indicated that they had adequate knowledge, whereas 45.8% (n=22) responded NQRNs had basic knowledge, while 4.2% (n=2) stated NQRNs had little knowledge on the administration of oxygen therapy (Table 4.38).

Table 4.38: Administering oxygen therapy (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	2	4.2	4.2	4.2
Basic knowledge	22	45.8	45.8	50.0
Adequate knowledge	13	27.1	27.1	77.1
Completely competent	11	22.9	22.9	100.0
Total	48	100.0	100.0	

Item 2.4.18: Interpreting of medicine prescription chart (n=47)

On whether NQRNs could interpret a medicine prescription chart, 10.4% (n=5) unit managers pointed out that NQRNs were completely competent and could do so efficiently and confidently without supervision, and 25.0% (n=12) indicated that they had adequate knowledge. A majority 54.2% (n=26) indicated that NQRNs had basic knowledge, and 8.3% (n=4) stated that NQRNs had little knowledge and, therefore, needed to be guided and supervised, while one manager (2.1%) did not indicate a response (Table 4.39).

Table 4.39: Interpretation of medicine prescription chart (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	4	8.3	8.5	8.5
	Basic knowledge	26	54.2	55.3	63.8
	Adequate knowledge	12	25.0	25.5	89.4
	Completely competent	5	10.4	10.6	100.0
	Total	47	97.9	100.0	
Missing	System	1	2.1		
Total		48	100.0		

Item 2.4.19: Preparing of patient for operation (n=46)

In terms of preparing a patient for operation, 18.8% (n=9) of the unit managers pointed out that NQRNs were completely competent, while 16.7% (n=8) said NQRNs had adequate knowledge and could do so without guidance and supervision. On the other hand, 56.3% (n=27) responded NQRNs had basic knowledge, while 4.2% (n=2) stated NQRNs had little knowledge and, therefore, needed guidance and supervision. Two unit managers (4.2 %) did not reflect their opinion on this item (Table 4.40).

Table 4.40: Preparation of patient for operation (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	2	4.2	4.3	4.3
	Basic knowledge	27	56.3	58.7	63.0
	Adequate knowledge	8	16.7	17.4	80.4
	Completely competent	9	18.8	19.6	100.0
	Total	46	95.8	100.0	
Missing	System	2	4.2		
Total		48	100.0		

Item 2.4.20: Caring for patient after operation (n=46)

A few (10.4% (n=5) unit managers pointed out that NQRNs were completely competent in caring for a patient after operation, while 25% (n=12) indicated that they had adequate knowledge. The majority (52.1% (n=25) responded NQRNs had basic knowledge, while 8.3% (n=4) indicated that NQRNs had little knowledge, hence they needed guidance and supervision and two unit managers (4.2%) did not provide responses (Table 4.41).

Table 4.41 : Caring of patient after operation (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	4	8.3	8.7	8.7
	Basic knowledge	25	52.1	54.3	63.0
	Adequate knowledge	12	25.0	26.1	89.1
	Completely competent	5	10.4	10.9	100.0
	Total	46	95.8	100.0	
Missing	system	2	4.2		
Total		48	100.0		

Item 2.4.21: Performing aseptic wound care (n=46)

Regarding wound care, only 10.4% (n=5) of the unit managers regarded NQRNs as completely competent, while 29.2% (n=14) indicated that they had adequate knowledge on caring for wounds aseptically. However, the majority (47.9% (n=23) responded that NQRNs had basic knowledge, while 8.3% (n=4) felt that NQRNs had little knowledge and needed to be supervised and guided when performing wound care. However, two unit managers (4.2%) did not respond to this question (Table 4.42).

Table 4.42: Performing aseptic wound care (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	4	8.3	8.7	8.7
	Basic knowledge	23	47.9	50.0	58.7
	Adequate knowledge	14	29.2	30.4	89.1
	Completely competent	5	10.4	10.9	100.0
	Total	46	95.8	100.0	
Missing	system	2	4.2		
Total		48	100.0		

Item 2.4.22: Understanding infection control principles (n=48)

On understanding infection control principles, 8.3% (n=4) of unit managers said NQRNs were completely competent, while 12.5% (n=6) indicated that they only had adequate knowledge. However, most unit managers 60.4% (n=29) responded NQRNs had basic knowledge, with 18.8% (n=9) stating they had little knowledge (Table 4.43).

Table 4.43: Understanding infection control principles (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	9	18.8	18.8	18.8
	Basic knowledge	29	60.4	60.4	79.2
	Adequate knowledge	6	12.5	12.5	91.7
	Completely competent	4	8.3	8.3	100.0
	Total	48	100.0	100.0	

Item 2.4.23: Administering intravenous fluids and medications (n=48)

On administering intravenous fluids and medications, 10.4% (n=5) of the unit managers pointed out NQRNs were completely competent, while 25% (n=12) indicated that they had adequate knowledge. A majority 56.3% (n=27) indicated that NQRNs had basic knowledge, while 8.3% (n=4) stated that NQRNs had little knowledge about the administration of intravenous fluids and medications (Table 4.44).

Table 4.44: Administering intravenous fluids and medications (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	4	8.3	8.3	8.3
	Basic knowledge	27	56.3	56.3	64.6
	Adequate knowledge	12	25.0	25.0	89.6
	Completely competent	5	10.4	10.4	100.0
	Total	48	100.0	100.0	

Subdivision: Evaluation (2.5)

Item 2.5.1: Monitoring and documenting patient progress accurately and completely (n=46)

Regarding monitoring and documenting patient progress accurately, 6.3% (n=3) unit managers pointed out that NQRNs were completely competent, while 18.8% (n=9) indicated that they had adequate knowledge. A majority 54.2% (n=26) responded NQRNs had basic knowledge, with 16.7% (n=8) indicating that NQRNs had little knowledge and two managers (4.2%) did not respond (Table 4.45).

Table 4.45: Monitoring and documenting patient progress accurately and completely (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	8	16.7	17.4	17.4
	Basic knowledge	26	54.2	56.5	73.9
	Adequate knowledge	9	18.8	19.6	93.5
	Completely competent	3	6.3	6.5	100.0
	Total	46	95.8	100.0	
Missing	System	2	4.2		
Total		48	100.0		

Item 2.5.2: Evaluate patient progress in relation to nursing care plan (n=46)

In terms of the evaluation of patient progress in relation to nursing care plan, 6.3% (n=3) of the unit managers pointed out that NQRNs were completely competent, while 16.7% (n=8) responded that NQRNs had adequate knowledge. Most unit managers (45.8% (n=22)) responded NQRNs had basic knowledge, whereas 27.1% (n=13) indicated that

NQRNs had little knowledge and should be guided to execute this task, while two unit managers (4.2%) did indicate their opinion (Table 4.46).

Table 4.46: Evaluate patient progress in relation to nursing care plan (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	13	27.1	28.3	28.3
	Basic knowledge	22	45.8	47.8	76.1
	Adequate knowledge	8	16.7	17.4	93.5
	Completely competent	3	6.3	6.5	100.0
	Total	46	95.8	100.0	
Missing	System	2	4.2		
Total		48	100.0		

Item 2.5.3: Uses evaluation data to modify the nursing care plan (n=48)

On the last item on whether NQRNs were competent in using evaluation data to modify the nursing care plan, a few (6.3% (n=3)) unit managers pointed out that NQRNs were completely competent, whereas 10.4% (n=5) responded that NQRNs had adequate knowledge. Most unit managers (43.8% (n=21)) responded that NQRNs had basic knowledge, while 35.4% (n=17) stated that they had little knowledge and should be guided and supervised when performing this duty and two unit managers (4.2%) did not indicate their opinion on this item (Table 4.47).

Table 4.47: Uses evaluation data to modify the nursing care plan (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	17	35.4	37.0	37.0
	Basic knowledge	21	43.8	45.7	82.6
	Adequate knowledge	5	10.4	10.9	93.5
	Completely competent	3	6.3	6.5	100.0
	Total	46	95.8	100.0	
Missing	System	2	4.2		
Total		48	100.0		

4.2.3.4.3. Responses on domain 3: Management and leadership competencies (n=48)

Domain 3 comprised of nine items in which the unit managers were required to rate the management and leadership competencies of NQRNs. Next are the responses received from 48 participants.

Item 3.3.1: Identify priority nursing duties (n=48)

In terms of the identification of priority in completing nursing duty priorities, 4.2% (n=2) of the unit managers responded that NQRNs were completely competent, while 18.8% (n=9) indicated that NQRNs only had adequate knowledge. On the other hand, a majority 56.3% (n=27) pointed out that NQRNs only possessed basic knowledge. The remaining 20.8% (n=10) indicated that NQRNs had little knowledge, therefore, they required guidance and supervision in identifying priority nursing duties (Table 4.48).

Table 4.48: Identify priority nursing duties (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	10	20.8	20.8	20.8
Basic knowledge	27	56.3	56.3	77.1
Adequate knowledge	9	18.8	18.8	95.8
Completely competent	2	4.2	4.2	100.0
Total	48	100.0	100.0	

Item 3.3.2: Planning nursing care according to patient needs (n=48)

Asked whether NQRNs plan nursing care according to patient needs, in terms of completing nursing duties on time, only 8.3% (n=4) of the unit managers responded that NQRNs were completely competent, while 14.6% (n=7) indicated that NQRNs have only adequate knowledge. The majority (58.3% (n=28) indicated that they possessed basic knowledge, with only 18.8 % (n=9) indicating that NQRNs had little knowledge (See Table 4.49).

Table 4.49: Planning nursing care according to patient needs (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	9	18.8	18.8	18.8
Basic knowledge	28	58.3	58.3	77.1
Adequate knowledge	7	14.6	14.6	91.7
Completely competent	4	8.3	8.3	100.0
Total	48	100.0	100.0	

Item 3.3.3: Delegation of nursing care duties (n=48)

Regarding the delegation of nursing care duties, only 6.3% (n=3) of the unit managers regarded NQRNs completely competent, while 25% (n=12) indicated that NQRNs had only adequate knowledge. A majority 52.1% (n=25) answered that NQRNs possess basic knowledge, whereas 16.7% (n=8) indicated that NQRNs had little knowledge (Table 4.50).

Table 4.50: Delegation of nursing care duties (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	8	16.7	16.7	16.7
Basic knowledge	25	52.1	52.1	68.8
Adequate knowledge	12	25.0	25.0	93.8
Completely competent	3	6.3	6.3	100.0
Total	48	100.0	100.0	

Item 3.3.4: Scheduling off duties based on the workload (n=47)

In relation to the completion of scheduling off duties based on the workload, only 4.2% (n=2) of the unit managers stated that NQRNs were completely competent, while 25% (n=12) indicated that NQRNs had adequate knowledge. A majority 47.9% (n=23) indicated that NQRNs possess basic knowledge, with only 20.8% (n=10) indicating that NQRNs only had little knowledge and needed guidance and supervision, while one participant (2.1%) did not answer this question (Table 4.51).

Table 4.51: Scheduling off duties based on the workload (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	10	20.8	21.3	21.3
	Basic knowledge	23	47.9	48.9	70.2
	Adequate knowledge	12	25.0	25.5	95.7
	Completely competent	2	4.2	4.3	100.0
	Total	47	97.9	100.0	
Missing	system	1	2.1		
Total		48	100.0		

Item 3.3.5: Completion of nursing duties on time (n=48)

In terms of completing nursing duties on time, only 6.3% (n=3) of the unit managers believed that NQRNs were completely competent, while 20.8% (n=10) indicated that NQRNs had only adequate knowledge. However, a majority 52.1% (n=25) indicated that NQRNs only possess basic knowledge, while 20.8% (n=10) indicated that NQRNs only have little knowledge (see Table 4.52).

Table 4.52: Complete nursing duties on time (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	10	20.8	20.8	20.8
	Basic knowledge	25	52.1	52.1	72.9
	Adequate knowledge	10	20.8	20.8	93.8
	Completely competent	3	6.3	6.3	100.0
	Total	48	100.0	100.0	

Item 3.3.6: Communication of clear and accurate information (n=47)

Regarding the completion of nursing duties on time, only 6.3% (n=3) of the unit managers responded that NQRNs were completely competent and could execute this task confidently without supervision, while 18.8% (n=9) indicated that NQRNs had adequate knowledge. A majority 52.1% (n=25), however, indicated that NQRNs had basic knowledge, while 20.8% (n=10) responded that NQRNs had little knowledge and needed guidance and supervision. However, one unit manager (2.1%) did provide a response on this item (Table 4.53).

Table 4.53: Communication of clear and accurate information (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	10	20.8	21.3	21.3
	Basic knowledge	25	52.1	53.2	74.5
	Adequate knowledge	9	18.8	19.1	93.6
	Completely competent	3	6.3	6.4	100.0
	Total	47	97.9	100.0	
Missing	System	1	2.1		
Total		48	100.0		

Item 3.3.7: Managing staff conflict in the ward (n=48)

On whether NQRNs were competent in managing staff conflict in the ward, a few 4.2 % (n=2) unit managers indicated that NQRNs were completely competent, while the same number said NQRNs had adequate knowledge and, therefore, did need guidance and supervision. The majority (47.9% (n=23) indicated that NQRNs possess basic knowledge, while 43.8% (n=21) indicated that NQRNs had little knowledge and needed to be guided and supervised when performing this task (Table 4.54).

Table 4.54: Managing staff conflict in the ward (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	21	43.8	43.8	43.8
	Basic knowledge	23	47.9	47.9	91.7
	Adequate knowledge	2	4.2	4.2	95.8
	Completely competent	2	4.2	4.2	100.0
	Total	48	100.0	100.0	

Item 3.3.8: Assisting patients to make informed decisions (n=47)

Pertaining to assisting patients to make informed decisions, a few (4.2% (n=2)) unit managers indicated that NQRNs were completely competent and could complete this task confidently and without supervision, while 22.9% (n=11) pointed out that they had adequate knowledge. However, 39.6% (n=19) indicated that NQRNs possessed basic knowledge, while 31.3% (n=15) indicated that NQRNs had little knowledge, while one participant (2.1%) did not reflect their opinion on this item (Table 4.55).

Table 4.55: Assisting patients to make informed decisions (n=48)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Little knowledge	15	31.3	31.9	31.9
	Basic knowledge	19	39.6	40.4	72.3
	Adequate knowledge	11	22.9	23.4	95.7
	Completely competent	2	4.2	4.3	100.0
	Total	47	97.9	100.0	
Missing	System	1	2.1		
Total		48	100.0		

Item 3.3.9: Supervision of junior nurses and subordinates (n=48)

In terms of supervising junior nurses and subordinates, only 8.3% (n=4) of the unit managers responded that NQRNs were completely competent, while 16.7% (n=8) indicated that NQRNs only had adequate knowledge. However, 35.4% (n=17) indicated that NQRNs possessed basic knowledge, with the majority (39.6% (n=19)) indicating that NQRNs had little knowledge (See Table 4.56).

Table 4.56: Supervision of junior nurses and subordinates (n=48)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Little knowledge	19	39.6	39.6	39.6
Basic knowledge	17	35.4	35.4	75.0
Adequate knowledge	8	16.7	16.7	91.7
Completely competent	4	8.3	8.3	100.0
Total	48	100.0	100.0	

This section deliberated on the unit managers’ ratings of NQRNs’ competencies. The findings revealed that unit managers felt that NQRNs were not completely competent in the three domains discussed.

The following section discusses the findings on the correlation between NQRNs and unit managers’ responses.

4.2.3.5. SECTION 3: Descriptive analysis on support rendered to NQRNS by their unit managers

In this section, unit managers had to respond to 11 questions on support rendered to NQRNs to facilitate their competencies. All the 48 unit managers responded to the items.

Item 3.1: Annual employment of NQRNs (n=48)

A report on the annual employment of NQRNs was extracted from the responses of unit managers. The results showed that most hospitals employ more than 10(70.83%) NQRNs annually, as seen in Figure 4.3.

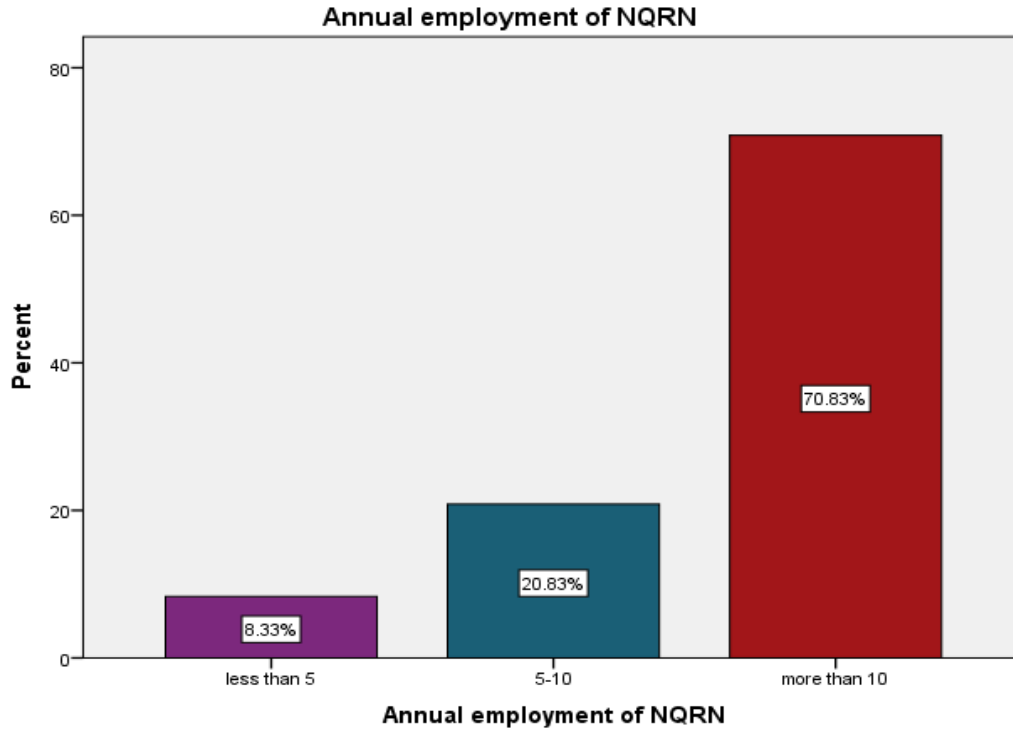


Figure 4.3: Annual NQRNs employed at study sites (n=48)

Item 3.2: Question on whether NQRNs received ward orientation

The unit managers were required to indicate whether NQRNs in their units receive ward orientation. Of the 48 unit managers, only 93.75% (n=45) indicated that there was some sort of orientation given to the NQRNs.

Item 3.3: Opinion on number days sufficient for NQRNs orientation

On this item, unit managers had to indicate the number of days they deemed sufficient for the orientation of NQRNs. Of the 48 unit managers, 47.9 % (n=23) believed that three to six days are sufficient for the orientation of NQRNs.

Item 3.4: Support rendered to NQRNs (n=48)

Regarding the kind of support rendered to NQRNs, 52.08% (n=25) of the unit managers reported that they provide support by assigning experienced registered nurses for each shift. Of the remainder, 29.2% (n=14) provide mentorship, 10.42% (n=5) assist through clinical instructors, while 6.3% (n=3) provide peer support and 2.1% (n=1) provide preceptorship.

Support rendered to NQRN in ward

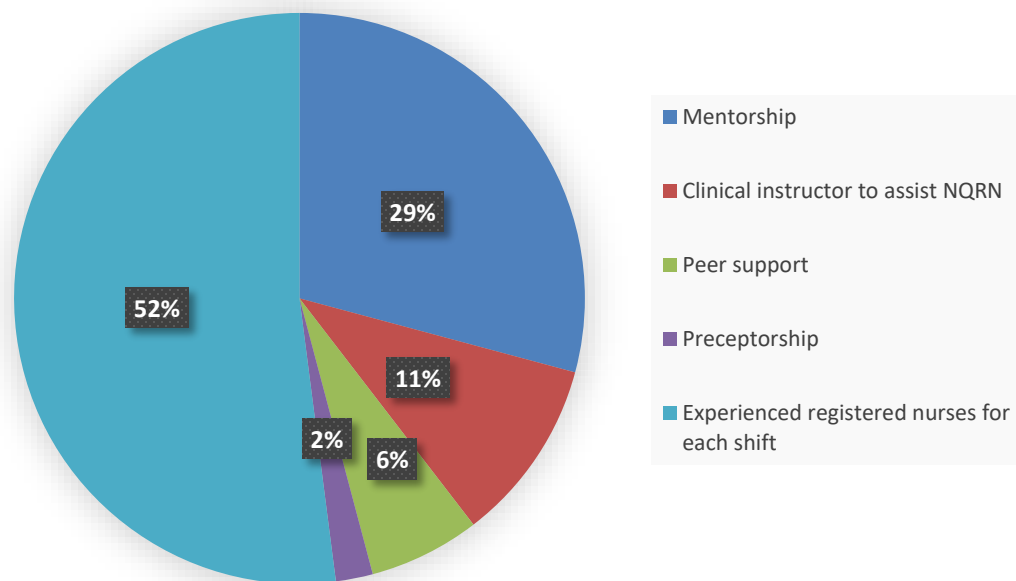


Figure 4.4: Support rendered to NQRNs in wards/unit (n=48)

Source: Research data

Item 3.5: Provision of in-service training to NQRNs (n=48)

The unit managers were asked if they provide in-service training to NQRNs, 93.75% (n=45) said 'YES', while 6.25 % (n=3) said 'NO'. Table 4.57 shows the content of the in-service training.

Table 4.57: In-service training content (n=48)

In-service training	Yes %	N=	No %	N=
Medical legal hazards	75	36	25	12
Ethical decision making	68.8	33	31.1	15
Professional conduct	68.8	33	31.1	15
Ward policies and procedures	77.1	37	22.9	11
Clinical nursing procedures	83.3	40	16.7	8
Management skills	52.1	25	47.9	23
Leadership skills	54.2	26	45.8	22
Interpersonal relationship	70.8	34	29.2	14
Other forms of in-service-training content	14.6	7	85.4	41

Item 3.6: Teaching strategies used during in-service training

The respondents were also required to indicate the kind of teaching strategies used for in-service training, as seen in Table 4.58 below.

Table 4.58: Teaching strategies used during in-service training (n=48)

Teaching strategies	Yes %	N=	No %	N=
Case discussion method	64.6	31	35.4	17
Debates	22.9	11	77.1	37
Demonstrations	91.7	44	8.3	4
Problem-solving method	50.0	24	50.0	24
Formal lectures	60.4	29	39.6	19
Role plays	20.8	10	79.2	38
Other forms of teaching strategies	12.5	6	87.5	42

Item 3.7: Question on competency assessment

The unit managers were also asked if they conduct regular competency assessments. Only 64.58% (n=31) attested to conducting competency assessment for NQRNs while 35.4% (n=17) indicated that they do not conduct any form of assessment.

Item 3.8: Question whether unit managers render support to improve NQRNs' competencies

Regarding whether the unit managers render support to improve the competency level of NQRNs, 89.58% (n=43) of the respondents claimed they render support while 10.42% (n=5) do not help NQRNs improve their levels of competency.

4.3. CORRELATION BETWEEN NQRNS AND UNIT MANAGERS' RESPONSES

As indicated earlier, data were gathered from both NQRNs and their unit managers, not only to prevent bias and subjectivity, but also to give more credibility to the study findings. The correlation of the findings in different domains is discussed next.

Domain 1 was based on ethical, legal and professional competencies, which reflected contradictory opinions from both unit managers and NQRNs. In terms of ensuring the physical safety of patients, 43.7% (n=45) of the NQRNs said they were completely competent, while the unit managers shared different opinions with only 4.2% (n=2) indicating that NQRNs are completely competent.

Regarding maintaining clear and legible documentation and records, 44.7% (n=46) of the NQRNs reflected adequate knowledge compared to 62.5% (n=30) basic knowledge from the unit managers. In terms of recognising medical legal hazards, 45.6% (n=47) of the NQRNs responded that they were completely competent, while 52.1% (n=25) of unit managers reported that NQRNs had basic knowledge.

Finally, the NQRNs' opinion on their ability to practice in a manner that conforms to their job description showed that 50.5% (n=52) have adequate knowledge. This was also in contrast to the views of unit managers with 56.3% (n=27) indicating that NQRNs possessed basic knowledge.

Domain 2 presented the knowledge-based practice competency correlations. In terms of how to gather accurate and relevant objective and subjective data, organising and

interpreting patient data and making correct nursing diagnosis, NQRNs showed that they have adequate knowledge of 57.3% (n=59), 58.3% (n=60) and 49% (n=50), respectively. However, the unit manager shared different opinions on NQRNs having basic knowledge with 54.2% (n=26), 50% (n=24) and 47.9% (n=23), respectively.

Based on the area of planning, the following items were analysed: Formulation of a comprehensive nursing care plan according to patients needs and prioritising nursing care plan based on urgency, the results showed that NQRNs rated themselves as having adequate knowledge with a respective score of 47.0% (n48) and 54.0% (n=56). On the other hand, the unit managers with scores of 42.6% (n=20) and 56.2% (n=27), respectively, indicated that NQRNs possessed basic knowledge.

In terms of implementation, the following items were analysed: performing nursing procedures according to patient needs and documenting nursing interventions accurately and in a timely manner. The NQRNs reflected 49% (n=50) and 54.0 % (n=56) respective scores of adequate knowledge. However, unit managers shared different opinions with respective basic knowledge scores of 47.9% (n=23) and 62.5% (n=30).

Regarding care provision, NQRNs reflected lack of competence in the areas of recognising possible cardiac arrest and performing CPR correctly, with a score of 38. % (n=39) and 28. % (n=29) respectively. The unit managers shared the same views of basic knowledge in recognising possible cardiac arrest with a majority score of 47.8% (n=23). However, they reflected a lower competency score (little knowledge) in the area of performing CPR correctly with a majority score of 58.3% (n=28).

On the other hand, NQRNs reflected they had adequate knowledge or were completely competent in other areas of providing care, however, the unit managers shared different opinions. Most unit managers believed have NQRNs little knowledge on the following items: recognising of anaphylactic shock, calculation of dosages of emergency drugs, insertion of nasogastric tube, performing of gastric aspiration and stoma care with a score of 43.8% (n=21), 41.6% (n=20), 58.3% (n=28), 52.0% (n=25) and 48.1% (n=23), respectively.

The unit managers have a major low competency score of basic knowledge on most areas of provision of care, which contradicts with NQRNs' opinion. Concerning evaluation of care, NQRNs have a majority score of completely competent in monitoring and documenting patient progress accurately of 69.3% (n=71) and evaluation of patient progress in relation to nursing care plan of 57.3% (n=59), while regarding the evaluation of data to modify the nursing care plan, NQRNs reflected adequate knowledge of 62.1% (n=64). The unit managers shared different opinion with NQRNs on basis of evaluation. Most unit managers indicated that NQRNs had basic knowledge on all areas of evaluation with respective scores of 53.2% (n=26), 42.6% (n=20) and 40% (n=19).

In Domain 3, the area of management and leadership was analysed. The NQRNs showed that they lacked competence, but rather possessed basic knowledge only in managing staff conflict in the ward, with a major score of 42.7% (n=44). In other areas, NQRNs reflected either they possessed adequate knowledge or were completely competent. On the same assessment, the unit managers shared the same opinion of basic knowledge in terms of managing staff conflict in the ward with a score of 47.9% (n=23). However, the unit

managers' opinions differed from those of NQRNs on other items. For example, the unit managers reflected a majority score of basic knowledge on the following items: identifying priority nursing duties 56.3% (n=27), planning nursing care according to patient needs 68.7% (n=33), delegation of nursing care duties 52.1% (n=25), scheduling off duties based on the workload 47.9%(n=23), complete nursing duties on time 52.0% (n=25), communication of clear and accurate information 52.1% (n=25) and assisting patients to make informed decisions 39.6% (n=19). The item on supervision of junior nurses and subordinates, the unit managers had a majority opinion of little knowledge with a score of 39.6% (n=19).

4.4. CONCLUSION

This chapter presented the results of the situational analysis of the data collected from NQRNs and unit managers on the competence of NQRNs. NQRNs had to rate themselves on certain competencies while unit managers also rated the competence of NQRNs on the same competency items. The findings are discussed in the next chapter, Chapter 5.

CHAPTER 5

DISCUSSION OF FINDINGS (PHASE 1)

“Research is creating new knowledge” Neil Armstrong

5.1. INTRODUCTION

The findings of the study, as presented in the previous chapter, will now be discussed. The discussions are based on the findings on the competency items presented in the preceding chapter (Chapter 4). The findings are also in relation to the research objectives 1 and 2 of the study, namely to determine and describe the self-reported competence of NQRNs, as well as to determine and describe the views of unit managers at public hospitals regarding the competence of NQRNs.

5.2. RESPONDENTS' PROFILES

5.2.1. Profile of NQRNs

The demographic data of NQRNs will now be discussed as follow: *The demographic data* of the study revealed that the majority (88.3 percent) of the respondents in the study were women, while 11.7% were male. This is not surprising because the nursing profession is deemed to be a female dominated career. However; in Namibia more and more male nurses are joining the nursing profession. The proportion of males versus females is a common phenomenon in Namibia as the ratio is translated to 94 men for every 100

women, or nearly 70 000 more women than men (Namibia's 5th National Development Plan, 2017).

The majority (90.3%) of NQRNs were in their *first-year post-training*. Therefore, the researcher is of the opinion that NQRNs might face challenges in incorporating theory into practice during this time. The findings further indicate that there was a weak, however insignificant relationship between experience and competence. Therefore, this justifies the need for developing transition support programme to facilitate the competencies of NQRNs during the first year of practice.

As alluded to earlier, Namibia has *four major training institutions* for nurses, which are UNAM, IUM, Welwitchia Health Training Centre and MoHSS that closed down recently. Among these institutions, 49% (n=59) respondents received their training from UNAM while the other institutions trained the rest.

Through the analysis, it was found that the *type of training institution* does not influence NQRNs' competencies. This might not only be because the nursing curricula at different training institutions cover the same content, but also because most NQRNs conducted their clinical practice at the same public hospitals. Therefore, one can expect the same outcomes in terms of the NQRNs' competencies.

In terms of *level of qualification* of the NQRNs, 95.1% (n=98) completed a Bachelor's degree in Nursing, with the remaining 4.9% having diploma-level education. However, the level of qualification was not found to be a determining factor for competence. One can expect that the higher the educational level, the higher the level of competence, but

this study proved that a NQRN's qualification does not necessarily determine their level of competence.

Regarding *previous training in nursing*, 85.4% (n=102) of the NQRNs were not previously trained as enrolled nurses. Only 14.6 % (n=15) had been exposed to previous nursing training. The study indicated that the majority (85.4%) of NQRNs did not have prior nursing knowledge and experience (Table 4.4). Explicably, the study discovered that those with prior knowledge as enrolled nurse were more competent in some clinical skills than those without prior knowledge. Therefore, the researcher concluded that there is a need for the educational institution to revisit the curriculum and explore areas for change.

Looking at *where the NQRNs worked* at the time of data collection, (46.6%) of NQRNs were working in the medical and surgical wards. From the researcher's experience, this could be because these wards are overcrowded with many seriously ill patients and have a high workload coupled with staff shortages (Emvula, 2016).

The findings indicate that the majority of NQRNs were still new in their wards/units of practice, as the majority (90.3%) only worked in these departments between six and 12 months. This seems to be a reasonable period to acquire the necessary ward-specific knowledge and skills. However, the study revealed that both NQRNs and their unit managers perceived NQRNs as not competent in most clinical areas. This seems to be a common phenomenon among NQRNs, as literature revealed that NQRNs might lack confidence in the beginning, which is accompanied by role confusion (Duscher, 2009).

NQRNs gain experience over time in practice. This is supported by Benner (1982), who reported in her “From Novice to Expert Theory” that NQRNs become competent only after two years of practice. Thus, if it is the case, it explains why most NQRNs indicated that they possessed basic knowledge, but did not feel competent. Therefore, the researcher believes that a transition support programme could bridge the theory-practice gap during the first two years of practice while NQRNs develop their competencies.

5.2.2. Profile of unit managers

It is interesting to note that most unit managers had extensive experience of 21 years and above. Thus, this indicates that they are experienced in supervising NQRNs and their judgement of the clinical competence of NQRNs was based on their extensive clinical experience and knowledge. One can thus agree that the responses from the unit managers can be considered acceptable and accurate due to their extensive knowledge and skills in supervising NQRNs.

Most of the unit managers, 45.8% (n=22), were also working in the medical and surgical wards. These findings are similar to those responses from NQRNs, as discussed earlier, which indicated that most NQRNs, 30% and 16.5% were also assigned to medical and surgical wards, respectively.

With reference to the unit managers’ qualifications, most of the unit managers, 52% (n=63), possessed a nursing diploma. These findings correlate with the years of their experience as (35.4%) have 21years and longer. Considering the years of service they

were seemingly trained during the time when only a Diploma in Nursing Science was offered in the country by the then National University of Namibia.

5.3. DISCUSSION OF FINDINGS ON DIFFERENTCOMPETENCY DOMAINS

5.3.1. Domain 1: Professional, legal and ethical competencies of newly qualified registered nurses

In relation to *professional, ethical and legal competencies* (domain 1) of NQRNs, the different items reviewed on the NQRNs indicated that they were not completely competent in this domain. Similarly, the responses from unit managers supported these responses, with the unit managers indicating that NQRNs were not completely competent in the professional, legal and ethical domain, but rather possess basic competencies.

These findings are very worrisome, as they demonstrate lack of fulfilment of the WHO standards, which require all nurse graduates to demonstrate professional competency after training (WHO, 2016). This includes the application of professional standards into care that ensures the rights of and obligation to patients.

In terms of this domain, WHO (2016) further requires that nurses should be able to identify professional nursing roles and responsibilities, including recognising independent roles of various members of the health team. Therefore, WHO (2016) requires that registered nurses uphold the professional standards of practice and promote the positive image of nursing.

Therefore, WHO (2016) calls for all nurses/midwives to be able to apply the nursing code of ethics and professional guidelines to clinical practice. According to WHO (2016), registered nurses should be competent in implementing a nursing care plan within the legal, ethical and regulatory framework of the nursing profession.

Furthermore, WHO (2016) indicates that all nurses/midwives should be able to uphold and support ethical and legal standards of nursing, and, by so doing, advocate for and protect patients from unfair and discriminatory practices. This statement by WHO (2016) is supported by Kajander-Unkuri et al. (2014), who posit that the competence of graduating nursing students is an important issue in health care, as it is related to professional standards, patient safety and the quality of nursing care. Thus, in this study context, NQRNs should be supported so that they can meet these requirements mandated by WHO.

Moreover, Mogotlane et al. (2018) state that NQRNs should conform to ethical, professional and legal standards of the profession. The researcher concurred with this statement, as lack of the necessary competencies could compromise the quality of nursing care rendered by NQRNs.

Equally so, the ICN (2009) postulates that registered nurses should always portray professional attitude and behaviour, act as role models and show respect to other team members. Therefore, registered nurses should be competent and skilful in meeting the complex patient needs.

Correspondingly, the HPCNA (2010) points out that health professionals have moral and ethical duties to others including to society. Therefore, registered nurses should adhere to ethical values and standards such as respect for persons, non-maleficence, beneficence, autonomy, justice, human rights, veracity, confidence, compassion, including professional competence (HPCNA, 2010).

Nonetheless, the findings of this study are supported by Holt and Convey (2012), who found that in nursing practice, nurses face many ethical situations daily. These authors believe that to practice ethically, registered nurses need certain skills such as: ethical decision-making skills, critical thinking skills and problem-solving skills.

However, several authors reported on the lack of ethical competencies among NQRNs, especially in ethical decision making, which may increase due to the complexity of patient care (Duscher, 2009; Silva et al., 2014).

5.3.2. Discussion on domain 2: Knowledge-based practice

This domain summarised the clinical competencies of NQRNs in relation to the provision of nursing care based on knowledge base practice. This study revealed that NQRNs are not completely competent in most clinical areas, but rather possess basic or adequate knowledge.

These findings are like those of Small and Pretorius (2015 in a study in Namibia that NQRNs lack competence in different clinical areas such as performing vital signs, performing invasive procedures, patient assessment, as well as performing CPR.

However, the lack of clinical competency among NQRNs is not unique to Namibia, as a review of literature revealed previous study conducted in South Africa that also found that NQRNs lacked clinical competencies to practice as a registered nurse (Dlamini et al., 2014). Thus, it seems much needs to be done to facilitate the competencies of NQRNs. These authors further posit that quality health care delivery is vitally important, however, as Baatiema et al. (2017), and Florczak (2016) found, it can be derailed by lack of competence. Another related study conducted in Sweden shares the same views and reports that barriers related to institutional settings such as resources, information access, staffing, and support are common among NQRNs (Llasus, & Angosta, 2014).

However, the issue related to incompetence of NQRNs seems to be a known phenomenon as outlined in Benner's Novice to Expert Theory (Benner, 1982), which states that novice nurses have been associated with low level of clinical competence and inadequate clinical experience. Benner et al. (2010) observe that NQRNs only acquire competence after two years after practice. This observation is supported by Spector et al. (2015), who concur that NQRNs are often incompetent, and recommend the need for a one-year transition model to reduce medical errors and improve patient care.

The issue of lack of clinical skills is a serious concern in health care in an era where the community is more aware of their rights to quality health care. It is also expected of all nurses to be competent, safety conscious, responsible and self-directed (WHO, 2016). However, many factors at public hospitals in Namibia could influence NQRNs' competencies. These factors range from staff shortages, nurse-patient ratio and work load (Emvula, 2016). Service delivery in the public health care facilities is also considered

ineffective or inefficient due to a high number of patients coupled with a shortage of healthcare staff (Awases, Bezuidenhoudt & Roos, 2013).

On the other hand, a supportive environment is key to providing clinical skills and management of patient care (Chang & Daly, 2012). Despite the different methods of support rendered, it seems they do not provide enough support to facilitate NQRNs' competencies. In this regard, the researcher suggests that the transition support programme might be the solution to the lack of competencies among NQRNs (Silva et al., 2014).

5.3.3. Domain 3: Management and Leadership

Domain 3 reviewed the competencies on the identification of priority nursing duties, planning of nursing care according to patient needs, delegation of nursing duties, scheduling off duties based on the workload, completion of nursing duties on time, communication of clear and accurate information, managing staff conflict in the unit, assisting patients to make informed decisions, and supervision of junior nurses and subordinates.

The findings reveal that NQRNs perceived not to be completely competent, but rather possess either basic or little knowledge. These findings are alarming as all registered nurses should possess management and leadership competencies and be able to apply management activities of planning, directing and controlling (Muller & Bester, 2016). Jooste (2017) concurs that registered nurses, as leaders should be able to contribute

towards the achievement of the organisational goals through the managerial functions of planning, organising, directing and controlling.

Moreover, the above findings are like other research findings that reported that newly graduated nurses often lack management skills needed to prioritise, manage and delegate workload. They also had poor inter-professional communication skills (Pfaff, Baxter, Jack & Ploeg (2014) and lacked the skills to deal with unexpected events such as a deteriorating patient (Hussein, Everett, Ramjan, Hu, & Salamonson (2017)).

Similarly, a study in Australia by Parker, Giles, Lantry and McMillan (2014) indicates that NQRNs faced challenges in managing and prioritising routine work and heavy workloads in the first few months after graduating. These authors, therefore, warned that basic knowledge skills acquired during the basic training are helpful, but not sufficient. This, therefore, indicates the need for further support during the transition period, as it is reported that good leaders are made and not born (Jooste, et.al (2015)).

One of the gaps identified in this study was the lack of identification and management of emergency situations that corresponded with findings from other study in a tertiary level teaching hospital in Sydney, Australia such as that of Hussein, Everett, Ramjan, Hu, & Salamonson, (2017), who found that NQRNs often encounter challenges with handling of emergency situations because of lack of experience and confidence. The NQRNs also lacked skills in basic life support, cardio-pulmonary resuscitation, medication management, performing venepuncture and blood drawing (Hussein, Everett, Ramjan, Hu, & Salamonson, 2017).

Regarding planning and prioritising tasks and responsibilities, the study revealed that the NQRNs were not competent, as supported by a study by Hezaveh, Rafii, & Seyedfatemi (2013) that indicated competency challenges among NQRNs in the areas of monitoring and controlling tasks, decision making, coordination, planning and prioritisation, accountability, responsibility, time management, and delegating tasks (delegation). Thus, NQRNs were unable to accept responsibility and lacked skills in completing their tasks on time (Hezaveh et al., 2013). They further reveal that newly graduated nurses were unable to plan, prioritise and organise ward activities. Moreover, Hezaveh et al. (2013) reveal that NQRNs' time management skills were poor and that they had difficulty executing ward managerial duties.

Based on the above, it seems NQRNs need support to bridge the theory-practice gap, therefore, supporting the researcher's indication of the need to develop a transition support programme to facilitate the NQRNs' competencies.

5.4. DISCUSSION ON SUPPORT RENDERED TO NQRNS AT STUDY SITES

This section discusses the support unit managers rendered to NQRNs. The results show that most hospitals employ more than 10 NQRNs annually. However, it is worth noting that orientation is given to the NQRNs. Considering a high consensus on the importance of orientation to NQRNs, unit managers (47.9%) believed three to six days were sufficient for the orientation, as generally accepted as a requirement by most public hospitals in Namibia.

Regarding the kind of support rendered to NQRNs, it was determined that unit managers provide support by assigning experienced registered nurses for each shift to assist with NQRNs' socialisation into professional practice (Figure 4.4). Other assistance is through clinical instructors, peer support and preceptorship. It was also confirmed from the study findings that in-service training is provided during transition to improve NQRNs' competencies. The study further reveals that regular competency assessment is conducted not only to ascertain NQRNs' competencies, but also to assist NQRNs improve their competency levels. Research shows that the NQRNs' competencies are enhanced based on the type of support rendered. For instance, it has been reported that preceptorship reduces transition shock and helps to integrate theory into practice (Chang & Daly, 2012; Hofler & Thomas, 2016; Kaihlanen et al., 2013).

5.5. SUMMARY

This chapter discussed the research findings of phase 1 (situational analysis). The situation analysis provided in-depth information on the competency levels of NQRNs, as perceived by themselves and the unit managers. It is apparent from the discussion that NQRNs are not ready to take on the tasks as expected soon after appointment, which supports the researcher's intention to develop a transition support programme. The following chapter discusses the conceptual framework of the study.

CHAPTER 6

CONCEPTUAL FRAMEWORK

“The proper concepts are needed to formulate a good theory, but we need a good theory to arrive at the proper concepts” Abraham Kaplan

6.1. INTRODUCTION

The previous two chapters described the findings of the study, which revealed that NQRNs at selected public hospitals in Namibia either possessed basic or adequate competencies, but are not fully competent in professional, ethical, legal, knowledge-based practice as well as management and leadership competencies.

This chapter covers phase 2 of the study, which serves to develop a conceptual framework that guides the development of the programme to facilitate the competencies of NQRNs.

6.2. CONCEPTUAL FRAMEWORK

The development of the conceptual framework was based on objective three of the study, namely to develop a conceptual framework that could guide the development of a transition support programme to facilitate the competencies of NQRNs.

The conceptual framework illustrates the relevant variables for the programme and maps out how they relate to each other. (Ivy, 2015). For the design of the programme, the researcher adopted the Programme Logic Model which is a logical representation of

components, namely inputs, activities; output, outcomes and impacts, which guided the researcher in the programme design (Knowlton & Phillips, 2013).

These components consisted of the researcher's systematic image of the context (the settings and the perspective in which the transition support programme should be conducted), the inputs (the resources required to implement the transition support programme), the activities (the actions that need to be performed to execute the transition support programme), the outputs (the outcomes brought about as a result of the activities performed during the implementation of the transition support programme), the outcomes or the impact (the changes in NQRNs' competency level as a result of the programme activities), the outcomes or the achievements of the transition support programme on the competencies of NQRNs, and the evaluation or assessment of the programme interventions.. A reasoning map, as discussed below, was also created based on the components of this model.

6.3. THE REASONING MAP FOR THE DEVELOPMENT OF THE TRANSITION SUPPORT PROGRAMME

A reasoning map is a graphical representation of a person's cognitive model for a given process or concept (Si, Kong & Lee, 2019). The components of the Programme Logic Model were used in this study as the reasoning map (Figure 6.1). The Programme Logic Model was selected as it is a systematic and visual way of presenting and sharing the ideas and understanding of the relationships among the resources one need to operate your

programme, the activities you plan, and the changes or results you hope to achieve (Knowlton & Phillips, 2013). The researcher linked these components to the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018) to guide the design of the transition support programme to facilitate the competencies of NQRNs.

- **Context:** This relates to the programme's contextual factors such as policies, institutional, cultural and socio-economic factors , legal frameworks guiding the delivery of the programme.
- **Inputs:** What are the resources needed to execute the transition support programme?
- **Interventions:** What are the interventions required to facilitate the competencies of NQRNs?
- **Outputs:** What are the products expected from the transition support programme?
- **Outcomes:** What are the desired or intended results of the transition support programme?
- **Impacts:** What changes in NQRNs' competencies are expected?

Following is an illustration of the different components of the reasoning map (Figure 6.1).

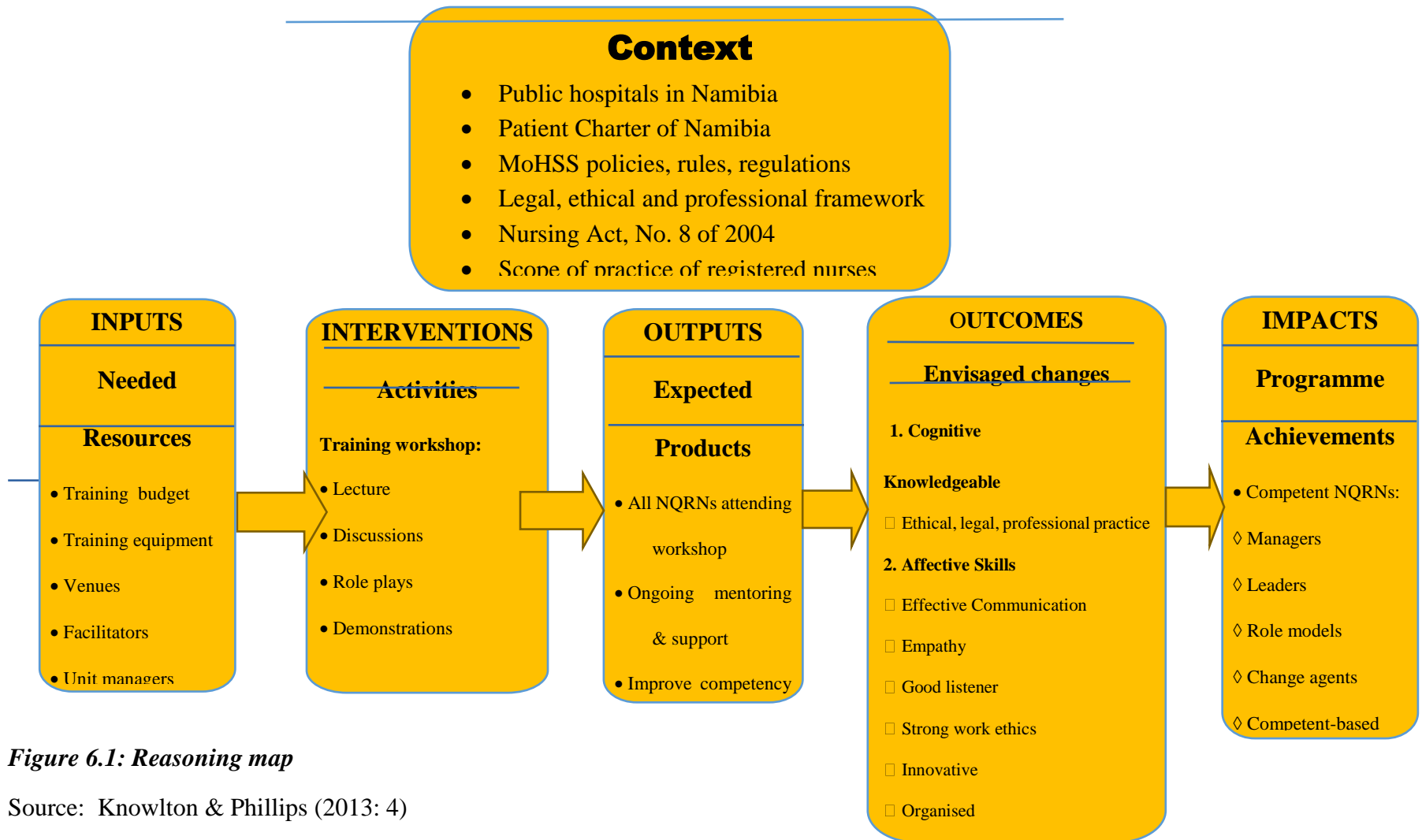


Figure 6.1: Reasoning map

Source: Knowlton & Phillips (2013: 4)

6.3.1. The context

The context refers to the environment or setting in which the transition support programme will be implemented. First, the transition support programme could be implemented at the public hospitals in Namibia within the MoHSS quality management systems (MoHSS, 2014). MoHSS is committed to ensuring the provision of quality health care, which is one of the most important goals of the Ministry (MoHSS, 2014). Therefore, the development of the transition support programme could contribute to the efforts of MoHSS in tackling quality health care issues, such as the competencies of NQRNs. Therefore, the transition support programme will facilitate the competencies of NQRNs at public hospitals in Namibia, which are the public hospitals in Namibia where NQRNs are practising.

The transition support programme was further developed within the ethical, legal and professional framework for registered nurses and midwives/accoucheurs in Namibia (HPCNA, 2018). Hence, the content of the transition support programme, and the research instruments were based on this framework, which incorporates the different competency domains required of registered nurses and midwives/accoucheurs in Namibia.

The framework represents the link between the registered nurse's educational preparation, self-regulation, patient safety and competencies required for practice. Furthermore, the development of the transition support programme is guided by the applicable laws and policies of Namibia and the Nursing Council of Namibia to ensure quality of care and safe health care, as the cornerstone or centrepiece of the framework. Thus, safe, competent,

compassionate and ethical registered nursing practice requires the integration and performance of many competencies at the same time.

Professional responsibility and accountability demonstrate professional conduct of registered nurses of which the primary duty is to ensure safe, competent, compassionate and ethical care to the patient/client. Ethical practice establishes competence in professional judgement and practice decisions guided by the values and ethical responsibilities in the scope of practice for registered nurses.

Registered nurses and midwives/accoucheurs in Namibia practice according to Act, 2004 (no. 8 of 2004), Regulations no. 143, 13, 178 and 206, the Namibian Constitution and the Patient Charter of Namibia. They are accountable for their scope of practice, as outlined in the scope of practice of a registered nurse (Government Notice, no. 206, 2014) and may practice in a variety of clinical contexts (Government Gazette of the Republic of Namibia, 2014).

Supplementary to the above standards of practice, core competencies are required of a registered nurse and midwife/accoucheur and it is set at the entry to practice level. These competencies also describe the required qualities, attributes, and skills for registered nurses and midwives/accoucheurs to practice in Namibia.

By establishing and applying core competencies in the profession, the Nursing Council of Namibia sets the foundation for registered nurses and midwives/accoucheurs to maintain their competence levels and to acquire additional competencies or advanced clinical skills to enable them to deliver safe patient/client care in response to changing healthcare needs.

Registered nurses and midwives/accoucheurs in Namibia also practice in a manner consistent with Namibia's laws and regulations, as required by HPCNA and outlined in the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018) as illustrated in Fig. 6.2.

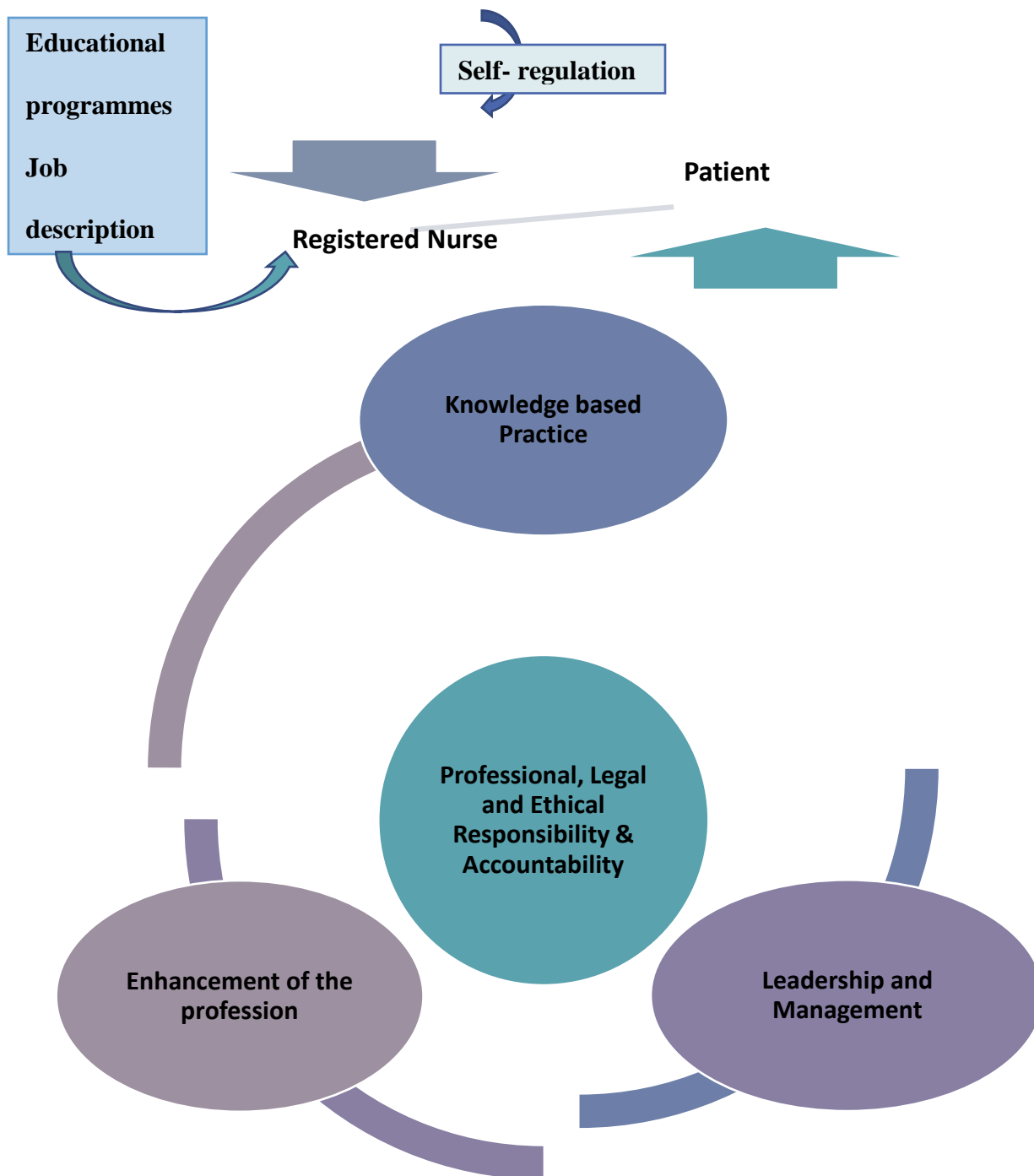


Figure 6.2: Conceptual Framework for Organising Competencies of the Namibian Registered Nurse and Midwife/Accoucheur

Source: HPCNA (2018)

This framework as indicated in Fig.6. 2, illustrates the balances to be maintained by the registered nurse during their nursing care, namely a balance between professional regulations on one side and the client/patient on the other side. This means the registered nurses require specific training from an authorised educational institution to register as a health professional and then enter the work environment with a specific job description and functions. However, it is the registered nurse's responsibility to understand the requirements of self-regulation in the interest of public protection.

Knowledge-based practice refers to the competent application of knowledge in the provision of nursing care. Critical thinking and analysis are one of the subdomains of knowledge-based practice and they relate to self-appraisal, professional development and the value of evidence and research for practice. Leadership and management determine an understanding of the concept of public protection and the duty to provide nursing care in the best interest of the public. Figure 6.2 illustrates the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018).

Next is a discussion of the elements of the reasoning map. This map guided the researcher on how to approach the development of the transition support programme.

6.3.2. Inputs

According to Knowlton and Phillips (2013), inputs are the resources required to implement the transition support programme. In this study context, inputs (as shown in Figure 6.3) include the time allocated to designing the transition support programme. The transition support programme further expects the trainers at the public hospitals to train the NQRNs as part of in-service training. Inputs further refer to the time required for the

training of NQRNs, namely six months after employment as a NQRNs. Materials and equipment required for the training needs, and the training venues need to be identified and planned prior to the training to ensure efficacy.

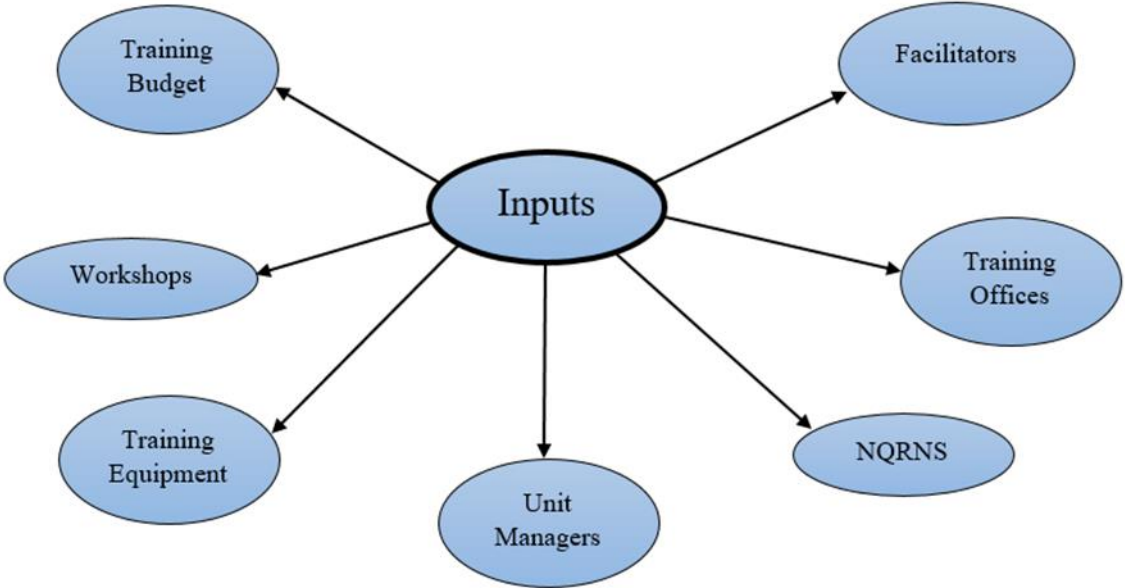


Figure 6.3: Transition support programme inputs

Adapted from Knowlton and Phillips (2013: 4)

6.3.3. Interventions

These are the actions the facilitators should take to implement the transition support programme, as shown in Figure 6.4. They are the teaching strategies the facilitator will use to transfer knowledge and skills to NQRNs during the training workshop. The transition support programme was not implemented during this study. However, the proposed activities were provided, as discussed in Chapter 7. (See 7.5.)

Adapted from Knowlton and Phillips (2013: 4)

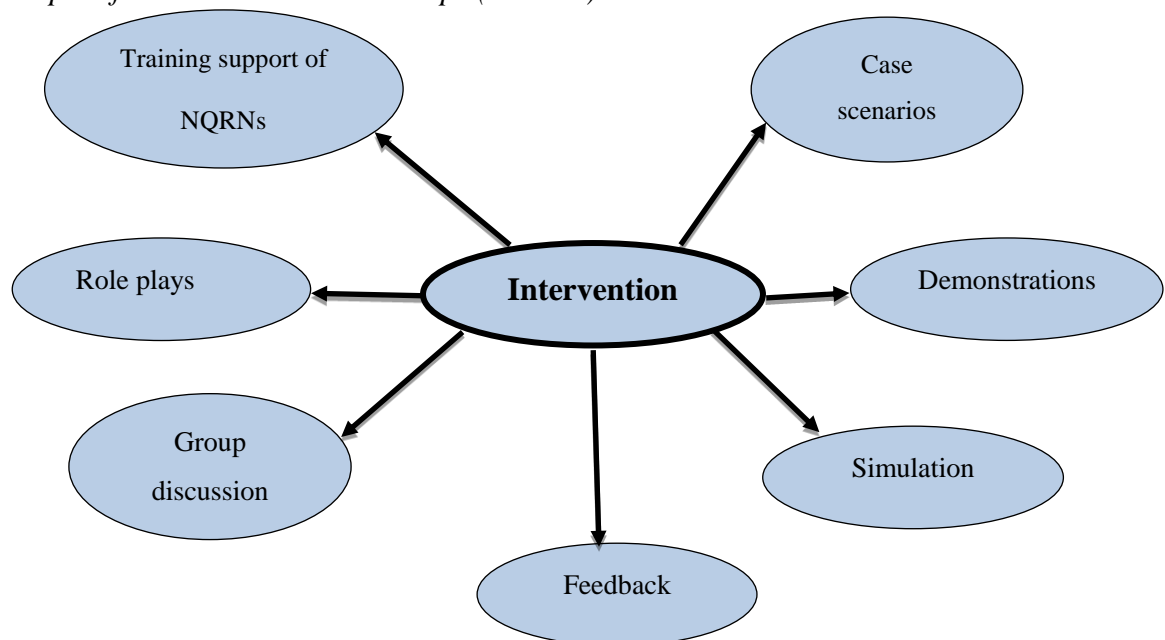


Figure 6.4: Interventions for the transition support programme

6.3.4. Outputs

According to the Programme Logic Model, outputs refer to what is produced from the programme interventions or activities, which are the knowledge and skills enhanced by NQRNs (Knowlton & Phillips, 2013). NQRNs will complete a course evaluation questionnaire in which they will assess the outputs of each unit, as shown in Figure 6.5.

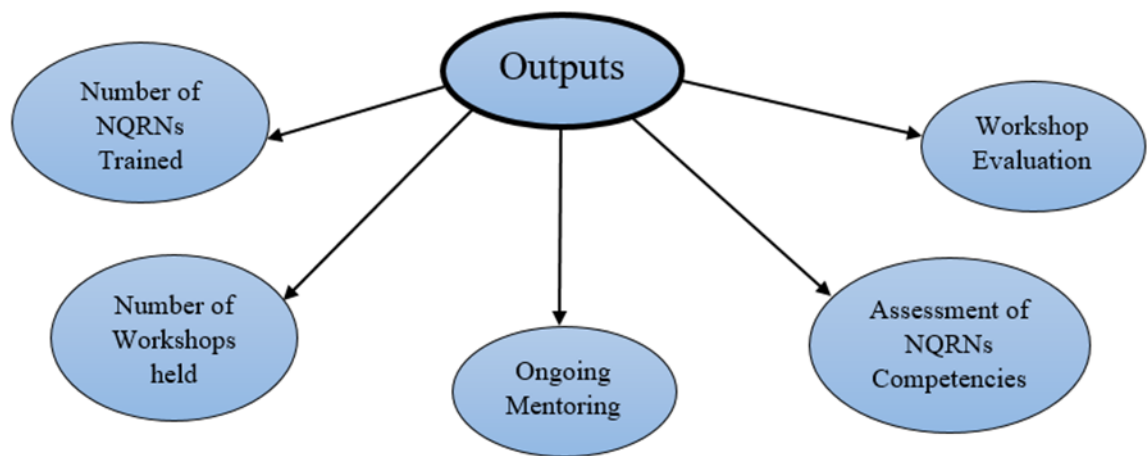


Figure 6.5: Transition support programme outputs

Adapted from Knowlton and Phillips (2013: 4)

6.3.5. Outcomes

According to the Programme Logic Model, outcomes are the results of the programme (Knowlton & Phillips, 2013). Outcomes in this transition support programme represent the knowledge, skills and attitudes NQRNs have at the end of the implementation of the programme (see Figure 6.6). In other words, the intended competencies NQRNs acquire at the end of the training. In this study, outcomes are the changes in the level of

competence brought about by the programme, such as cognitive, affective and psychomotor skills.



Figure 6.6: Transition support programme outcomes

Adapted from Knowlton and Phillips (2013: 4)

6.3.6. Impacts

Impact evaluations will be done to provide information about the effects of the transition support programme (see Figure 6.7). The public hospitals can conduct impact assessment of the transition support programme to reorient their support for NQRNs and to decide on whether to continue, discontinue, replicate, or scale up the transition support programme (Rogers, 2014). Evaluation of the impact of the transition support programme on the NQRNs competencies at public hospitals can be conducted in Namibia through a quasi-experimental research project.

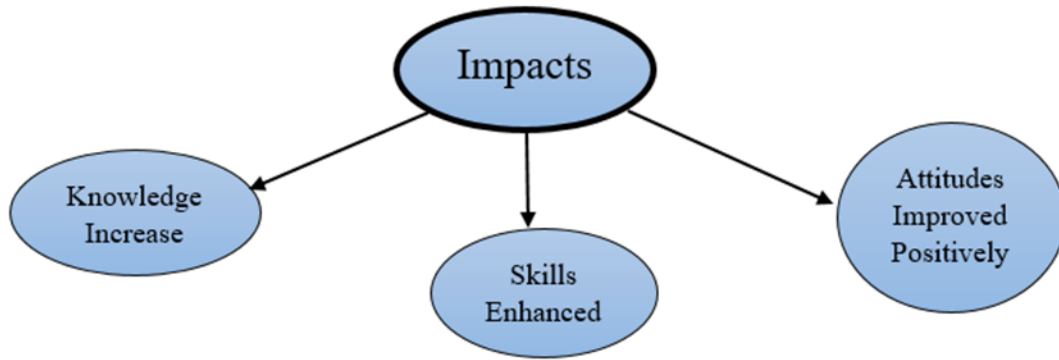


Figure 6.7: Transition support programme impacts

Adapted from Knowlton and Phillips (2013: 4)

6.4. SUMMARY

This chapter presented the conceptualisation of the findings within the framework of the study. The conceptualisation guided the researcher on the development of the transition support programme based on the gaps identified. The following chapter discusses the development of the transition support programme based on the study findings.

CHAPTER 7

DEVELOPMENT OF THE TRANSITION SUPPORT PROGRAMME

“You may never know what results come of your actions, but if you do nothing, there will be no results” Mahatma Gandhi

7.1. INTRODUCTION

The previous chapter described the conceptual framework of the study using a reasoning map based on the Programme Logic Model (Knowlton & Phillips, 2013), as illustrated in Figure 6.1. This chapter presents the development of the transition support programme for facilitating the competencies of NQRNs within the framework. During the situational analysis, it was found that NQRNs lacked some core competencies when they start working as registered nurses. The development of the transition support programme was aimed at addressing these competency gaps, as evidenced by the situational analysis (Phase 1).

7.2. RATIONALE FOR THE DEVELOPMENT OF THE TRANSITION SUPPORT PROGRAMME

For NQRNs, the transition can be demanding, challenging and daunting. They are newly employed with new roles, responsibilities and accountability for their practice, yet they are still learning and developing their knowledge and skills required in performing nursing duties competently. This stage of professional development can be a stressful time,

inciting anxiety and doubt in NQRNs (Duscher, 2009). In addition, NQRNs often experience problems relating theory to practice, with specific reference to practical procedures (Sugathapala & Chandrika, 2021).

Additionally, NQRNs often experience confusion in the wards because of incongruities between what was taught in class and what is implemented in the clinical environment. There are also disparities between what was learned outside the classroom and simulation laboratory and the actual practice in clinical practice (Safadi, Saleh, Nasser, Amre & Froelicher, 2011). Therefore, the transition support programme focuses on competency development among NQRNs to enhance their lack of competence as revealed in phase 1.

Following the analysis of the data in phase 1, the researcher discovered that some NQRNs lack core competencies, namely professional, legal, ethical, management and leadership required to render safe and quality nursing care. These competencies are among the generic competencies stipulated by the Health Professions Council of Namibia (HPCNA, 2018). These findings are in line with the observations made by different researchers (Chang & Daly, 2012; Hofler & Thomas, 2016; Kaihlanen et al., 2013). These researchers revealed that some of the common issues that occur during NQRNs' transition range from theory-to-practice gaps, caring for increasingly complex patients with multiple comorbidities, time management, medicine administration, patient-assessment skills, documentation skills, limited proficiency in managing and executing technical skills, working and collaborating within teams, accountability, decision-making, developing competency in planning and organising, prioritising to coping with unexpected events.

The transition support programme is a practice-oriented programme designed to help a NQRN transition into practice from a novice to an experienced professional registered nurse. This programme comprises both theoretical and clinical components designed to assist NQRNs bridge the theory practice gap. However, the programme is not aimed at repeating the educational components covered during the NQRNs' training, but merely to assist them to cover the theory-practice gap as NQRNs employed at the public hospitals in Namibia.

The transition support programme was not only designed to facilitate competencies and skills, but also to ease the transition of NQRNs. This is based on the understanding that a formal structured transition support programme for NQRNs can lead to confident, competent, independent and safe nurse practitioners. Additionally, the transition support programme was developed to guide unit managers and in-service training officers on how to effectively support NQRNs during transition.

The transition support programme focuses on the facilitation of the competencies of NQRNs, as outlined in the Generic Competency Framework for Registered Nurses in Namibia (HPCNA, 2018). Consequently, the transition support programme outlines the programme goal, objectives, learning outcomes, structure, activities, processes and approaches to be followed to achieve optimum competency outcomes. The programme consists of a variety of clinical activities, including educational sessions to address the identified lack of competencies among NQRNs during the transition period.

7.3. APPROACHES WHICH SERVED AS A BASIS FOR THE DEVELOPMENT OF THE TRANSITION SUPPORT PROGRAMME

The researcher selected different theories and philosophical approaches in the fields of nursing and education, which were considered relevant to guide the development of the transition support programme. These are discussed next.

7.3.1. Humanistic existentialism approach

Humanistic existentialism, as a philosophical approach, informs that NQRNs should become aware of their ability to realise their own potential in the execution of their nursing duties. The basic views determined in the humanistic learning approach are that much important learning is gained by doing, and learning is eased when the student focuses on responsibility in the learning process (Khatib et al., 2013). In this study context, the programme includes both theoretical and clinical skills, which NQRNs should be competent in to reach their full potential in their professional roles.

7.3.2. Knowles's Andragogic Learning Theory

Knowles' theory of andragogy was included because it illuminates how adults learn best and their attitude towards learning. Since NQRNs are adults, the researcher considered the inclusion of Knowles' theory on andragogy appropriate because of its core adult principles. The following Figure, 7.1 illustrates the characteristics of andragogic learning, as outlined by Knowles (1984).

According to Knowles (1984), there are six adult learning principles, namely adults are internally motivated and self-directed, adults bring life experiences and knowledge to learning, adults are goal-oriented, adults are practical, adult learners like to be respected, and adult learners are relevancy-oriented (see Figure 7.1).



Figure 7.1: Adult learning principles

(Source: Knowles (1984))

Following is a discussion of the adult learning principles.

- ***Self-concept***

According to Knowles (1984), when people get older, the concept of the person who we are (self-concept) moves from one of being a dependent personality towards one of being a self-directed human being. Equally, NQRNs are in transition, thus moving from being students into their professional role of registered nurse. Thus, adult learners learn when they feel the need to learn, motivated from the inside.

- ***Adults bring life experiences and knowledge to learning***

Adults have experiences gained throughout their lives and can use these experiences to facilitate their learning. As people grow and gain more experience in life, they accumulate knowledge based on this experience that then becomes a valuable resource for future learning. By the time they are adults, they would have accumulated experience to draw upon across a variety of contexts. Knowles (1984) further posits that as people mature, they accumulate experience that becomes an increasing resource for learning. Similarly, new graduates, who have accumulated knowledge during their academic training, need further refining and integration into practice. During this transition support programme, they can, therefore, build on the existing gaps in their knowledge and competencies.

- ***Adults are goal-oriented***

Adult learners strive to achieve goals, for example, they improve their knowledge to gain more recognition at work. This aspect will be very important and useful during the transition support programme.

- *Adults are practical*

Learning should be practically based, for example, a nursing example should be used for adult nursing students, so that they find it useful in their practical applications. Therefore, as many of the competencies addressed through this transition support are practically inclined, this is an important aspect.

- *Adult learners like to be respected*

Even if they are learners, adults need to be respected for them to enjoy learning. It is, therefore, important that the facilitator of the programme respects the participants as such. Exposing those who know less than others will not be in favour of the participants and will inhibit learning.

- *Adults are relevancy-oriented*

Due to the orientation to relevance principle, it is important that the participants understand the purpose of the transition support programme that will enhance their participation.

- *Readiness to learn*

According to Knowles (1984), as a person matures their readiness to learn becomes increasingly oriented towards the developmental tasks of their social roles. In this study, it is also assumed that as NQRNs become oriented to their professional role that will, therefore, bring meaning to their participation in the programme.

- ***Orientation to learning***

As adults, people's perspectives change from one of postponed application of knowledge to immediate application, and as such their orientation shifts from subject-centred to problem-centred. However, NQRNs' orientation may rather focus on a shift from theory to practice. Therefore, the main aim of the transition support programme is to facilitate NQRNs competencies.

- ***Motivation to learn***

As people mature, intrinsic motivation to learn becomes prominent (Knowles, 1984).

This principle from Knowles' theory is very important to the success of the programme. If participants are intrinsically motivated, it will facilitate their learning during the implementation of the transition support programme.

In addition, Knowles (1984) describes adult learning in terms of seven elements of self-directedness, which will be applied during the programme development of this study. Next is a description of these elements.

- ***Newly qualified registered nurses must identify their learning needs***

NQRNs must diagnose a need to know their own status regarding their competencies. A questionnaire was designed for NQRNs to assess their competencies after six months in practice. As adults, they must feel an inner desire to want to know their strengths and weaknesses regarding the performance of their professional practice. During the situational analysis, the structured questionnaire gave NQRNs an opportunity to identify their own needs regarding their competencies, which indicated the support needs. This

information determined the content to be included in the transition support programme to facilitate the NQRNs' competencies.

- *An environment conducive for learning should be created*

According to Quinn and Hughes (2013), Knowles asserts that a supportive learning environment is a critical aspect of the development of human resources. The development of a transition support programme can be valuable to newly qualified registered nurses as a support in competency enhancement and skills development.

The clinical environment is a setting in which theory and practice are integrated. It is also here where NQRNs can apply what they have learned in the classroom to the clinical setting and begin to build their clinical skills. However, it is difficult for them to accomplish this independently. Therefore, they require support and guidance to help them develop into competent registered nurses, who can render safe care to patients and the community.

As newly qualified nurses begin to practice their professional roles, support is essential to ensure competence and to build confidence. Against the background, it is evident that transitional support for NQRNs is imperative. Therefore, the researcher is of the opinion that NQRNs, as adults, have special needs and requirements to enhance their competencies. Hence, a transition support programme was developed to facilitate these competencies. However, ensuring the success of the transition support programme involves understanding how adults learn best.

Registered nurses, as adult learners, should be able to plan and manage their own learning (Quinn & Hughes, 2013). Therefore, the researcher found it relevant to identify the need for supporting the competencies of NQRNs. Self-directed learning, on the other hand, gives individuals an opportunity to develop their own learning. It is further believed that self-directed learning allows learning to progress beyond knowledge acquisition to increase learners' confidence in and capacity for independent learning in dynamic and challenging work environments (Quinn & Hughes, 2013).

7.3.3. Nicholls`s cyclic curriculum development model

The researcher followed the five-point plan curriculum cyclical model of Nicholls and Nicholls (1978) to guide the design of the curriculum for the transition support programme. The five steps of the model were followed in designing a curriculum, namely: 1) situation analysis, 2) selection of objectives, 3) selection and organisation of content, 4) selection and organisation of methods, and 5) evaluation. Figure 7.2 below depicts the steps the researcher followed in the development of the curriculum of the transition support programme.

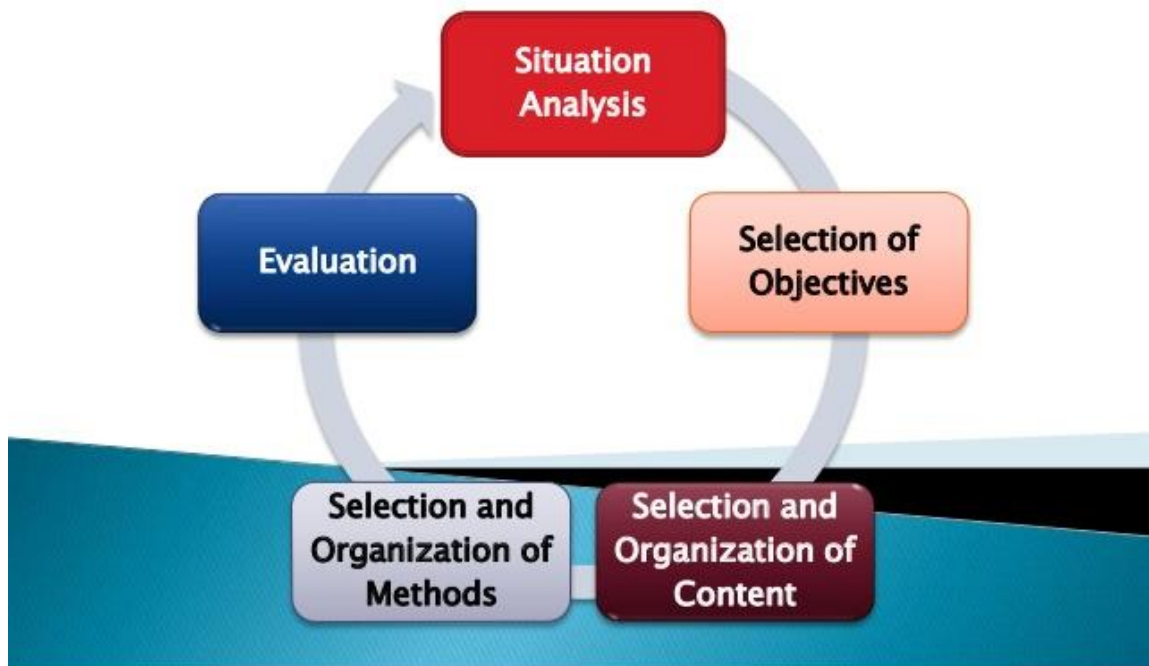


Figure 7.2: Curriculum development steps

Source: Nicholls (1978)

- **Situational analysis**

The situational analysis (phase 1) was conducted to determine the competence of NQRNs, as reported by themselves and their unit managers. This phase was important in guiding the researcher on the competency gaps of NQRNs.

- **Selection of objectives**

The objectives of the transition support programme were based on the findings of the situational analysis. The objectives were aimed at addressing the competency gaps of NQRNs (refer to 7.4.3).

- **Selecting and organising the content**

The content of the transition support programme was guided by the conceptual framework of the study, which was based on the generic competencies of registered nurses (**refer to 7.5**).

- **Selection of the teaching methods**

The teaching methods for this programme were carefully selected to suit the content to be delivered. These are discussed later in this chapter (**7.6**).

- **Evaluation**

The evaluation of the learning activities delivered will be done by the facilitators to ascertain whether the workshop objectives were met (**refer to 7.6**).

7.3.4. Bloom's Taxonomy of Learning

To ensure educational excellence, Bloom's taxonomy of learning domains was applied in the development of the content of the transition support programme (Cook, 2013). This learning approach was deemed appropriate, as NQRNs are expected to possess knowledge and skills to deliver quality and safe nursing care. To ensure mastery of competency for NQRNs, the programme included objectives on knowledge, skills and attitudes. These intellectual abilities include cognitive, affective and psychomotor skills, which are essential in nursing education.

Cognitive skills concentrate on knowledge and understanding thereof. NQRNs need information to understand facts, concepts, rules and policies as outlined in the different domains of competencies. In this regard, some programme objectives are based on the

cognitive domain to enable NQRNs to remember relevant information (Mogotlane et al., 2018).

Affective skills include the compassion and caring aspects of nursing. This area is concerned with feelings, attitudes, characteristics and values NQRNs need to be competent in their practice. In other words, it focuses on ethical conduct, legal issues, and professional standards, as outlined in the professional, ethical and legal competency domain. Thus, the objective of including this skill is mainly for NQRNs to always display competence in professional commitment to ethical practice when they deal with the patient in their care (Mogotlane et al., 2018).

Psychomotor skills deal with the hands-on skills of NQRNs in nursing practice. These are skills NQRNs need to perform physical nursing activities or interventions where the gross and fine muscles are used, for example, administering an injection. In this study, domain 2 (Table 2.1.) is based on knowledge-based practice where NQRNs are expected to be competent in executing nursing activities or procedures, for example, to conduct CPR effectively. In some of these skills, adequate or little competency cannot be tolerated, therefore, the NQRNs should strive towards total competence (Mogotlane et al., 2018).

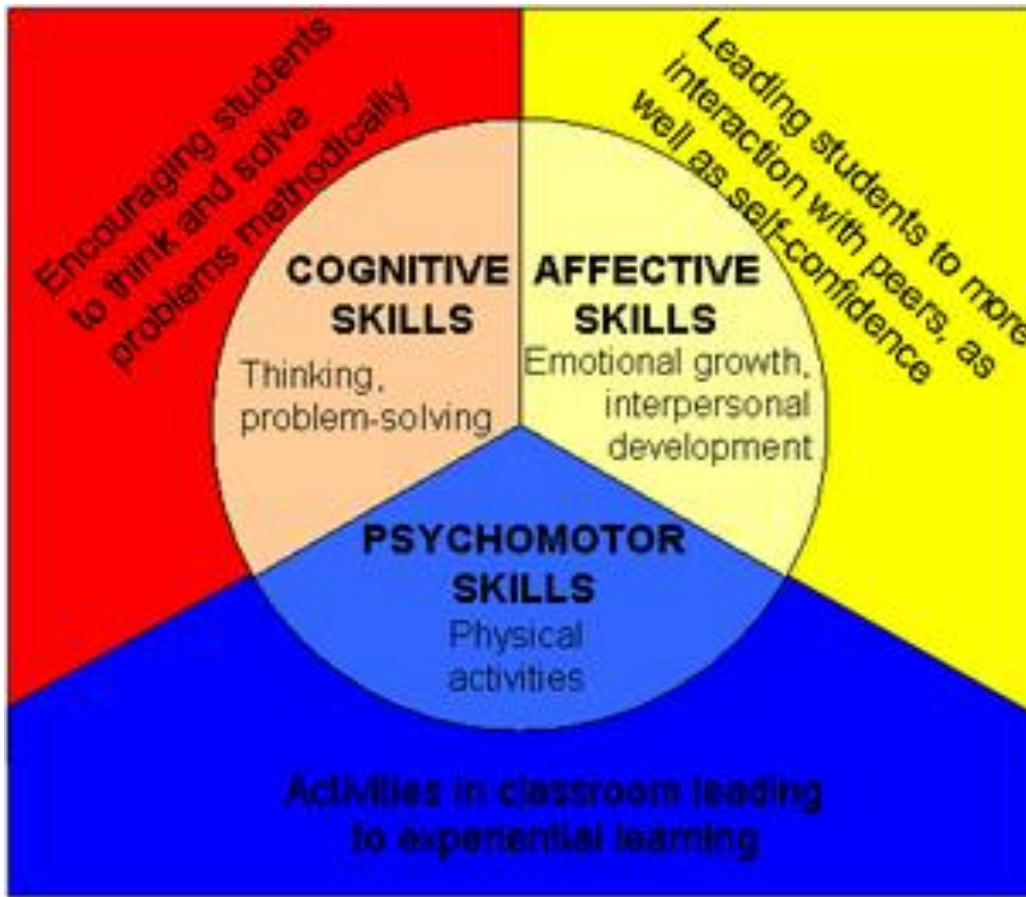


Figure 7.3: Bloom's Taxonomy of Learning

Source: <http://www.nwlink.com/~donclark/hrd/bloom.html>

7.4. PROGRAMME COMPONENTS

The components of the transition support programme will be discussed next.

7.4.1. Title of the programme

The programme is titled the *“Transition support programme to facilitate the competencies of newly qualified registered nurses at public hospitals in Namibia”*.

7.4.2. The aim of the transition support programme

The overall aim of the transition support programme is to provide a safe and positive environment that assists NQRNs to develop skills and build confidence in their professional roles. It is also aimed at developing a formal standardised programme for the public hospitals in Namibia to give NQRNs the opportunity to integrate their knowledge and skills and develop their competencies as professional registered nurses. Consequently, the programme focuses on providing public hospitals in Namibia with a structured standardised framework to support NQRNs’ transition into practice and, by so doing, promote quality nursing care and public safety.

The situational analysis revealed areas in which NQRNs still lacked core competencies after six months of practice as registered nurses. These competencies range from professional, ethical, legal and knowledge-based practice. Consequently, the facilitation of the competencies of NQRNs would ensure competent and confident registered nurses, who are able to deliver safe and quality nursing care.

7.4.3. The objectives of the programme

The objectives for the transition support programme focused on the facilitating the strengthening of NQRNs' competence in different domains during transition from newly qualified to experienced registered nurses. Therefore, the following objectives were formulated:

7.4.3.1. Objective 1: Provide newly qualified registered nurses with knowledge and skills to render professional, ethical and legal nursing care

This objective addresses the issue of professional accountability, meaning the registered nurses' ability to be answerable for their actions and omissions. It also focuses on the standards and norms of legal practice, as outlined by the Namibian Nursing Act, 8 of 2004 (Republic of Namibia, 2004), and in a manner consistent with Namibia's laws and regulations. NQRNs' competence on ethical practice are also addressed to establish competence in professional judgement and practice decisions guided by the values and ethical responsibilities in the scope of practice for registered nurses. Therefore, to achieve this objective, much focus will be on safety of patients by recognising medical legal hazards as well as maintaining of clear and legible documentation.

7.4.3.2. Objective 2: Empower newly qualified registered nurses to render quality knowledge-based practice

This objective addresses the gap identified concerning NQRNs' provision of care competencies (4.2.3.2.2). The programme was further developed to empower NQRNs to render quality nursing care. Thus, NQRNs would be empowered to be competent in the application of knowledge and to be critical thinkers.

This objective includes domain 2(item 2.2.1) of competencies and focuses on the competencies within the nursing care plan.

7.4.3.3. Objective 3: Enhance the skills of newly qualified registered nurses to be effective managers and leaders of health care

The assessment of NQRNs competence was covered in domain 3 (Table 4.50) of the data collection tool. This objective addresses NQRNs' competencies in achieving the health services goals and objectives. It would empower NQRNs to effectively supervise subordinates, help patients make informed decisions and communicate information clear and effectively. Thus, this objective focuses on planning, organisation, directing and controlling of health care. In summary, the NQRNs will be empowered with leadership and management skills, which will enable them to understand the concept of public protection and the duty to provide nursing care in the best interest of the public.

7.4.4. Target population for the programme

The programme, which is designed for NQRNs with less than two years' practice experience, their supervisors and in-service training officers at public hospitals in Namibia, provides guidance on how best to support NQRNs.

7.5. PROGRAMME CONTENT

The content of the transition support programme was guided by the findings of the situational analysis in phase 1. It was established that NQRNs lack some core competencies when they start working as NQRNs. These competencies were the survey

results which was based on the opinions of NQRNs and their unit managers. The content of the programme is based on competency domains contained in the Namibian Competency Framework for Registered Nurses (HPCNA, 2018), which the researcher found applicable to NQRNs. These are: Module 1: professional, ethical and legal practice; Module 2: Provision of care (knowledge-based practice), and Module 3: management and leadership. This programme is a proposal by the researcher, therefore it will be reviewed by experts in education, as well as by relevant stakeholders before rolling it out to the hospitals. An outline of the content and the sources to facilitate the implementation of the transition support programme are presented in **Table 7.1**.

Table 7.1: Content of the transition support programme

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
Unit 1: Introduction and overview	<ul style="list-style-type: none"> • Introduction of the transition support programme • The Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia 	Lecture: PowerPoint slides	<ul style="list-style-type: none"> • Adult learning theory • Humanistic Existentialism 	- Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018).

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
Unit 2 : 2.1. Professional competencies	<ul style="list-style-type: none"> • Professional responsibility and accountability • Professional Code of conduct • Patient safety • Maintaining clear and legible records 	Lecture, group discussions, case scenarios	<ul style="list-style-type: none"> • Adult learning theory • Humanistic Existentialism 	-Republic of Namibia. (2004). Nursing Act No. 8 of 2004. <i>Government Gazette</i> , 28 July 2004. -WHO. (2016). <i>Four-year integrated nursing and midwifery competency-based, prototype curriculum</i> . Brazzaville: World Health Organization Regional Office for Africa. pp. 39-42. -Searle, C; Human, S; Mogotlane, SM (2014). <i>Professional Practice: A Southern African Nursing</i>

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
				<p>Perspective 5th Edition. Pearson</p> <p>-Booyens, S.W., Jooste, K., & In Sibiya, N. (2015). <i>Introduction to health services management for the unit manager</i>. (4th ed.) Cape Town; Juta.</p> <p>-Mogotlane, S.M. (ed), Mokoena, J. D., Chauke, M.E. & Young, A. (2018). <i>Juta's Complete Textbook of Medical and Surgical Nursing</i>. (2nd ed.). Cape Town: Juta.</p>

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
Unit 2: 2.2. Legal competencies	<ul style="list-style-type: none"> • Legal issues in nursing: ✓ <i>Negligence</i> ✓ <i>Misconduct</i> ✓ <i>Malpractice</i> • Legal framework in Nursing 	Lectures, group discussions, case scenario	<ul style="list-style-type: none"> • Adult learning theory • Humanistic Existentialism 	-Republic of Namibia. (2004). Nursing Act No. 8 of 2004. <i>Government Gazette</i> , 28 July 2004. -WHO. (2016). <i>Four-year integrated nursing and midwifery competency-based, prototype curriculum</i> . Brazzaville: World Health Organization Regional Office for Africa. pp. 39-42. -Searle, C; Human, S; Mogotlane, SM (2014). <i>Professional Practice: A Southern African Nursing</i>

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
				<p>Perspective 5th Edition. Pearson</p> <p>-Booyens, S.W., Jooste, K., & In Sibiya, N. (2015). <i>Introduction to health services management for the unit manager</i>. (4th ed.) Cape Town; Juta.</p> <p>-Mogotlane, S.M. (ed), Mokoena, J. D., Chauke, M.E. & Young, A. (2018). <i>Juta's Complete Textbook of Medical and Surgical Nursing</i>. (2nd ed.). Cape Town: Juta.</p>

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
<p>Unit 2:</p> <p>2.3. Ethical competencies</p>	<ul style="list-style-type: none"> • Ethical concepts: confidentiality, responsibility, privacy, fidelity, veracity, informed consent, self-determination, non-discrimination • Ethical duties in health care: • ethical decision-making • Malpractice/Unethical conduct 	<p>Lectures, group discussions, case scenario</p>	<ul style="list-style-type: none"> • Adult learning theory • Humanistic Existentialism 	<p>Republic of Namibia. (2004). Nursing Act No. 8 of 2004. <i>Government Gazette</i>, 28 July 2004.</p> <p>-WHO. (2016). <i>Four-year integrated nursing and midwifery competency-based, prototype curriculum</i>. Brazzaville: World Health Organization Regional Office for Africa. pp. 39-42.</p> <p>-Searle, C; Human, S; Mogotlane, SM (2014). <i>Professional Practice: A Southern African Nursing Perspective</i> 5th Edition. Pearson</p> <p>-Booyens, S.W., Jooste, K., & In Sibiya, N. (2015). <i>Introduction to health services management for the unit manager</i>. (4th ed.) Cape Town; Juta.</p> <p>-Mogotlane, S.M. (ed), Mokoena, J. D., Chauke, M.E. & Young, A. (2018). <i>Juta's</i></p>

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
				<i>Complete Textbook of Medical and Surgical Nursing.</i> (2nd ed.). Cape Town: Juta.
Unit 3: Knowledge /competency-based practice	<ul style="list-style-type: none"> • Assessment • Planning • Implementation • Evaluation • Recordkeeping • Compilation of Nursing care plans 	Lectures, demonstrations, case scenario, group work	<ul style="list-style-type: none"> • Adult learning theory • Humanistic Existentialism 	<p>Republic of Namibia. (2013). Procedure manuals for nurses. <i>Ministry of Health and Social Services</i>, 1.</p> <p>WHO. (2016). <i>Four-year integrated nursing and midwifery competency-based, prototype curriculum</i>. Brazzaville: World Health Organization Regional Office for Africa.</p> <p>Republic of Namibia. (2014). Regulations relating to the scope of practice of persons registered or enrolled und the Nursing Act, 2004. <i>Government Gazette</i>, 17 October 2014.</p>

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
				<p>Republic of Namibia. (2004). Nursing Act No. 8 of 2004. <i>Government Gazette</i>, 28 July 2004.</p> <p>Mogotlane, S.M. (ed), Mokoena, J. D., Chauke, M.E. & Young, A. (2018). <i>Juta's Complete Textbook of Medical and Surgical Nursing</i>. (2nd ed.). Cape Town: Juta.</p> <p>Mogotlane, S., Chauke, M.E., Matlakala, M., Mokoena, Manaka- Mkwanazi, I. M., J. & Randa, M.B. (2015). <i>Juta's Manual of Nursing Volume 2. The Practical Manual</i>. Juta & Company. Cape Town, South Africa.</p>

Units	Content	Teaching strategies	Teaching /Learning Approach(es)	Sources
Unit 4: Management and leadership competencies	<ul style="list-style-type: none"> • Planning • Organising • Supervision • Controlling • Conflict management 	Lectures, group discussions, problem solving case scenarios	<ul style="list-style-type: none"> • Adult learning theory • Humanistic Existentialism 	-Booyens, S. W., In Jooste, K., & In Sibiya, N. (2015). <i>Introduction to health services management for the unit manager</i> . (4th ed.). Cape Town: Juta. -J Jooste K. (2017). <i>Leadership in health services management</i> . (3rd ed.). Cape Town: Juta. -Jooste, K. (2018). <i>The principles and practice of nursing and health care 2nd Edition</i> . Pretoria: Van Schaik. - Muller, M. (2009). <i>Nursing Dynamics</i> . 4 th Edition Johannesburg Heinemann

(For detailed description of the transition support programme – see Appendix 1.11)

7.6. FACILITATION TECHNIQUES

As mentioned earlier, the transition support programme is a proposal by the researcher and was not implemented during this study. Therefore, the following teaching strategies were also proposed to be followed during the implementation workshop to facilitate teaching and learning.

- **Lectures**

A lecture is a step-by-step instruction type of educational encounter in which the facilitator conveys information to a receiver, in this case the NQRNs (Quinn & Hughes, 2013). As indicated in Table 7.1, the lecture method can be applied in all units in the form of PowerPoint slides to present the content of the different competency domains. The lecture would enable facilitators to introduce the transition programme to participants by illustrating the aim and objectives of the transition support programme (Armstrong & Rispel, 2015).

- **Group Discussions**

Group discussions can be used to promote active participation and explore different viewpoints on certain issues (Sravani, Doshi, Kulkarni, Reddy & Reddy, 2018). This technique uses past experiences, attitudes and values in a deliberated manner. Group discussions are based on real life experiences where relevant subject matter or questions are discussed. The aim of group discussions is to solve a problem, to enhance NQRNs' knowledge on certain complex matters, such as moral and ethical dilemmas.

During the training, NQRNs can be divided into small groups and given the opportunity to voice their opinions on real life situations, express themselves, which can empower

them to realise their ability to think critically and, accordingly, change through this method (Quinn & Hughes, 2013). **Brainstorming** can be used during group discussions that involves the spontaneous contribution of ideas from all NQRNs to generate creative ideas to solve clinical problems.

- **Problem-solving**

Problem-solving is an effective way facilitators can use to enhance NQRNs' problem-solving skills by providing guidance on how best to solve some challenging tasks. NQRNs can be given a problem to solve and given certain sources of information from which they can draw their solutions. The main aim is to encourage critical thinking of the NQRNs (Quinn & Hughes, 2013).

- **Role play**

The role play method can be applied not only to allow NQRNs apply their experiences to real-life situations, but also to make it easier for them to discuss complex social issues in a non-threatening environment (Dawood, 2013). Role plays are also applied to develop interpersonal and communication, conflict resolution and group decision-making skills (Dawood, 2013). Role plays would be effective in explaining ethical and legal issues pertaining to nursing practice.

- **Demonstrations**

This is a teaching method based mainly on the demonstration of knowledge and skills. It is a visual presentation of a nursing technique using equipment to show how nurses should do a procedure (Human & Mogotlane, 2017). Unit 4 of the transition support programme is based on the provision of care competencies, of which most items are

clinical procedures. Hence, demonstrations would be ideal to show NQRNs how to do various activities and procedures in which they lack competence.

Following the demonstration, NQRNs practice under the supervision of the facilitator. Finally, independent practice is done to the point of competency. The demonstration method is accompanied by a lecture to enhance effectiveness, because discussion expands and deepens the learner's knowledge (Hasan, 2011).

- **Simulation**

There is increasing evidence in literature that simulation can be an effective means of promoting learning in nursing and other health care professions. Simulation has been found effective in improving student cognitive skills and critical thinking (Cato, 2013). Despite that NQRNs are newly trained, they might still lack confidence in some clinical procedures. Following demonstration of procedures, facilitators can develop a realistic patient scenario where NQRNs use mannequins as patients in a simulated environment. NQRNs can practice multiple aspects of patient care in which they feel they lack competence and can practice without the risk of making mistakes with real patients (Cato, 2013).

- **Feedback**

NQRNs should be given feedback regarding their performance or behaviour. It can be either verbal or written feedback. The purpose of feedback in the learning process is to improve NQRNs' performance. NQRNs should be given feedback immediately after the assessment, because if the feedback is delayed, the momentum is lost and the NQRNs might not connect the feedback with the action (Reynolds, 2013).

When giving feedback, facilitators should be sensitive to the individual needs of the NQRNs. It is vital to take into consideration the diversity of NQRNs when giving feedback and to be careful not to hurt feelings, but providing proper encouragement is essential (Reynolds, 2013).

7.7. GUIDELINES FOR IMPLEMENTING THE TRANSITION SUPPORT PROGRAMME

Guidelines are the information intended to advise people on how something should be done or what something should be (American Heritage, 2016). As the transition support programme was not implemented during this study, guidelines are proposed for the implementation. The guidelines are to facilitate the implementation of this programme and may be used for in-service training under quality assurance at public hospitals in Namibia. Following are the guidelines under discussion.

7.7.1. Programme context

The transition support programme could be implemented to facilitate the competencies of NQRNs at public hospitals in Namibia. To achieve this, a training workshop should be conducted at the hospital where the NQRNs employed to deliver the learning content during the first year in which NQRNs start working as registered nurses.

7.7.2. Philosophical and educational approaches

To ensure programme effectiveness, the following approaches can be incorporated in the delivery of the transition support programme. The participants in the discussion refer to NQRNs.

- **Adult learning theory**

The principles of adult learning theory that can be applied during the training are:

Facilitators should know the audience by doing an analysis of the audience, because instruction must be relevant to the needs of the participants. Thus, it is important to understand the profile and competencies needed by the NQRNs.

Facilitators should watch their voice tone and should not “talk down” in a pedagogical manner. Instead, acknowledge the professionalism and expertise that NQRNs bring to the table.

Facilitators should keep NQRNs motivated throughout the session. Learning must be perceived to be of value to the adult learner, and it must satisfy some internal drive or need. Make clear connections between learning activities and the learner’s life. Make sure your learners know why they need this training and of what benefit it will be to them.

NQRNs’ time should be respected as time is perceived as of value. The NQRNs must be taught skills they will need in their practice. Thus, the learning objectives and strategies should be concise and focused on the facilitation of NQRNs’ competencies.

Let NQRNs practice by incorporating a special time for that. Give NQRNs sufficient time and opportunities to practice what they have learned, both individually and

collectively. Assist them to link the new information to how they will apply it on the job (Wang, 2015).

- **Humanistic existentialism philosophical approach**

The facilitators should consider the broad needs of NQRNs, including not just cognitive but also social and emotional needs, such as the transition shock they may encounter (Nath, Kumar & Kumar, 2017). If humanism is realised during this programme, NQRNs will achieve their personal best and are able to grow and achieve self-actualisation (Crain, 2015). During training, the facilitators should also develop rationality, autonomy, empowerment, creativity, affections and a concern for humanity (Veugelers, 2011.). It is of utmost importance to create an ideal and conducive environment, which caters to the social, emotional and cognitive needs of the NQRNs (Crain, 2015; Duchesne & McMaugh, 2016; Veugelers, 2011).

- **Bloom's taxonomy of learning**

To ensure NQRNs acquire the necessary skills, all domains should be assessed such as cognitive, affective and psychomotor domains. NQRNs should be helped to understand the basic concepts, including information. Similarly, the affective domain should be emphasized such as attitudes and professional values. Most importantly, the NQRNs should be assisted to practice to acquire the psychomotor skills to practice effectively and confidently.

7.7.3. Programme phases

This programme could be delivered within three phases over a period of one week, as discussed in Table 7.2 below. The researcher will be available to assist during programme implementation by ensuring that the facilitators are guided on the implementation thereof.

Table 7.2: Phases in conducting NQRNs training- programme implementation

No:	Phase	Activities
1	Orientation phase	<ul style="list-style-type: none">• Welcoming address and introduction of participants• Overview of the workshop• Outline of the aim and objectives of the workshop• Setting up ground rules for the workshop
2	Working phase	<ul style="list-style-type: none">• Pre-test on NQRNs knowledge on generic competencies• Teaching/learning activities on generic competencies of registered nurses: professional, ethical, legal, and knowledge-based practice, management and leadership competencies.• Clinical practice sessions on practical procedures
3	Termination phase	<ul style="list-style-type: none">• Daily evaluation of programme activities• Evaluation and discussion of activities (post-test evaluation)• Reflection reports on training impact• Closure of the workshop

7.7.3.1. Orientation phase

This phase involves the welcoming and introduction of the participants. Facilitators and NQRNs introduce themselves and outline workshop aims and objectives. Participants' expectations are explored to guide the facilitators on how to conduct the workshop. Participants establish and agree on the ground rules for the workshop, which will be pasted on the wall to serve as a reminder throughout the training.

7.7.3.2. Working phase

This phase was aimed at facilitating the competencies of NQRNs. Thus, the activities to be performed should accomplish the aims and objectives of the transition support programme. Therefore, the facilitator should focus on addressing the competency challenges of NQRNs identified during the situational analysis. The content to be covered is outlined in Table 7.1. To ensure effectiveness in implementing this phase of the transition programme, facilitators should apply Knowles' model of andragogy, humanistic existentialism philosophical approach, and Bloom's taxonomy of learning (**refer to 7.6.2**).

7.7.3.3. Termination phase

During this phase, the lessons are reviewed to evaluate the effectiveness and to guide future actions. NQRNs should complete a post-test evaluation to reflect the impact of programme activities and make recommendations for improvement.

7.7.3.4. Programme evaluation

The programme should be implemented after six months of appointment of NQRNs to allow them sufficient time to identify their challenges during practice. Evaluation of the workshop should be done daily after each module is delivered whereby NQRNs evaluate the daily training activities. A similar evaluation should also be done towards the end of the workshop to gauge the impact and outcomes of the training.

7.7.3.4.1. Daily workshop evaluation

The daily training evaluation is aimed at assessing the programme's aims and objectives and to provide evidence of the extent to which the training has achieved its aims and objectives. In addition, this practice will allow participants to give their views regarding the implementation of the programme. Table 7.3 below illustrates the workshop evaluation tool to be used in this study.

Table 7.3: Daily workshop evaluation tool

Dear Participant
Please indicate your views on the training by answering the following questions.
1. What did you learn in today's training?
2. What did you like most about today's activities? Provide a reason.
3. What did you not like about today's activities? Provide a reason.
4. What did you not understand in today's sessions?
5. What suggestions do you have to improve the presentations?

7.7.3.4.2. Programme impact evaluation

Programme evaluation should be done by NQRNs after completing the training to determine the impact of the transition support programme (Figure 6.6).

With regard to the programme outcomes, the researcher envisage conducting a post-doctoral research to evaluate the outcomes (results) of the programme (Figure 6.7.). During this study, the researcher intends to conduct a quasi -experimental study using a pretest-posttest design to assess the competence of NQRNs prior to and after the implementation of the transition support programme.

Table 7.4 below indicate the tool that could be completed by NQRNs at the end of the training to assess the impact of the transition support programme.

Transition Support Programme impact evaluation tool

Table 7.4: Programme impact evaluation tool

Dear Participant	
After completing the training, please answer the following questions, including any comments you have. Answer the questions by ticking the appropriate space provided.	
1. Unit 1: This unit enhanced my understanding of the transition support programme	
Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

2. Unit 2: Professional competencies

I gained knowledge on professional competencies

Strongly agree	
Agree	
Disagree	
Strongly disagree	

3. Unit 2: Legal competencies

I have acquire the knowledge on legal issues pertaining to professional nursing practice.

Strongly agree	
Agree	
Disagree	
Strongly disagree	

4. Unit 2: Ethical competencies

4.1. I have acquire the knowledge and skills to render ethical nursing care.

Strongly agree	
Agree	
Disagree	
Strongly disagree	

4.2. I better understand the ethical responsibilities of a registered nurse

Strongly agree	
Agree	
Disagree	
Strongly disagree	

4.3. I gained knowledge on ethical principles in professional nursing

Strongly agree	
Agree	
Disagree	
Strongly disagree	

5. Unit 3: Knowledge-based care competencies

5.1: I am able to perform the required clinical procedures

Strongly agree	
Agree	
Disagree	
Strongly disagree	

6. Unit 4: Management and leadership competencies

6.1. I gained an understanding of management and leadership in nursing

Strongly agree	
Agree	
Disagree	
Strongly disagree	

6.2. I now understand the management and leadership competencies needed of my role.

Strongly agree	
Agree	
Disagree	
Strongly disagree	

7. The training enhanced my knowledge and skills to practice confidently

Strongly agree	
Agree	
Disagree	
Strongly disagree	

7.8. SUMMARY

This chapter encompassed the development of the transition support programme for NQRNs in its totality. It explains the rationale, objectives and approaches to the development of this programme. In addition, implementation sources were highlighted and guidelines to the implementation of the programme were provided. The following chapter discusses the conclusions, recommendations and limitations of the study.

CHAPTER 8

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

“Unless we are making progress in our nursing every year, every month, every week, take my word for it we are going back”. – Florence Nightingale

8.1. INTRODUCTION

NQRNs go through transition from new to experienced registered nurses. This is the period during which they need to adjust to a new role to become confident and competent with various aspects of the role such as knowledge, skills and attitudes (Henderson et al., 2012). NQRNs further move from a state whereby they were always guided and supported by registered nurses, lecturers and clinical instructors to where they will now act independently. During this transition, they are confronted with significant changes in goals, roles, and responsibilities (Meleis, 2012).

NQRNs often face challenges in effectively applying knowledge, skills and judgement in their daily practice as registered nurses. Moreover, these nurses often lack competencies to efficiently execute their professional roles and responsibilities (Reinert et al., 2012).

As a nursing lecturer, the researcher’s interest was triggered by reports on graduates’ lack of competencies in Namibia. It was not clear whether the reference also applied to nurse graduates, therefore, the researcher embarked on this study to determine the competence of NQRNs at public hospitals in Namibia. The overall aim was to address the competency challenge of NQRNs in the form of a transition support programme that can facilitate these competencies.

The researcher, therefore, posed the question whether NQRNs at public hospitals in Namibia are competent to deliver safe, quality and competent nursing care, as expected of them after they qualified?

8.2. CONCLUSIONS

The conclusions of this study are presented according to the different phases and objectives.

Phase 1:

Objective 1: To determine and describe the self-reported competence of newly qualified registered nurses at public hospitals in Namibia (Phase 1)

Conclusions

This study concludes that NQRNs at selected public hospitals in Namibia are not competent in some core competencies to practice as competent registered nurses, namely professional, ethical, legal, provision of care, and management and leadership competencies. This was supported by the self-reported responses of NQRNs regarding their competence in different domains. In general, however, they reported that they mostly possess basic knowledge and skills.

Objective 2: To determine and describe the views of unit managers at public hospitals in Namibia regarding newly qualified registered nurses' competence (Phase 1)

Conclusion

In conclusion, the researcher can report that unit managers perceive NQRNs not competent in most competency domains. They rated NQRNs as either having adequate or little knowledge in most competencies.

Phase 2

<p>Objective 3: To develop a conceptual framework to inform the development of the transition support programme</p>
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Conclusion

The results of the situational analysis led to the development of the conceptual framework. The conceptual framework was guided by the Programme Logic Model and the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia, which formed the basis for the development of the transition support programme to facilitate the competencies of NQRNs at public hospitals in Namibia. The framework consists of domains of competencies for registered nurses and midwives/accoucheurs in Namibia, which were adopted to guide the content of the transition support programme. The three domains that are incorporated in the transition support programme are: professional, ethical and legal competencies (domain 1), knowledge-based practice (domain 2), and leadership and management competencies (domain 3).

Phase 3

Objective 4: To develop a transition support programme to facilitate the competencies of newly qualified registered nurses at public hospitals in Namibia (Phase 3)

Conclusion

Following the situational analysis, it was clear that a transition support programme could fill the gap in the competence of NQRNs after graduation. Such intervention would facilitate the competencies of NQRNs once they assumed duty as registered nurses. As a result, the researcher developed the transition support programme, which addresses the competency gaps of NQRNs at public hospitals in Namibia. The transition support programme comprises five units based on the three main domains of the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018), as reported above.

8.3. CONTRIBUTION OF THE STUDY

This study has provided a distinctive contribution to the body of knowledge in nursing education in the form of a standardised programme to facilitate the competencies of NQRNs at public hospitals in Namibia. The transition support programme will support NQRNs by enhancing the competence they need after graduation.

Consequently, as the NQRNs improve their competence, the quality of nursing care improves. The transition support programme can be used to guide the orientation and

induction of NQRNs to cover the theory-practice gap. A unique conceptual framework was arrived at by integrating the Generic Competency Framework of Registered Nurses/ Accoucheurs in Namibia (HPCNA, 2018) with the Programme Logic Model and, in addition, also adding outcomes from Bloom's taxonomy. The said Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018) is relatively new in Namibia, and as such has not been applied to nursing care and the development of competencies. Resultantly, an awareness of the framework and its application to nursing practice is facilitated.

8.4. RECOMMENDATIONS

The following recommendations, based on the findings of the study, have been formulated:

8.4.1. Recommendations to the Ministry of Health and Social Services

As the study particularly speaks to NQRNs' competence, the following recommendations are made to MoHSS.

The quality assurance (QA) department of the public hospitals should place more emphasis on improving NQRNs' competencies when they start duty. In-service training officers at public hospitals under QA should use similar transition support programme questionnaires to assess the competence of NQRNs after six months of employment.

- The programme approaches could also be incorporated into the in-service training programmes of NQRNs at public hospitals in Namibia by following the guidelines provided on the implementation of the programme.
- In reference to the above, the researcher will avail herself to the MoHSS for the initial implementation of the transition support programme to give guidance on the content and strategies to follow.
- The transition support programme should be extended to all public regional hospitals to ensure all NQRNs competencies are equally facilitated.

8.4.2. Recommendations for nursing education

As the training of nursing students and nursing practice cannot be separated, it is recommended that the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018) be incorporated into the undergraduate curriculum of the Bachelor in Nursing Science programme at higher education institutions (HEIs). Student nurses should be taught on the different domains of competencies, as required by HPCNA and its application in nursing practice. It is further recommended that student nurses undergo a competency assessment before exiting the undergraduate programme. Therefore, to facilitate the operationalisation of this recommendation, the researcher will avail herself to address HEIs across Namibia concerning the findings of this study and the implementation of the transition support programme.

8.4.3. Recommendations towards future research

Regarding future research, the researcher suggests the following studies:

- Research on the factors that influence NQRNs' competency development at public hospitals in Namibia
- Evaluation of the impact of the transition support programme on the NQRNs competence at public hospitals in Namibia through a quasi-experimental research project.

8.5. LIMITATIONS OF THE STUDY

Hornby (2015) refers to limitations as shortcomings or influences that a research is unable to control during a research study. The researcher encountered limitations related to the population of the study. The study was initially targeting public and private hospitals. However, internal policies prevented private hospitals from participating, therefore, the findings of the study only represent the NQRNs at public hospitals in Namibia where the study was conducted. The situational analysis focused solely on 103 responses for NQRNs and 48 responses for unit managers from public hospitals.

8.6. CONCLUDING REMARKS

The study determined and described the self-rated competence of NQRNs, and established the need for a transition support programme. It further determined and described the unit managers' views regarding NQRNs' competence. The limitations encountered by the researcher were described, while recommendations were made regarding the support of NQRNs and for future research.

Though the researcher did not implement the transition support programme, the content of the latter and guidelines to the implementation were provided. Furthermore, the

researcher pledged to support the public hospitals in the implementation of the transition support programme.

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ANNEXURES

ANNEXURE 1: Research permission letter from UNAM

CENTRE FOR POSTGRADUATE STUDIES

University of Namibia, Private Bag 13301, Windhoek, Namibia
340 Mandume Ndemufayo Avenue, Pioneer Park
☎ +264 61 206 3275/4662; Fax +264 61 206 3290; URL: <http://www.unam.edu.na>



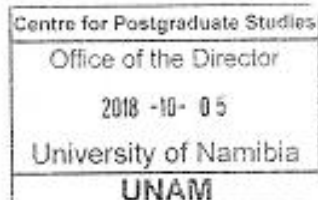
RESEARCH PERMISSION LETTER

Date: 25/09/2018

Student Name: Emvula O

Student number: 9001867

Programme: Doctor of Nursing Science



Approved research title: A transition support programme to facilitate the competencies of newly qualified registered nurses at public hospitals in Namibia.

TO WHOM IT MAY CONCERN

I hereby confirm that the above mentioned student is registered at the University of Namibia for the programme indicated. The proposed study met all the requirements as stipulated in the University guidelines and has been approved by the relevant committees.

The proposal adheres to ethical principles as per attached Ethical Clearance Certificate. Permission is hereby granted to carry out the research as described in the approved proposal.

Best Regards

A handwritten signature in black ink, appearing to read 'Marius Hedimbi', written over a horizontal dotted line.

Prof Marius Hedimbi

Director: Centre for Postgraduate Studies

Tel: +264 61 2063275

E-mail: directorpgs@unam.na

A handwritten date '05/10/18' in black ink, written over a horizontal dotted line.

Date

ANNEXURE 2: Permission from MoHSS



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 - 203 2537
Fax: 061 - 222558
E-mail: btjivambi@mhss.gov.na

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3 OE
Enquiries: Mr. B. Tjivambi

Date: 22 November 2018

Ms. Olivia Emvula
PO Box 70326
Khomasdal
Windhoek

Dear Ms. Emvula

Re: A Transition support programme to facilitate the Competencies of newly qualified nurses at Public Hospitals in Namibia

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for academic purpose;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

- 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
- 3.5 Preliminary findings to be submitted upon completion of the study;
- 3.6 Final report to be submitted upon completion of the study;
- 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and not of the MoHSS.

Yours sincerely,


MR. B.T. NANGOMBE
PERMANENT SECRETARY



ANNEXURE 3: Permission from Rundu Intermediate Hospital



9 - 0 /

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Private Bag 2094
RUNDU
Namibia

Intermediate Hospital Rundu
Kavango East Region
Namibia

Tel: 066-265500
Fax: 066-255371
email: hospru@lway.na
Date: 22 May 2019

Enq: Dr. J.K. Mukerenge

TO WHOM IT MAY CONCERN

**RE: APPROVAL FOR MS. OLIVIA EMVULA TO CONDUCT RESEARCH
AT RUNDU INTERMEDIATE HOSPITAL.**

Dear Ms. Emvula, kindly be informed that Intermediate Hospital Rundu has no objections for your request to carry out study research at our institution.

Condition: only information contained in your research should be collected.

You are therefore advised to report to the office of the Medical Superintendent upon your arrival.

Wishing you all the best for the study opportunity in this regard.

Yours sincerely

2019 -05- 22

DR. J.K.MUKERENGE
MEDICAL SUPERINTENDENT

REPUBLIC OF NAMIBIA

"Your health, our concern"

ANNEXURE 4: Permission from Oshakati Intermediate Hospital



REPUBLIC OF NAMIBIA
Ministry of Health and Social Services

Private Bag X5501
OSHAKATI

Tel: + 264 65 2233000
Fax: + 264 65 221390/224564

INTERMEDIATE HOSPITAL OSHAKATI

Enq: Dr A Kibandwa

2 January 2019

TO: Ms Olivia Emvula
Cell: +264 81 2748226
Email: oliviaemvula@rocketmail.com

AUTHORIZATION TO CONDUCT RESEARCH STUDY.

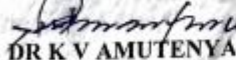
This is to inform you that your request to conduct a research study in Oshakati State Hospital have been approved.

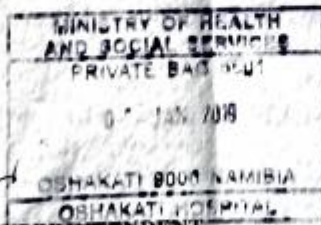
Kindly be informed that confidentiality of the patient information seen during your research must be observed, in case of breach of confidentiality you will be charged by the Medical and Dental Council of Namibia Regulation Act.

We wish you all the best during your research.

Yours Sincerely

obsourd


DR K V AMUTENYA
ACTING MEDICAL SUPERINTENDENT



ANNEXURE 5: Permission from Windhoek Central Hospital

9 - 0/0001



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13215

Tel. No: (061) 2033024

Windhoek

Harvey Street

Fax No: (061) 222886

Namibia

Windhoek

Enquiries: Ms. S.Ipinge

Date: 03 December 2018

OFFICE OF THE CHIEF MEDICAL SUPERINTENDENT WINDHOEK CENTRAL HOSPITAL

Ms. Olivia Emvula
University of Namibia
Windhoek
0812748226

Dear Ms.Emvula

SUBJECT: PERMISSION TO CONDUCT A STUDY ON TRANSITION SUPPORT PROGRAMME TO FACILITATE THE COMPETENCIES OF NEWLY QUALIFIED NURSES AT WINDHOEK CENTRAL HOSPITAL.

1. Reference is made to your application to conduct the above-mentioned study.
2. This letter serves to inform you that permission has been granted for you to conduct a research on the above mentioned subject as per you request.
3. Patients/Clients information should be kept confidential at all times.
4. Copy of report to be submitted at Chief Medical Superintendent and Customer care office, Windhoek Central Hospital upon completion of the study.

Thank you.

Yours sincerely

 05/12/2018

**DR. K.H.NAKANGOMBE
ACTING MEDICAL SUPERINTENDENT**



ANNEXURE 6: Permission from Katutura Intermediate Hospital



Republic of Namibia

Ministry of Health and Social Services

Private Bag 13215
WINDHOEK
Namibia

Intermediate Hospital Katutura
Independence Avenue
WINDHOEK

Telephone (061) 263 40045
Telefax (061) 1212706

Enquiries: Dr.F.M Shiweda

Date: 29/11/2018

OFFICE OF THE CHIEF MEDICAL OFFICER

Ms. Olivia Emvula
PO Box 70326
Khomasdal
Windhoek

Dear Ms. Emvula

**RE: A TRANSITION SUPPORT PROGRAMME TO FACILITATE THE
COMPETENCIES OF NEWLY QUALIFIED REGISTERED NURSES AT PUBLIC
HOSPITALS IN NAMIBIA**

The above mentioned subject refers:

This office hereby grants you permission to do an academic investigation on transition support programme to facilitate the competencies of newly qualified registered nurses at Katutura State Hospital, Khomas Region and MoHSS.

Thank you

Yours in health,

Dr F.M. Shiweda
Chief medical officer



ANNEXURE 7: Ethical clearance certificate



ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SON /460/2019

Date: 13 June, 2019

This Ethical Clearance Certificate is issued by the University of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: A Transition Support Programme To Facilitate The Competencies Of Newly Qualified Registered Nurses At Public Hospitals In Namibia

Researcher: OLIVIA EMVULA

Student Number: 9001867

Supervisors: Prof. L. Small (Main) Dr. L. Pretorius (Co)

Faculty: School of Nursing

Take note of the following:

- (a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
- (b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
- (c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
- (d) The UREC retains the right to:
 - (i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
 - (ii) Request for an ethical compliance report at any point during the course of the research.

UREC wishes you the best in your research.

Dr. J.E. de Villiers: Chairperson

Ms. P. Claassen: Secretary

A handwritten signature in black ink, appearing to read "J.E. de Villiers", is written over a horizontal line.

A handwritten signature in black ink, appearing to read "P. Claassen", is written over a horizontal line.

ANNEXURE 8: Participant information leaflet and consent form



TITLE OF THE RESEARCH PROJECT: A TRANSITION SUPPORT PROGRAMME TO FACILITATE THE COMPETENCIES OF NEWLY QUALIFIED REGISTERED NURSES AT PUBLIC HOSPITALS IN NAMIBIA

REFERENCE NUMBER: 9001867

PRINCIPAL INVESTIGATOR: Olivia Emvula

ADDRESS: P.O. Box 70326 Khomasdal, 9000

CONTACT NUMBER: 0812748226

oliviaemvula@rocketmail.com

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Research Ethics Committee at The University of Namibia and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and Namibian National Research Ethics Guidelines.

1. What is this research study all about?

The study will be conducted at Oshakati, Rundu, Katutura and Windhoek Central Hospitals in three regions of Namibia, namely Khomas, Oshana and Kavango East.

For newly qualified registered nurses, the transition can be demanding, challenging and daunting. They are newly employed with new roles, responsibilities and accountability for their practice, yet they are still learning and developing their knowledge and skills required in performing nursing duties competently. The transition support programme was specifically designed to increase competencies and skills, but moreover to ease the transition of newly qualified registered nurses. This is based on the fact that a formal structured transition support programme for newly qualified registered nurses can lead to confident, competent, independent as well as safe nurse practitioners.

Therefore, information gathered from this study will be used to identify the needs of newly qualified registered nurses and to develop the programme to support newly qualified registered nurses transition in order to enhance their competencies.

This study will further help in the development of a programme for the provision of support for newly qualified registered nurses when newly employed in the hospitals. If newly qualified registered nurses are supported during transition, they are able to render safe and quality nursing care. Therefore, you are requested to provide honest responses.

2. Why have you been invited to participate?

Your participation as registered nurse is very valuable as it will provide information which will guide the researcher to develop a programme to support newly qualified registered nurses during transition. The information will be used to identify the needs of newly qualified registered nurses and to develop the programme to support newly qualified registered nurses to enhance their competencies. Therefore, you are requested to provide honest responses.

3. What will your responsibilities be?

If you agree to participate, you are required to complete the attached questionnaire. It will take approximately 20-30 minutes to complete. After completion of the questionnaire, you may inform the researcher to collect it if possible. Alternatively, the questionnaire will be kept in a safe place until the researcher collect it. The information will be used to identify the needs of newly qualified registered nurses and to develop the programme to support newly qualified registered nurses to enhance their competencies. Therefore, you are requested to provide honest responses.

4. Will you benefit from taking part in this research?

There are no direct benefits to you such as payment, however, it will improve the competencies of newly qualified registered nurses and in so doing benefit nursing care delivery.

5. Are there any risks involved in your taking part in this research?

There are no specific risks associated with this study as the study will not have any influence on your job.

6. If you do not agree to take part, what alternatives do you have?

You are free to withdraw from the study at any time. The participation is voluntarily, thus you will not be punished for withdrawing from the study.

7. Who will have access to your medical records? (Where applicable)

The information collected will be treated as confidential and protected. The research findings will be published, however, your identity will remain anonymous. Only the researcher, the statistician and the research supervisors will have access to the information. The findings will be published, however, the information collected will be treated as confidential and protected.

8. What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?

You will not be subjected to any risks. You are only expected to complete the questionnaire. No experiments will be done during this study.

9. Will you be paid to take part in this study and are there any costs involved?

There are no payment for taking part in the study. Thus, participation is voluntary.

10. Is there anything else that you should know or do?

If, you have any concerns or queries, you may contact the researcher or the supervisors at the following contact details:

Mrs. Olivia Emvula Telephone: 0812748226

Email: oliviaemvula@rocketmail.com

Supervisor: Proff. L. Pretorius (061)2063111

You can also contact the Centre for Research and Publications at +264 061 2063061; pclaassen@unam.na if you have any concerns or complaints that have not been adequately addressed by the investigator.

You will receive a copy of this information and consent form for your own records.

11. Declaration by participant

By signing below, I agree to take part in a research study entitled (*insert title of study*).

I declare that:

- a) I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- b) I have had a chance to ask questions and all my questions have been adequately answered.
- c) I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- d) I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- e) I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*)
2005.

.....
Signature of participant

.....
Signature of witness

12. Declaration by investigator

I (*name*) declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If a interpreter is used then the interpreter must sign the declaration below.*)

Signed at (*place*) on (*date*)
2005.

.....
Signature of investigator

.....
Signature of witness

13. Declaration by interpreter

I (*name*) declare that:

- a) I assisted the investigator (*name*) to explain the information in this document to (*name of participant*) using the language medium of (*Oshiwambo, Oshierero, Afrikaans, etc.*)

ANNEXURE 9: Research instrument 1: NQRNS

Section 1: Demographic Information

Answer the following questions by ticking the appropriate box (es) or space (s) provided.

1. 1. SEX (Indicate M or F)

A	M	
B	F	

1. 2. Years of experience as a registered nurse

A	6-12 months	
B	13-17 months	
C	18-23 months	

1.3. Training Institution attended

A	UNAM	
B	IUM	
C	Welwitschia	
D	MOHSS	

1.4. Highest Nursing Qualification Obtained

A	Diploma	
B	Degree	

1.5. Do you have any previous training as an enrolled nurse?

A	YES	
B	NO	

1.6. Type of ward/Unit where you are currently practicing?

A	Medical	
B	Surgical	
C	Orthopedic	
D	Gynecology	
E	Maternity	
F	Pediatric	
G	Emergency Care	
H	ICU	
I	Others	

J. If others, Specify

.....

1.7. How long have you worked in your current Ward/Unit?

A	6-12 months	
B	13-17 months	
C	18-23 months	

SECTION 2

SECTION 2.1.:

Domain 1: Professional, Legal & Ethical Competencies

According to the following scale, please indicate your competencies regarding the nursing activities provided below.

Please read the following statements and then indicate where you think is applicable by marking with an [X] in the appropriate box.

	1	2	3	4
Rating Scale	I have little knowledge and skills. Supervision and guidance needed	I have basic knowledge and skills, but need supervision	I have adequate knowledge and skills and can perform without supervision	I feel completely competent. I can perform efficiently and confidently without supervision
1. Domain 1: Professional, Legal & Ethical Accountability				
1.1. Ensuring physical safety of patients				

1.2. How to practice in a manner that conforms to my job description				
1.3. Recognizing medical legal hazards				
1.4.				
1.5. Maintaining clear and legible documentation and records				

SECTION 2.2:

Domain 2: Provision of care competencies

Please read the following statements and then indicate where you think is applicable by marking with an [X] in the appropriate box.

	1	2	3	4
Rating Scale	I have little knowledge and skills. Supervision and guidance needed	I have basic knowledge and skills, but need supervision	I have adequate knowledge and skills and can perform without supervision	I feel completely competent. I can perform efficiently and confidently without supervision

2. Domain 2: Knowledge- based Practice				
2.1 Assessment				
2.1.1. How to gather accurate and relevant objective and subjective data				
2.1.2. Organizing and interpreting patient data				
2.1.3. Making correct nursing diagnosis				
2.2.Planning				
2.2.1. Formulation of a comprehensive nursing care plan according to patient needs				
2.2.2. Prioritizing nursing care plan based on urgency				
2.3. Implementation				
2.3.1. Performing nursing procedures according to patient needs				
2.3.2. Documenting nursing interventions accurately and in timely manner				
2.4. Provision of care				
2.4.1. Recognizing possible cardiac arrest				

2.4.2. Performing Cardiopulmonary Resuscitation (CPR) correctly				
2.4.3. Recognizing possible emergency situations				
2.4.4. Recognizing of anaphylactic shock				
2.4.5. Calculations of dosages of emergency drugs				
2.4.6. Administering of different emergency drugs				
2.4.7. Admission of patients correctly				
2.4.8. Discharge of patients correctly				
2.4.9. Provision of a safe environment for patients				
2.4.10. Performing accurate intake & output recording				
2.4.11.. Insertion of nasogastric tube				
2.4.12. Performing of gastric aspiration				
2.4.13. Insertion of female catheter				
2.4.14. Insertion of male catheter				
2.4.15. Drawing of blood specimen				
2.4.16. Stoma care				
2.4.17. Administering oxygen therapy				

2.4.18. Interpretation of medicine prescription chart				
2.4.19. Preparation of patient for operation				
2.4.20. Caring of patient after operation				
2.4.21. Performing aseptic wound care				
2.4.22. Understanding infection control principles				
2.4.23. Administering intravenous fluids and medications				
2.5. Evaluation				
2.5.1. Monitoring and documenting patient progress accurately and completely				
2.5.2. Evaluate patient progress in relation to nursing care plan				
2.5.3. Uses evaluation data to modify the nursing care plan				

SECTION 2.3.: Domain 3: Management and leadership competencies

Please read the following statements and then indicate where you think is applicable by marking with an [X] in the appropriate box.

	1	2	3	4
Rating Scale	I have little knowledge and skills. Supervision and guidance needed	I have basic knowledge and skills, but need supervision	I have adequate knowledge and skills and can perform without supervision	I feel completely competent. I can perform efficiently and confidently without supervision
3.Domain 3: Management and leadership				
3.3.1. Identify priority nursing duties				
3.3.2. Planning nursing care according to patient needs				
3.3.3. Delegation of nursing care duties				
3.3.4. Scheduling off duties based on the workload				
3.3.5. Complete nursing duties on time				
3.3.6. Communication of clear and accurate information				
3.3.7. Managing staff conflict in the ward				

3.3.8. Assisting patients to make informed decisions				
3.3.9. Supervision of junior nurses and subordinates				

Thank you for your participation

ANNEXURE 10: Research instrument: Unit managers

Section 1: Demographic Information

Answer the following questions by ticking the appropriate box (es) or space (s) provided.

1.1. Years of experience as unit manager

A	2-5 years	
B	6-10 years	
C	11-15- years	
D	16-20 years	
E	21 years and above	

1.2. Indicate the type of clinical unit /ward in which you work

A	Medical	
B	Surgical	
C	Orthopedic	
D	Gynecology	
E	Maternity	
F	Pediatric	
G	Emergency Care	
H	ICU	
I	Others	

J. If others, Specify

.....

1.3. Indicate your highest nursing qualification

A	Nursing diploma	
B	Nursing Degree	
C	Post graduate Diploma	
D	Master's Degree	
E	Doctoral Degree	

SECTION 2: THIS SECTION IS BASED ON QUESTIONS RELATED TO THE COMPETENCIES OF NEWLY QUALIFIED REGISTERED NURSES WORKING IN YOUR WARD/UNIT.

Domain 1: Professional, Legal & Ethical Competencies

According to the following scale, please indicate in your opinion the competencies of the newly qualified nurses working in your ward/unit regarding the nursing activities provided below.

Please read the following statements and then indicate where you think is applicable by marking with an [X] in the appropriate box.

	1	2	3	4
Rating Scale	The newly qualified registered nurse has little knowledge and skills. Supervision and guidance needed	The newly qualified registered nurse has basic knowledge and skills, but need supervision	The newly qualified registered nurse has adequate knowledge and skills and can perform without supervision	The newly qualified registered nurse is completely competent and can perform efficiently and

				confidently without supervision
3. Domain 1: Professional, Legal & Ethical Accountability				
1.1. Ensuring physical safety of patients				
1.2. Practicing in a manner that conforms to their job description				
1.3. Recognizing medical legal hazards				
1.4. Maintaining clear and legible documentation and records				

Domain 2: Provision of care competencies

Please read the following statements and then indicate where you think is applicable by marking with an [X] in the appropriate box.

	1	2	3	4
Rating Scale	The newly qualified registered nurse has little knowledge and skills. Supervision and guidance needed	The newly qualified registered nurse has basic knowledge and skills, but need supervision	The newly qualified registered nurse has adequate knowledge and skills and can perform without supervision	The newly qualified registered nurse is completely competent and can perform efficiently and confidently without supervision
2.1 Assessment				
2.1.1. How to gather accurate and relevant objective and subjective data				
2.1.2. Organizing and interpreting patient data				
2.1.3. Making correct nursing diagnosis				
2.2.Planning				
2.2.1. Formulation of a comprehensive nursing care plan according to patient needs				
2.2.2. Prioritizing nursing care plan based on urgency				

2.3. Implementation				
2.3.1. Performing nursing procedures according to patient needs				
2.3.2. Documenting nursing interventions accurately and in timely manner				
2.4. Provision of care				
2.4.1. Recognizing possible cardiac arrest				
2.4.2. Performing Cardiopulmonary Resuscitation (CPR) correctly				
2.4.3. Recognizing possible emergency situations				
2.4.4. Recognizing of anaphylactic shock				
2.4.5. Calculations of dosages of emergency drugs				
2.4.6. Administering of different emergency drugs				
2.4.7. Admission of patients correctly				
2.4.8. Discharge of patients correctly				
2.4.9. Provision of a safe environment for patients				
2.4.10. Performing accurate intake & output recording				
2.4.11. Insertion of nasogastric tube				
2.4.12. Performing of gastric aspiration				
2.4.13. Insertion of female catheter				
2.4.14. Insertion of male catheter				
2.4.15. Drawing of blood specimen				
2.4.16. Stoma care				
2.4.17. Administering oxygen therapy				
2.4.18. Interpretation of medicine prescription chart				
2.4.19. Preparation of patient for operation				

2.4.20. Caring of patient after operation				
2.4.1.21. Performing aseptic wound care				
2.4.22. Understanding infection control principles				
2.4.23. Administering intravenous fluids and medications				
2.5. Evaluation				
2.5.1. Monitoring and documenting patient progress accurately and completely				
2.5.2. Evaluate patient progress in relation to nursing care plan				
2.5.3. Uses evaluation data to modify the nursing care plan				

Domain 3: Management and leadership

Please read the following statements and then indicate where you think is applicable by marking with an [X] in the appropriate box.

	1	2	3	4
Rating Scale	The newly qualified registered nurse has little knowledge and skills.	The newly qualified registered nurse has basic knowledge and skills,	The newly qualified registered nurse has adequate knowledge and skills	The newly qualified registered nurse is completely competent and can

	Supervision and guidance needed	but need supervision	and can perform without supervision	perform efficiently and confidently without supervision
3.3.1. Identify priority nursing duties				
3.3.2. Planning nursing care according to patient needs				
3.3.3. Delegation of nursing care duties				
3.3.4. Scheduling off duties based on the workload				
3.3.5. Complete nursing duties on time				
3.3.6. Communication of clear and accurate information				
3.3.7. Managing staff conflict in the ward				
3.3.8. Assisting patients to make informed decisions				
3.3.9. Supervision of junior nurses and subordinates				

SECTION 3:

This section is based on questions related to support rendered to newly qualified registered nurses to facilitate their competencies. Answer by circling your option or indicating with an X in the appropriate box.

3.1. More or less, how many newly qualified registered nurses does your hospital employ every year?

Less than 5	
5-10	
More than 10	

Others	
---------------	--

If others, specify

.....

3.2. Do newly qualified registered nurses in your ward receive orientation?

Yes	
No	

3.3. In your opinion, indicate how many days you think are sufficient for newly qualified registered nurses (NQRNs) orientation?

Less than 3 days	
3-6	
7-10	
Others	

If others, specify

.....

3.4. Indicate the support rendered to newly qualified registered nurses (NQRNs) in your ward.

A	Mentorship	
B	Clinical instructor to assist newly qualified nurse	
C	Peer support	
D	Preceptorship	
E	Experienced registered nurses for each shift	
G	Others	

If others, specify

.....

 3.5. Is any in- service training offered to newly qualified registered nurses in your ward?
YES / NO

If yes, what is the content of the in- service training? Tick all that are applicable.

Medical- legal hazards	
Ethical decision making	
Professional conduct	
Ward policies and procedures	
Clinical nursing procedures	
Management skills	
Leadership skills	
Inter personal relationships	
Others	

If others, specify

.....

3.6. Indicate teaching strategies used in the in- service training? Tick all that are applicable.

Case discussion method.	
Debates	
Demonstrations	
Problem solving method	
Formal lectures	
Role plays	
Others	

If others, specify

.....

3.7. Do newly qualified registered nurses in your ward have regular competency assessment?

YES / NO

If yes, indicate the aspects on which the competency assessment is based?

.....
.....
.....
.....

3.8. If performance is poor, do newly qualified registered nurses receive support to improve their competencies?

YES/ NO

If yes, elaborate

.....
.....
.....
.....
.....
.....
.....
.....

11. Do you have any suggestions on how to improve newly qualified newly qualified registered nurses' competencies?

Yes/ No

If yes, elaborate

.....
.....
.....
.....

THANK YOU FOR YOUR PARTICIPATION

ANNEXURE 11: Proposed Transition Support Programme

**TITLE: A TRANSITION SUPPORT PROGRAMME TO FACILITATE THE
COMPETENCIES OF NEWLY QUALIFIED REGISTERED NURSES AT
PUBLIC HOSPITALS IN NAMIBIA**

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A. Programme Description:

The transition support programme is a practice-oriented programme designed to help NQRNs transition into practice from a novice to an experienced professional registered nurse. This programme comprises both theoretical and clinical components designed to assist NQRNs in facilitating their competencies. However, the programme is not aimed at repeating the educational components covered during the NQRNs' training, but merely to assist them to address challenges experienced during transition.

The transition support programme is not only designed to facilitate competencies and skills, but also to ease the transition of NQRNs. This is based on the understanding that a formal structured transition support programme for NQRNs can lead to confident, competent, independent and safe nurse practitioners. Additionally, the transition support programme was developed to guide unit managers and in-service training officers on how to effectively support NQRNs during transition.

The transition support programme focuses on the facilitation of the competencies of NQRNs, as outlined in the Generic Competency Framework for Registered Nurses in Namibia (HPCNA, 2018). Consequently, the transition support programme outlines the programme goal, objectives, learning outcomes, structure, activities, processes and approaches to be followed to achieve optimum competency outcomes.

B. Target population:

The programme is designed for NQRNs with six months, but less than two years' practice experience, their supervisors and in-service training officers at public hospitals in Namibia as it provides guidance on how best to support NQRNs to enhance their competence during transition.

C. Programme aim:

The overall aim of the transition support programme is to provide a safe and positive environment that assists NQRNs to develop skills and build confidence in their professional roles. It is also aimed at developing a formal standardised programme for the public hospitals in Namibia to give NQRNs the opportunity to integrate their knowledge and skills and develop their competencies as professional registered nurses. Consequently, the programme focuses on providing public hospitals in Namibia with a structured standardised framework to support NQRNs' transition into practice and, by so doing, promote quality nursing care and public safety.

D. OBJECTIVES OF THE TRANSITION SUPPORT PROGRAMME

The learning content to be delivered is based on the programme objectives and to be presented in the form of a training workshop. The objectives of the transition support programme to be achieved are:

Objective 1: Provide newly qualified registered nurses with knowledge and skills to render professional, ethical and legal nursing care.

This objective addresses the issue of professional accountability, meaning the registered nurses' ability to be answerable for their actions and omissions. It also focuses on the

standards and norms of legal practice, as outlined by the Namibian Nursing Act, 8 of 2004 (Republic of Namibia, 2004), and in a manner consistent with Namibia's laws and regulations. NQRNs' competence on ethical practice are also addressed to establish competence in professional judgement and practice decisions guided by the values and ethical responsibilities in the scope of practice for registered nurses. Therefore, to achieve this objective, much focus will be on safety of patients by recognising medical legal hazards as well as maintaining of clear and legible documentation.

Objective 2: Empower newly qualified registered nurses to render quality knowledge-based practice.

This objective addresses the gap identified concerning NQRNs' provision of care competencies. The programme was further developed to empower NQRNs to render quality nursing care. Thus, NQRNs would be empowered to be competent in the application of knowledge and to be critical thinkers.

Objective 3: Enhance the skills of newly qualified registered nurses to be effective managers and leaders of health care.

The assessment of NQRNs competence was covered in domain 3 (Table 4.50) of the data collection tool. This objective addresses NQRNs' competencies in achieving the health services goals and objectives. It would empower NQRNs to effectively supervise subordinates, help patients make informed decisions and communicate information clear and effectively. Thus, this objective focuses on planning, organisation, directing and controlling of health care. In summary, the NQRNs will be empowered with leadership and management skills, which will enable them to understand the concept of public protection and the duty to provide nursing care in the best interest of the public.

E. PHILOSOPHICAL AND EDUCATIONAL APPROACHES

To ensure programme effectiveness, the following approaches can be incorporated in the delivery of the transition support programme. The participants in the discussion refer to NQRNs.

- **Adult learning theory**

The principles of adult learning theory that can be applied during the training are:

Facilitators should know the audience by doing an analysis of the audience, because instruction must be relevant to the needs of the participants. Thus, it is important to understand the profile and competencies needed by the NQRNs.

Facilitators should watch their voice tone and should not “talk down” in a pedagogical manner. Instead, acknowledge the professionalism and expertise that NQRNs bring to the table.

Facilitators should keep NQRNs motivated throughout the session. Learning must be perceived to be of value to the adult learner, and it must satisfy some internal drive or need. Make clear connections between learning activities and the learner’s life. Make sure your learners know why they need this training and of what benefit it will be to them.

NQRNs’ time should be respected as time is perceived as of value. The NQRNs must be taught skills they will need in their practice. Thus, the learning objectives and strategies should be concise and focused on the facilitation of NQRNs’ competencies.

Let NQRNs practice by incorporating a special time for that. Give NQRNs sufficient time and opportunities to practice what they have learned, both individually and

collectively. Assist them to link the new information to how they will apply it on the job (Wang, 2015).

- **Humanistic existentialism philosophical approach**

The facilitators should consider the broad needs of NQRNs, including not just cognitive but also social and emotional needs, such as the transition shock they may encounter (Nath, Kumar & Kumar, 2017). If humanism is realised during this programme, NQRNs will achieve their personal best and are able to grow and achieve self-actualisation (Crain, 2015). During training, the facilitators should also develop rationality, autonomy, empowerment, creativity, affections and a concern for humanity (Veugelers, 2011.). It is of utmost importance to create an ideal and conducive environment, which caters to the social, emotional and cognitive needs of the NQRNs (Crain, 2015; Duchesne & McMaugh, 2016; Veugelers, 2011).

- **Bloom's taxonomy of learning**

To ensure NQRNs acquire the necessary skills, all domains should be assessed such as cognitive, affective and psychomotor domains. NQRNs should be helped to understand the basic concepts, including information. Similarly, the affective domain should be emphasized such as attitudes and professional values. Most importantly, the NQRNs should be assisted to practice to acquire the psychomotor skills to practice effectively and confidently.

F. PROGRAMME PHASES

No:	Phase	Activities
1	Orientation phase	<ul style="list-style-type: none"> <input type="checkbox"/> Welcoming address and introduction of participants <input type="checkbox"/> Overview of the workshop <input type="checkbox"/> Outline of the aim and objectives of the workshop <input type="checkbox"/> Setting up ground rules for the workshop
2	Working phase	<ul style="list-style-type: none"> <input type="checkbox"/> Overview on generic competencies for registered nurses in Namibia <input type="checkbox"/> Teaching/learning activities on generic competencies of registered and leadership competencies. <input type="checkbox"/> Clinical practice sessions on practical procedures
3	Termination phase	<ul style="list-style-type: none"> <input type="checkbox"/> Daily evaluation of programme activities <input type="checkbox"/> Evaluation of the programme impact <input type="checkbox"/> Reflection reports on training <input type="checkbox"/> Closure of the workshop

G. PROCESS OF PROGRAMME IMPLEMENTATION

Phase 1: Orientation phase

This phase involves the welcoming and introduction of the participants. Facilitators and NQRNs introduce themselves and outline workshop aims and objectives. Participants' expectations are explored to guide the facilitators on how to conduct the workshop. Participants establish and agree on the ground rules for the workshop, which will be pasted on the wall to serve as a reminder throughout the training.

Phase 2: Working phase

This phase is aimed at facilitating the competencies of NQRNs. Thus, the activities to be performed should accomplish the aims and objectives of the transition support programme. Therefore, the facilitator should focus on addressing the competency challenges of NQRNs identified during the situational analysis. The content to be covered is based on the Generic Competency Framework for Registered Nurses in Namibia (HPCNA, 2018). To ensure effectiveness in implementing this phase of the transition programme, facilitators should apply Knowles' model of andragogy, humanistic existentialism philosophical approach, and Bloom's taxonomy of learning.

Phase 3: Termination phase

During this phase, the lessons are reviewed to evaluate the effectiveness and to guide future actions. NQRNs should complete a daily training evaluation to reflect the impact of programme activities and make recommendations for improvement. Lastly, NQRNs evaluate the workshop to assess the impact of the training.

H. FACILITATION TECHNIQUES

The following teaching strategies are proposed to be followed during the implementation workshop to facilitate teaching and learning:

- Lectures
- Group Discussions
- Problem solving
- Demonstrations (Basic Skills)
- Case presentations
- Simulation
- Role plays
- Feedback sessions

Following is a description of the proposed teaching strategies.

- **Lectures**

A lecture is a step-by-step instruction type of educational encounter in which the facilitator conveys information to a receiver, in this case the NQRNs (Quinn & Hughes, 2013). As indicated in Table 7.1, the lecture method can be applied in all units in the form of PowerPoint slides to present the content of the different competency domains. The

lecture would enable facilitators to introduce the transition programme to participants illustrating the aim and objectives of the transition support programme (Armstrong & Rispel, 2015).

- **Group Discussions**

Group discussions can be used to promote active participation and explore different viewpoints on certain issues (Sravani, Doshi, Kulkarni, Reddy & Reddy, 2018). This technique uses past experiences, attitudes and values in a deliberated manner. Group discussions are based on real life experiences where relevant subject matter or questions are discussed. The aim of group discussions is to solve a problem, to enhance NQRNs' knowledge on certain complex matters, such as moral and ethical dilemmas.

During the training, NQRNs can be divided into small groups and given the opportunity to voice their opinions on real life situations, express themselves, which can empower them to realise their ability to think critically and, accordingly, change through this method (Quinn & Hughes, 2013). **Brainstorming** can be used during group discussions that involves the spontaneous contribution of ideas from all NQRNs to generate creative ideas to solve clinical problems.

- **Problem-solving**

Problem-solving is an effective way facilitators can use to enhance NQRNs' problem-solving skills by providing guidance on how best to solve some challenging tasks. NQRNs can be given a problem to solve and given certain sources of information from which they can draw their solutions. The main aim is to encourage critical thinking of the NQRNs (Quinn & Hughes, 2013).

- **Role play**

The role play method can be applied not only to allow NQRNs apply their experiences to real-life situations, but also to make it easier for them to discuss complex social issues in

a non-threatening environment (Dawood, 2013). Role plays are also applied to develop interpersonal and communication, conflict resolution and group decision-making skills (Dawood, 2013). Role plays would be effective in explaining ethical and legal issues pertaining to nursing practice.

- **Demonstrations**

This is a teaching method based mainly on the demonstration of knowledge and skills. It is a visual presentation of a nursing technique using equipment to show how nurses should do a procedure (Human & Mogotlane, 2017). Unit 4 of the transition support programme is based on the provision of care competencies, of which most items are clinical procedures. Hence, demonstrations would be ideal to show NQRNs how to do various activities and procedures in which they lack competence.

Following the demonstration, NQRNs practice under the supervision of the facilitator. Finally, independent practice is done to the point of competency. The demonstration method is accompanied by a lecture to enhance effectiveness, because discussion expands and deepens the learner's knowledge (Hasan, 2011).

- **Simulation**

There is increasing evidence in literature that simulation can be an effective means of promoting learning in nursing and other health care professions. Simulation has been found effective in improving student cognitive skills and critical thinking (Cato, 2013). Despite that NQRNs are newly trained, they might still lack confidence in some clinical procedures. Following demonstration of procedures, facilitators can develop a realistic patient scenario where NQRNs use mannequins as patients in a simulated environment.

NQRNs can practice multiple aspects of patient care in which they feel they lack competence and can practice without the risk of making mistakes with real patients (Cato, 2013).

- **Feedback**

NQRNs should be given feedback regarding their performance or behaviour. It can be either verbal or written feedback. The purpose of feedback in the learning process is to improve NQRNs' performance. NQRNs should be given feedback immediately after the assessment, because if the feedback is delayed, the momentum is lost and the NQRNs might not connect the feedback with the action (Reynolds, 2013).

When giving feedback, facilitators should be sensitive to the individual needs of the NQRNs. It is vital to take into consideration the diversity of NQRNs when giving feedback and to be careful not to hurt feelings, but providing proper encouragement is essential (Reynolds, 2013).

I. GUIDELINES FOR CONDUCTING THE WORKSHOP

The transition support programme could be implemented to facilitate the competencies of NQRNs at public hospitals in Namibia. To achieve this, a training workshop should be conducted at the hospital where the NQRNs employed to deliver the learning content during the first year in which NQRNs start working as registered nurses. The following table depicts the workshop schedule to be followed:

J. WORKSHOP SCHEDULE

SESSION	CONTENT	ACTIVITIES/ CONTENT
Day 1:	Introduction	Registration Welcoming Official opening of workshop Logistics and introduction of participants Introduction of workshop: aims, objectives of workshop Ground rules and expectations
Day 1.....	<p>Unit 1: Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018).</p> <p>- Overview of the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018).</p>	<ul style="list-style-type: none"> - Purpose of the competency framework - Competency domains - Competency indicators

Day 2:	Unit 2: Professional, ethical and legal practice	<ul style="list-style-type: none"> - Safe and competent care - Ethical- legal practice - Maintaining clear and legible records
Day 3:	Unit 3: Knowledge- based practice	<ul style="list-style-type: none"> - Assessment - Planning - Implementation - Evaluation - Recordkeeping
Day 4:	Unit 4: Management and leadership	<ul style="list-style-type: none"> - Management - Leadership
Day 5:	Termination phase	<ul style="list-style-type: none"> - Evaluation of workshop - Report writing - Closure of workshop

K. DESCRIPTION OF PROGRAMME CONTENT

The content of the transition support programme is based on the domains of the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018). Following is a detailed description of the content of the proposed transition support programme.

UNIT 1: GENERIC COMPETENCY FRAMEWORK FOR REGISTERED NURSES AND MIDWIVES/ACCOUCHEURS IN NAMIBIA (HPCNA, 2018).

Unit overview:

All registered nurses and midwives/accoucheurs practice in a manner consistent with Namibia's laws and regulations and as required by the Health Professions Council of Namibia. The registered nurse enters into the work environment with a specific job description and functions. It is the registered nurse's responsibility to understand the requirements of self-regulation in the interest of public protection. The framework outlines that the Registered Nurse and Midwife/Accoucheur practice according to the applicable laws and policies of Namibia to ensure quality of care and safe healthcare as the cornerstone or cornerstone of the framework.

Objective: To provide newly qualified registered nurses with knowledge on the generic competency framework for Registered Nurses and Midwives/Accoucheurs in Namibia.

Content:

- Overview of the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018) overview.
- Purpose of the competency framework

- Competency domains and indicators

Content description:

1. 1: Overview of the Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018).

Registered Nurses and Midwives/Accoucheurs in Namibia practice according to Act, 2004 (No. 8 of 2004), Regulations no 143, 13, 178 and 206, the Namibian Constitution and the Patient Charter of Namibia. They are accountable for their scope of practice and may practice in a variety of clinical contexts. Supplementary to the above Standards of Practice, core competencies need to be developed to define the minimum level of performance of a Registered Nurse and Midwife/ Accoucheur and it is set at the entry to practice level. These competencies will also describe the required qualities, attributes and skills for Registered Nurses and Midwives/ Accoucheurs to practice in Namibia

By establishing and applying core competencies in the profession, the Nursing Council of Namibia sets the foundation for Registered Nurses and Midwives/Accoucheurs to maintain their competence and to acquire additional competencies or advanced clinical skills to enable them to deliver safe patient/client care in response to changing healthcare needs.

1.2. Purpose of the competency framework

The purpose of the generic competency framework is to:

- Enlighten registered nurses on the minimum competencies required for safe practice.
- Guide pre-registration nursing curriculum development and review.
- Monitor the competency development and assessment of newly graduated RNs.

- Assess the competencies of internationally qualified nurses seeking employment in Namibia.
- Evaluate nurses seeking re-registration.
- Judge nurses involved in professional disciplinary

Following is an outline of the competency domains and indicators:

1.2. Competency domains and indicators

Domain 1: Professional, Ethical and Legal Practice, Accountability	
Competencies:	Competency indicators:
Professional Practice	<ul style="list-style-type: none"> ✓ Ensure own physical, cognitive, psychological and emotional fitness to practice and deliver safe care ✓ Support, collaborate and co-operate with team members and other healthcare professionals ✓ Respect the values, customs, spiritual beliefs and practices of individuals and groups ✓ Recognise own beliefs and values and how these may influence care giving

<p>Ethical Practice</p>	<ul style="list-style-type: none"> ✓ Practices in a manner that conforms to the Namibian Scope of Practice ✓ Engages in effective ethical decision-making with respect to own professional responsibilities or where ethical issues affect the broader health care team ✓ Acts in an advocacy role to protect human rights and questions violation of client in accordance with jurisdictional and Scope of practice for Nurses ✓ Respects the client’s right to privacy and dignity ✓ Challenges behavior and health care practice that could compromise client safety, privacy or dignity
<p>Legal Practice</p>	<ul style="list-style-type: none"> ✓ Practices in accordance with professional, relevant Namibian legislation and regulations ✓ Practices in accordance with jurisdictional and local policies and procedural guidelines ✓ Recognises and acts upon breaches of law relating to the professional role and conduct of a registered nurse and midwife/accoucheur ✓ Obtaining informed consent to respect the rights of patients ✓ Maintain clear and legible documentation and records
<p>Accountability</p>	<ul style="list-style-type: none"> ✓ Accepts accountability for own professional judgement, actions, outcomes of care and continued

	<p>competence in accordance with scope of practice, increased responsibility, legislative acts and regulations</p> <ul style="list-style-type: none"> ✓ Recognises the limits of scope of practice and own competence ✓ Seeks guidance from appropriate others when encountering situations beyond own knowledge
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Domain 2: Knowledge-based practice	
Competencies	Competency indicators
Health Education	<ul style="list-style-type: none"> ✓ Maintains own health and personal fitness for work ✓ Cooperates with nurses, other health professionals and community groups in activities to reduce illness and promote healthy lifestyles and environments ✓ Incorporates into practice a perspective that takes account of the multiple determinants of health ✓ Plans, develops and implements needs-based programmes to promote health

<p>Assessment</p>	<ul style="list-style-type: none"> ✓ Gathers accurate and relevant objective and subjective data required for practice in specialty practice area through systematic Health and Nursing Assessment ✓ Organizes, synthesizes, analyses and interprets data from different sources to derive nursing diagnoses and determine a care plan ✓ Shares and documents findings accurately, completely and timely to comply with Nursing Practice Standards and institutional policies
<p>Planning</p>	<ul style="list-style-type: none"> ✓ Formulates a comprehensive care plan according to patient needs ✓ Applies critical thinking and clinical reasoning skills underpinned by knowledge to plan care ✓ Prioritizes care in collaboration with other members of the health care team based on urgency ✓ Maintains a current, accurate care plan and related records
<p>Implementation</p>	<ul style="list-style-type: none"> ✓ Implements a range of procedures, treatments and interventions that fall within the scope of practice for the registered nurse and are in accordance with nursing and best practice ✓ Documents interventions and client responses accurately and in a timely manner

	<ul style="list-style-type: none"> ✓ Responds appropriately and in time to unexpected or rapidly changing situations ✓ Responds immediately and appropriately to emergency/disaster procedures
Evaluation	<ul style="list-style-type: none"> ✓ Monitors and document progress toward expected outcomes accurately and completely ✓ Evaluates progress towards planned outcomes in consultation with clients, families and health team members ✓ Uses evaluation data to modify the care plan
Therapeutic communication and relationships	<ul style="list-style-type: none"> ✓ Initiates, develops and discontinues therapeutic relationships through the use of appropriate communication and interpersonal skills ✓ Maintains a relationship that respects the boundary between clients and self ✓ Listens to others in an unbiased manner, respects point of view of other and promotes the expression of diverse opinions and perspectives ✓ Communicates clear, consistent and accurate information verbally or in writing, that falls within professional responsibility and maintains confidence in care

	<ul style="list-style-type: none"> ✓ Interacts in a manner that is respectful and culturally appropriate to the clients and family from diverse cultural backgrounds ✓ Communicates and shares relevant information including views of client and families with other health team members involved in providing services
<p>Critical Thinking and Education</p>	<ul style="list-style-type: none"> ✓ Identifies problems/issues in nursing practice that may be investigated through formal/informal research* ✓ Uses best available evidence, nursing expertise and respect for the values and beliefs of individuals in the provision of nursing care ✓ Demonstrates analytical skills in accessing and evaluating health information and research evidence ✓ Supports and contributes to nursing and health care research ✓ Participates in quality improvement activities

<p>Professional Development</p>	<ul style="list-style-type: none"> ✓ Undertakes regular self-evaluation of own nursing practice by engaging in reflection, critical examination and evaluation and seeking peer review ✓ Assumes responsibility for lifelong learning, own professional development and maintenance of competence ✓ Participates in unilateral and multidisciplinary teaching and learning activities ✓ Takes steps to remedy deficits in skills and/or personal knowledge
<p>Quality improvement</p>	<ul style="list-style-type: none"> ✓ Promotes dissemination, use, monitoring and review of Nursing Practice Standards and best practice guidelines ✓ Participates in developing and adapting Nursing Practice Standards to the health care environment ✓ Uses appropriate assessment tools to identify actual and potential risks to safety and security, takes appropriate actions and reports concerns where necessary to relevant authority ✓ Ensures safe and proper storage, administration and recording of therapeutic substances

	<ul style="list-style-type: none"> ✓ Complies with infection prevention procedures and challenges breaches in other practitioner's practice
Domain 3: Leadership and Management	
Leadership	<ul style="list-style-type: none"> ✓ Adapts leadership style and approaches to different situations ✓ Contributes to team leadership by reinforcing goals so as to promote respect and confidence amongst the team ✓ Able to articulate own leadership contributions and support expectations of other team members ✓ Leads in the development, review and modification of institutional practice policies, procedures and protocols
Management	<ul style="list-style-type: none"> ✓ Advocates for and acts within span of control to create a positive working environment ✓ Confronts conflict in a non-judgmental fashion ✓ Prioritizes workload and manages time effectively ✓ Acts as role model for students and within the care team
Delegation	<ul style="list-style-type: none"> ✓ Maintains accountability and responsibility when delegating aspects of care to others

	<ul style="list-style-type: none"> ✓ Delegates activities to others, according to ability, level of preparation, proficiency and Scope of Practice ✓ Accepts delegated activities in line with personal level of proficiency and legal scope of practice
Supervision	<ul style="list-style-type: none"> ✓ Supervise staff effectively ✓ Uses a range of supportive strategies such as precepting and mentoring when supervising and/or monitoring delegated care
Domain 4: Enhancement of the Profession	
Enhancement of the Profession	<ul style="list-style-type: none"> ✓ Promotes dissemination, use, monitoring and review of Nursing Practice Standards and best practice guidelines ✓ Promotes and maintains a positive image of nursing ✓ Acts as an effective role model within the care team ✓ Acts as a resource for students, other members of the health and the public ✓ Values research in contributing to developments in nursing and uses findings as a means to improve standards of care

References:

The following source is recommended for the content of this unit:

-Generic Competency Framework for Registered Nurses and Midwives/Accoucheurs in Namibia (HPCNA, 2018).

UNIT 2: PROFESSIONAL RESPONSIBILITY AND ACCOUNTABILITY**Unit overview:**

Professional responsibility and accountability demonstrates professional conduct and that the primary duty is to ensure safe, competent, compassionate and ethical care to the patient/client. Ethical practice establishes competence in professional judgement and practice decisions guided by the values and ethical responsibilities in the scope of practice for registered nurses.

Outcome:

- To provide newly qualified registered nurses with knowledge and skills to render professional, ethical and legal nursing care.

In order to enhance the professional, ethical and legal competence of NQRNs, the following actions are recommended:

Unit Content:

-Responsibility & accountability

-Safe and competent nursing care

-Ethical- legal practice

-Ethical decision -making

Content description:

2.1. Responsibility & accountability

2.1.1. Responsibility

- Responsibility is the allocation & acceptance of duty / obligation / instruction to carry out a duty.

2.1.2. Accountability

- Accountability is to be answerable to authority
- Integral part of prof practice
- Therefore ,a nurse should always evaluate and judge all situations
- Accountability to patients, public, co-workers, self & employer
- **Example:** Proper delegation & supervision

2.1.3. Forms of accountability:

There are different forms of accountability, such as:

2.1.3.1. Professional accountability

- Decisions on professional correct conduct
- Using code of ethics as guideline
- Ultimately, individual nurse decide & justify for all actions taken.

2.1.3.2. Moral accountability

- Not found in guideline, laws, codes etc.
- Based on own moral personal value system & knowledge
- Not transferable – individual choice

2.1.3. 3. Legal accountability

- Accountable to law

2.1.3. 4. Administrative accountability

- Accountability to employer according to job description & employment.

2.1.4. Liability and vicarious liability

- Obligation to pay compensation for damages/loss suffered by another.
- Applicable if responsibility can be proven by courts.

2.1.4.1. Vicarious liability

- Compensation for damages/loss is sought from employing authority (master).
- And *NOT* employee (servant)
- Master becomes liable for actions of servant, in this case MoHSS is liable for the damages caused by the employees.

2.1.4.2. Litigation

- When RN/M do not fulfil triple responsibility: professional, ethical and legal
- May result in litigation (lawsuit, trial, hearing)
- When damages or lost are suffered by person
- When found at fault, person must pay compensation

Scenario example: Ethical decision making

Mr. Abdul, an Indian national is admitted in your unit from Oluno prison center, as a patient –prisoner. Mr. Abdul, requested one of your junior nurses to go and deposit a large amount of money at the bank which he has been hiding since the day he was arrested. Mr. Huan paid the nurse about N\$ 3000 for the favor.

A) Would you regard this as an unethical conduct and why?

Group discussions example:

Why do we read horror stories in the media about nurses not caring and leaving patients to suffer without help?

Why does there seem to be such a wide gap between the ideal and the reality of nursing?

2.2. Safe and competent nursing care

For NQRNs to render safe and competent nursing care, they must be able to display the following competencies:

- Understand the disease or ill- health of patients
- Carries out a comprehensive and accurate nursing assessment of patients
- Prioritize select appropriate actions to provide adequate and effective nursing care based on identifies needs.

Group Activity: Participants provide examples of clinical scenarios for prioritizing nursing care based on needs.

2.3. Ethical – legal practice

Objectives: At the end of the training, participants should be able to:

- Apply the ethical principles *responsibility and accountability*
- Demonstrate a sound understanding of *liability and vicarious liability*
- Explain professional ethical challenges in nursing

2.3.1. Professional ethical challenges

Examples:

- - A nurse steals medicine from a unit to sell to the public
- - A nurse is involved in a publicly known incident of assault
- - A nurse is abusing alcohol publicly and on duty

Scenario example: Ethical – Moral decision making

Mr X has undergone laparotomy this morning, he is on a 6hourly pain medication. First dose of the injection was administered 1 hour post-op, 3 hours later, Mr X starts to complain of severe pain. What will you do in this situation?

2.3.2. Malpractice:

This refers to negligence or failure to do what can be expected from professional person

Common term/situation used where professional service or results are unsatisfactory.

Examples

- Reprehensible conduct towards client
- Evil/immoral/illegal conduct or practice
- Mistreatment/carelessness/criminal intent
- Unreasonable lack of skill or fidelity

Group Activity:

Participants provide more examples.

2.3.3. Misconduct:

- Unprofessional conduct
Conduct which is:
 - Lower standard as expected by public and/or the peer group.
 - Being guilty of indictable (illegal) offence in court of law.
 - Not in public interest to allow continuation of practice by nurse.
- Excessive, unnecessary, unreasonable for clients' well-being.
- Compromising client's wellbeing.
- Not complying with conditions, limitations, restrictions imposed by Health Professions Council of Namibia.
 - Failure to act, is regarded as negligence.

Case scenario example: Dr. X raping a patient under his care.

Group Activity: Participants provide more examples of unprofessional conduct.

2.4. Ethical decision –making

Ethical decision-making involves ethical reasoning and behaviour about best action, based on the conviction that some actions are better than others.

Group activity: Participants should apply ethical principles: Autonomy, beneficence and non-maleficence, justice, veracity and confidentiality to analyse ethical problems.

Scenario example:

Ms. is 23 years old, and is a repetitive drug addict who is now on a ventilator after a suicide attempt. She is being nursed by you in the intensive care unit. As the nurse in

charge of the ICU you are requested for a bed to admit a 62-year-old woman who has suffered severe injuries in a motor vehicle accident and who also needs mechanical ventilation. Your unit is equipped to ventilate only one client at a time.

Group activity: Debating: Which of the two clients should be ventilated?

References:

The following sources are recommended for the content of this unit:

Searle, C; Human, S; Mogotlane, SM (2014). Professional Practice: A Southern African Nursing Perspective 5th Edition. Pearson

Mogotlane, S.M. (ed), Mokoena, J. D., Chauke, M.E. & Young, A. (2018). *Juta's Complete Textbook of Medical and Surgical Nursing*. (2nd ed.). Cape Town: Juta.

WHO. (2016). *Four-year integrated nursing and midwifery competency-based, prototype curriculum*. Brazzaville: World Health Organization Regional Office for Africa. pp. 39-42.

UNIT 3: KNOWLEDGE- BASED PRACTICE

Objective: To provide newly qualified registered nurses with knowledge and skills to render quality knowledge-based nursing care.

Unit overview:

Knowledge-based practice refers to the competent application of knowledge. Critical thinking and analysis is one of the subdomains of knowledge-based practice and it relates to self-appraisal, professional development and the value of evidence and research for practice.

Content:

- Assessment
- Planning
- Implementation
- Evaluation
- Recordkeeping

3.1.1. Assessment

Gathering accurate and relevant objective and subjective data.

- Assessment**Nursing assessment**

To determine health needs, a comprehensive nursing assessment should be carried out to determine health needs. A comprehensive health assessment should be conducted at the time of admission or during the first visit to an outpatient clinic.

A comprehensive health assessment through observation, the measurement of vital signs and self-reported symptoms. It includes a medical history, a general survey and a complete physical examination.

 History taking

- Subjective
- Objective data

□ **Physical health examination Physical health examination**

When nurses perform physical health assessment, they may use methods such as:

Inspection

Nurses inspect skin color, lesions, bruises or rashes as well as pay attention to abnormal sounds and odors.

Auscultation

Nurses should listen to the internal sounds of the body using a stethoscope for the purposes of examining the circulatory system and respiratory system (heart sounds and breath sounds), as well as the gastrointestinal system (bowel sounds).

Palpation

Nurses should assess for texture, tenderness, temperature, moisture, pulsations and the presence of masses.

Percussion

Nurses firmly press on sections of a patient's body with the distal part the middle finger on their non-dominant hand. This technique will enable them to determine size and shape of the internal organs by establishing the borders.

3.1.2 .Making correct nursing diagnosis

- validate patients

data -sort and

group data

- interpret the data
- label the data with diagnostic label

3.1.3. Planning

- set priorities for patient care needs
- establish patient goals and outcome criteria
- plan the nursing interventions
- compile nursing care plan according to patient needs

3.1.4. Implementation

- Performing nursing procedures according to patient needs

3.1.5. Evaluation

- Evaluate patient progress in relation to nursing care plan
- Uses evaluation data to modify the nursing care plan

3.1.6. Recordkeeping

- Documenting nursing interventions accurately and in timely manner
- Monitoring and documenting patient progress accurately and completely

Scenario example

Mr. X was is admitted in the medical ward. He has not been well for the past 2 months. He had complained of tiredness, frontal headaches, dizziness, sore feet, poor vision, backache and poor appetite.

Group work example:

Participants working in groups, perform the following tasks:

1. Identify the patients care needs
2. Make a nursing diagnosis
3. Draw a nursing care plan to address Mr. X needs.

References

The following sources are recommended for the content of this unit:

Mogotlane, S.M. (ed), Mokoena, J. D., Chauke, M.E. & Young, A. (2018). *Juta's Complete Textbook of Medical and Surgical Nursing*. (2nd ed.). Cape Town: Juta.

Republic of Namibia. (2013). Procedure manuals for nurses. *Ministry of Health and Social Services*, Vol 1.

UNIT 4: LEADERSHIP AND MANAGEMENT COMPETENCIES

Unit overview:

Leadership and management determines an understanding of the concept of public protection and the duty to provide nursing care in the best interest of the public.

4.1. Management

Objectives: Upon completion of this unit, participants should be able to:

- Effectively understand and apply the principles of responsibility and accountability

- Demonstrate an understanding of effective and efficient resource management

Content:

- Planning
- organising
- directing
- Control
- Planning

4.2. Leadership

Objectives: Upon completion of this unit, participants should be able to:

- Define leadership
- Explain and differentiate different leadership styles
- Understand the principles of effective leadership in nursing
- Demonstrate an understanding o how to maintain harmony in nursing unit
- Managing staff conflict

Content:

- Leadership styles
- Key attributes of a leader
- Effective communication
- Maintaining a positive working environment

- Conflict resolutions

Group discussions and feedback: Participants questions:

1. How do you manage an uncooperative staff member?
2. How do you respond to an unprofessional doctor?
3. As a supervisor, how do you manage conflict between colleagues?
4. How will you motivate a nurse to become a top performer in your department?

References

The following sources are recommended for the content of this unit:

Booyens, S. W., In Jooste, K., & In Sibiyi, N. (2015). *Introduction to health services management for the unit manager*. (4th ed.). Cape Town: Juta.

Jooste, K. (2018). *The principles and practice of nursing and health care 2nd Edition*.

Pretoria: Van Schaik.

Jooste K. (2017). *Leadership in health services management*. (3rd ed.). Cape Town: Juta.

Muller, M. (2009). *Nursing Dynamics*. 4 th Edition Johannesburg Heinemann

L. GUIDELINES ON THE WORKSHOP AND PROGRAMME EVALUATION

Evaluation of the workshop should be done daily after each module is delivered whereby NQRNs evaluate the daily training activities. A similar evaluation should also be done towards the end of the workshop to gauge the impact and outcomes of the training.

Daily training evaluation

The daily training evaluation is aimed at assessing the programme’s aims and objectives and to provide evidence of the extent to which the training has achieved its aims and objectives. In addition, this practice will allow participants to give their views regarding the implementation of the programme.

Daily training evaluation tool

<p>Dear Participant</p> <p>Please indicate your views on the training by answering the following questions</p>
<p>1. What did you learn in today’s training?</p> <p>.....</p>
<p>2. What did you like most about today’s activities? Provide a reason.</p> <p>.....</p>
<p>3. What did you not like about today’s activities? Provide a reason.</p> <p>.....</p>
<p>4. What did you not understand in today’s sessions?</p> <p>.....</p>
<p>5. What suggestions do you have to improve the presentations?</p> <p>.....</p>

Overall programme evaluation should be done by NQRNs after completing the training to determine the impact of the transition support programme.

The following table indicate the tool that could be completed by NQRNs at the end of the training to assess the impact of the transition support programme. The evaluation tool

comprises questions on a 4-point Likert scale, which indicate the values as follows: 1 = strongly agree; 2 = agree; 3 = disagree; and 4 = strongly disagree. The tool is based on the different module units that will be covered and that participants need to complete daily after the respective unit is completed. The following table illustrates the training evaluation tool to be used.

Transition Support Programme impact evaluation tool

Dear Participant

After completing the training, please answer the following questions, including any comments you have. **Answer the questions by ticking the appropriate space provided.**

1. Unit 1: This unit enhanced my understanding of the transition support programme

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

2. Unit 2: Professional competencies

I gained knowledge on professional competencies

Strongly agree	<input type="checkbox"/>
Agree	<input type="checkbox"/>
Disagree	<input type="checkbox"/>
Strongly disagree	<input type="checkbox"/>

3. Unit 2: Legal competencies

I have acquire the knowledge on legal issues pertaining to professional nursing practice.

Strongly agree	
Agree	
Disagree	
Strongly disagree	

4. Unit 2: Ethical competencies

4.1. I have acquire the knowledge and skills to render ethical nursing care.

Strongly agree	
Agree	
Disagree	
Strongly disagree	

4.2. I better understand the ethical responsibilities of a registered nurse

Strongly agree	
Agree	
Disagree	
Strongly disagree	

4.3. I gained knowledge on ethical principles in professional nursing

Strongly agree	
Agree	
Disagree	
Strongly disagree	

5. Unit 3: Knowledge- based practice competencies

5.1: I am able to perform the required clinical procedures

Strongly agree	
Agree	
Disagree	
Strongly disagree	

6. Unit 4: Management and leadership competencies

6.1. I gained an understanding of management and leadership in nursing

Strongly agree	
Agree	
Disagree	
Strongly disagree	

6.2. I now understand the management and leadership competencies needed of my role.

Strongly agree	
Agree	
Disagree	
Strongly disagree	

7. The training enhanced my knowledge and skills to practice confidently

Strongly agree	
Agree	
Disagree	
Strongly disagree	

CONCLUDING REMARKS

With the development of this transition support programme, it is envisaged that it will build upon prior knowledge, skills and experiences of newly qualified registered nurses to practice competent and safe nursing care. Consequently, the NQRNs transition will be facilitated, while NQRNs will become competent and confident practitioners. The researcher will avail herself to assist with the implementation of this programme and can be contacted at: **Tel: +264- 612063753, +264812748226, or oemvula@unam.na or [oliviaemvula @rocketmail.co](mailto:oliviaemvula@rocketmail.co)**

ANNEXURE 12: Editor's report

EDITING CERTIFICATE

I, Nkazana Sarah Mwanandimai, confirm that I have edited
the language (Abstract and Chapter 1-8) and references of a

PhD research dissertation

by

OLIVIA EMVULA

titled

**A transition support programme to facilitate the
competencies of newly qualified registered nurses at
public hospitals in Namibia**

NB: The author has the prerogative to accept, reject, or change amendments made by the
editor before submission.

Signed:



Date: 20 September 2020

Ms Nkazana Sarah Mwanandimai, email: nkazana.mwana@gmail.com; Cell: +264 81 325 0360
Member: Professional Editors' Guild (SA)