New Graduate First Year of Clinical Practice Nursing Programme
Evaluation Report

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Foreword

I am pleased to present an evaluation of the three pilot New Graduate First Year of Clinical Practice Nursing Programmes, commissioned by the Clinical Training Agency (CTA).

The key Government goals for the public sector include improving New Zealanders’ skills, which puts a requirement on the Ministry of Health and wider sector to work to further develop the capability and skills of the health and disability support workforce. A key Ministry outcome is to address system capability issues, such as workforce development. The preparation of health professionals to deliver health and disability support services in a manner consistent with Government priorities has become an important focus for the Ministry of Health in recent years.

A number of reports and strategies have recommended that the first post-degree year of clinical nursing practice should be supported in a structured way, to achieve an effective transition from student to professional. Such programmes are believed to contribute to improved skill levels, confidence, recruitment and retention. In order to consider the potential for formal first year of nursing practice programmes in New Zealand, the CTA funded pilot programmes in three District Health Boards (DHBs) in 2002. The pilots have increased our understanding of issues related to the first year of clinical nursing practice.

This evaluation was an integral part of the CTA’s contract with the pilot DHBs. The DHBs worked with the evaluator to develop a range of ways to assess the pilot operations and outcomes from the perspectives of the new graduates, the clinical preceptors, and other key personnel. While the complexity of the programmes presented a challenge, the three pilot DHBs addressed the challenges well. One major result is good-quality information for future policy-making and programme design. This evaluation will assist decisions regarding support for nurse graduates during their professional transition year.

As New Zealand-based research, the results reflect the unique aspects of New Zealand’s health and education sectors and wider society. The CTA believes that investment in this type of local research is critical to the future of our health workforce.

Tony Gibling
Manager, Clinical Training Agency
Acknowledgements

The Ministry of Health gratefully acknowledges the time and information given by many individuals in the preparation of this evaluation report. In particular, the Ministry wishes to thank the evaluation respondents for taking the time to give honest and detailed feedback on the pilot programmes: new graduates, preceptors, programme co-ordinators, clinical charge nurses, clinical nurse educators, cultural supervisors, senior nurse managers and leaders, and directors of nursing. Without their co-operation this evaluation could not have taken place. Senior staff from the pilot providers made valuable contributions to the development of the evaluation framework and tools, and were instrumental in ensuring that the evaluation proceeded smoothly. The Nursing Council of New Zealand’s help and advice at all stages has also been greatly appreciated.

The evaluation could not have been completed without the work of Margaret Macadam, with the assistance of Clinical Training Agency colleagues, especially Maree Young and Heather Forsythe.
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Executive Summary

Background

In 1998 the Ministerial Taskforce on Nursing recommended that the Clinical Training Agency (CTA) work with nursing organisations to develop a national framework for the first year of clinical practice for new graduate nurses. This was based on advice from the New Zealand nursing sector, and international literature demonstrating the benefits of transitional programmes for new graduate nurses. After extensive consultation with nursing organisations, the CTA set up a pilot programme for the first year of nursing clinical practice. The pilot programmes ran for one year, starting in February 2002, with three District Health Boards as the lead providers. The evaluation described in this report sought to identify the impact of structured new graduate programmes on the nurses and their employers in a New Zealand context, with a focus on good programme practices. As the literature and sector strongly support the principle of new graduate nursing programmes, control groups were not utilised in the evaluation.

Aim and objectives

The overall aim of the pilot programme was to enable new graduates to practise confidently as registered nurses. This was to be achieved by ensuring that new graduates were provided with formal preceptoring and professional development in their first year of clinical practice. The pilots adopted an approach similar to a number of other professions, such as doctors, teachers, accountants and lawyers. It recognises that new professionals require support to make the transition from an education context to a professional practice context.

The programme was intended to include:

- a minimum of two and a maximum of three rotations in two scopes of practice\(^1\)
- new graduates’ ability to negotiate with employers to choose the areas and number of rotations
- assignment of a named preceptor who had attended an appropriate training programme for this role
- reduced clinical workload for a designated period of time
- release from the clinical setting for educational purposes
- provision of assistance in critical and reflective practice.

The programme specification signalled the CTA’s intention to conduct an evaluation. The purpose of this evaluation was to assess whether the pilot programmes met the aims and objectives as stated in the specification, and to identify any positive or negative consequences of participation in, or the running of, the pilot programmes.

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\(^1\) The new graduates were assessed against standards and competencies set by the Nursing Council for the first year of clinical practice. As stated in the programme specification, these standards and competencies were based on *Entry into Specialty Nursing Practice Programme Standards and Competencies*. The Nursing Council, in conjunction with the pilot provider, developed *Standards and Competencies for the New Graduate First Year of Clinical Practice*. Further information can be obtained from the Nursing Council of New Zealand.
Methodology

A programme evaluation approach was adopted, using a single set of evaluation tools across all programmes. The CTA developed the evaluation tools in conjunction with the Nursing Council and pilot providers. The evaluation took a multi-method approach, consisting of:

- self-administered questionnaires sent to all trainees, preceptors and programme co-ordinators near the start and at the end of the programme
- in-depth telephone interviews conducted at the end of the programme with key informants (clinical charge nurses, clinical nurse educators, cultural supervisors, senior nurse managers/leaders and directors of nursing)
- a literature review.

Key findings

Rotations

Most new graduate respondents had two clinical placements in a hospital setting during the course of the programme and had input into the choice of clinical areas for their rotations. Of those new graduates who had at least one placement in a clinical area that was not their initial preference, the majority thought that the experience gained in these areas was still useful to them.

Most new graduate respondents welcomed the opportunities that rotations offered to learn different skills, and to have broader and more varied clinical experiences. Half of the new graduate respondents commented on the disruption of having to move on just as they were starting to feel confident and useful and knew how things worked in their first placement. Few, however, suggested any changes to this system. All programme co-ordinator respondents and most key informants thought that rotations made an effective contribution to the development of new graduates’ clinical practice.

Supernumerary time

Orientation periods during which preceptors and new graduates shared a workload were offered at the start of each placement. The length of this ‘supernumerary time’ varied, mainly between two and six weeks. One-third of key informants noted that the supernumerary time had been flexible to allow for differing needs, and to ensure that the new graduate felt safe. The vast majority of key informants found this a very important – if not essential – time. New graduates had an opportunity to settle in to their new environment without the pressure of a workload, and to gradually build up the confidence to take on their own patients.

Preceptorship

Just over three-quarters of the end-of-programme new graduate respondents stated that they had a designated preceptor for each rotation. A further 10 percent had a preceptor for only one of their rotations. Less than two-thirds of these respondents agreed or strongly agreed that they had access to a designated preceptor for an agreed period of time. The difference in these two figures may be explained by the limited access some new graduates had to their preceptors.
At the end of the programme, over a third of new-graduate respondents:

- stated that their clinical workload had not allowed time for preceptorship in either rotation
- appeared not to have had much, if any, contact with their preceptor after the orientation period.

Over a quarter of preceptor respondents stated that their clinical workload had not allowed any time for preceptorship.

The limited access that some new graduates had to their preceptors is reflected in their ratings of the support that they received. Only just over half of the new-graduate respondents thought that their preceptor:

- had recognised their learning needs
- had used useful strategies to help them meet their learning needs
- had provided timely and appropriate feedback.

The main factor affecting the delivery of preceptorship was the underlying tension between the needs of the service and the support needs of the new graduates. For example:

- new graduates and preceptors were often not rostered together
- even if they were working the same shift, workload pressures might limit the amount of support the preceptor could provide
- there was little opportunity for off-ward teaching and reflection sessions.

Nevertheless, when preceptoring did occur it made a positive contribution to the new graduates’ clinical practice. New graduates commented on the benefits of having:

- ready access to advice on clinical skills
- support and guidance
- continuity and consistency from one person whom they knew they could turn to.

At the end of the programme most preceptor respondents thought that the clinical practice of the new graduates had improved as a result of preceptorship. Virtually all the key informants thought that preceptorship was a very effective means of developing new graduate nurses’ clinical practice. These findings are supported by the international literature, as discussed in the literature review below.

**Clinical release for educational purposes**

All three pilot providers offered regular study days as part of the programme. These were rostered at the beginning of the year, so that there was no question of nurses not being released to attend them. Most new graduate respondents found the teaching sessions useful. Those who did not find them useful thought that they were too basic or were not relevant to their clinical practice.

Two-thirds of key informants thought that clinical release time for study days had been an effective means of developing the new graduates’ clinical practice. It was seen as essential to be able to step back and assess experiences.
Other teaching sessions (such as reflection sessions) occurred less regularly, mainly due to workload pressures.

**Training and support for preceptors**

At the start of the programme only half of the preceptor respondents thought that the information given to them had made them feel confident about their role as preceptors. At the end of the programme just under two-thirds of preceptor respondents thought that the programme co-ordinator had provided them with adequate information about the programme. A similar proportion thought that the preceptor training had provided them with adequate information about their role.

The majority of preceptor respondents thought that the clinical charge nurse and other team members had supported them in their role. However, 41 percent of preceptor respondents felt that the programme co-ordinator had not supported them in their role.

**Were new graduates able to practise confidently as registered nurses at the end of the programme?**

The vast majority of new graduate respondents rated their confidence as either good or excellent at the end of the programme, compared with only one-third at the start of the programme. Virtually all new graduates passed the clinical assessments undertaken during the programme using the Nursing Council assessment tool.

Most preceptors surveyed at the end of the programme thought that the programme had been a safe and effective way to support new graduates to develop competencies in clinical practice. The majority of key informants thought that, overall, the programme had been effective in developing the clinical practice of new graduate nurses.

The vast majority of preceptor respondents, most programme co-ordinator respondents and all key informants thought that the structured and supportive environment of the programme had been of great benefit to new graduates. Most new graduates reported that their overall expectations of the programme had been met.

**Conclusions**

Despite the difficulties experienced with preceptoring, the overall view was that this had been an effective programme. Clearly the support provided to many of the new graduates and preceptors could have been better. Nevertheless, it appears that many new graduates did benefit from the structured educational opportunities, the varied clinical experiences and the generally supportive environment of the pilot programmes. Confidence levels were high among new graduates at the end of the programme, and actual clinical assessments reflected this confidence.

The health service appeared to benefit too: the majority of new graduates planned to stay at the DHB where they had undertaken the programme, many of whom cited the programme as influencing their decision.

The pilot programme’s positive contribution to the development of new graduate nurses is a long way from the ‘sink or swim’ environment of the past.
Part I: Introduction

1. The pilot programme

Background

The first year of clinical nursing practice has long been identified, both in New Zealand and internationally, as a key aspect of the development of professional nursing practice and the ongoing retention of nurses in the health workforce. In August 1998 the Report of the Ministerial Taskforce on Nursing stated:

The Taskforce believes that the health sector should stop treating first-year nurse graduates as if they are fully experienced professionals. Nursing graduates need to be treated in the same way as other professions treat their graduate – that is, they should work largely under supervision during their first year in the workforce (Ministry of Health 1998: 61).

The Ministerial Taskforce went on to recommend that the CTA work with nursing organisations to develop and fund a national framework for the first year of clinical practice. This recommendation was reiterated in the 2001 Strategic Review of Undergraduate Nursing Education (KPMG 2001). This review strongly supported the need for some structured and supported experiences for new graduate nurses in their initial practice following registration. It also recommended that the Ministry of Health commit resources to ensure that specialty practice programmes are established by DHBs (KPMG, 2001: Recommendation 8.2, p 99). The report also notes that other professions do not expect their graduates to be fully work-ready upon graduation.

As a result of these recommendations the CTA, in consultation with the Nursing Council and other nursing organisations and stakeholders, developed a specification for a pilot First Year of Clinical Practice Nursing Programme (see Appendix 1) and set up a tender process for providers interested in running the pilot for a period of one year. An expert panel selected three DHBs as lead providers. Panel members were not aware of the identity of the proposers prior to the selection process. One lead provider ran the programme with a neighbouring regional DHB. The pilot programme began in February 2002.

The programme specification signalled the CTA’s intention to conduct an evaluation. The purpose of this evaluation was to assess whether the programmes met the aims and objectives as stated in the specification, and to identify any positive or negative consequences of participation in, or the running of, the pilot programmes.

This evaluation has been made in addition to the quality improvement plan that each provider is expected to have in place. It was not intended to monitor trainee progress, and pilot providers were expected to meet all reporting requirements of the CTA.
Aims and objectives

The overall aim of the pilot programme was to enable new graduates to practise confidently as registered nurses. This was to be achieved by ensuring that new graduates were provided with formal preceptoring and professional development in their first year of clinical practice. The programme was intended to include:

- a minimum of two, and a maximum of three, rotations in two scopes of practice
- new graduates’ ability to negotiate with employers to choose the areas and number of rotations (for the purpose of the programme a ‘rotation’ was defined as time spent working in one scope of practice)
- assignment of a named preceptor who had attended an appropriate training programme for this role; the ratio of the preceptor to new graduates was to be no more than 1:2
- reduced clinical workload (ie, the workload was to be shared between the preceptor and the new graduate for a designated period of time)
- release from the clinical setting to attend formal tutorials, workshops, and education components, or for the purpose of guided self-reflection to provide consolidation of specific skills or areas
- provision of assistance in critical and reflective practice.

2. Methodology

There were three providers for the First Year of Clinical Practice Programme pilot. A programme evaluation approach was adopted, using a single set of evaluation tools across all programmes. The CTA, in conjunction with the Nursing Council and pilot providers, developed the evaluation tools. The evaluation took a multi-method approach, as detailed below.

Pilot providers were responsible for administering surveys and releasing other staff to enable interviews to be conducted. The CTA contracted an independent researcher to organise the end-of-programme survey, conduct the key informant interviews, analyse all the evaluation data, and prepare a written report.

The use of control groups was considered but not adopted for two main reasons. First, the literature as well as the sector’s support for the principle of new graduate nursing programmes was very strong. Therefore, the priority for the evaluation was deemed to relate to identification of the key elements of programme design in the New Zealand context. Second, the potentially large number of confounding factors suggested that a randomised controlled trial approach would not result in the definitive identification of causative factors.

2 The new graduates were assessed against standards and competencies set by the Nursing Council for the first year of clinical practice. As stated in the programme specification, these standards and competencies were based on Entry into Specialty Nursing Practice Programme Standards and Competencies. The Nursing Council, in conjunction with the pilot provider, developed Standards and Competencies for the New Graduate First Year of Clinical Practice. Further information can be obtained from the Nursing Council of New Zealand.
Clinical assessment

New graduate clinical practice was assessed against the standards set by the Nursing Council of New Zealand. The clinical assessment was made at the end of each rotation. The Nursing Council worked with the three programme co-ordinators to develop one clinical assessment tool that could be used across all sites. The programme co-ordinators managed the administration of the clinical assessment.

It was not considered necessary to conduct an assessment of clinical practice at the start of the programmes as all trainees were recent graduates and therefore had the same starting point (ie, all had met the standards for Registration of Comprehensive Nurses and competencies for entry to the Register of Nurses).

Self-administered questionnaires

All trainees, preceptors and programme co-ordinators were surveyed near the start (one month into the programme) and at the end of the programme. (See the appendices for copies of the questionnaires used in these surveys.)

Key informant interviews

At the end of the programme 39 key informant interviews were conducted with a self-selected sample of clinical charge nurses (11), clinical nurse educators (10), cultural supervisors (3), senior nurse managers/leaders (9) and directors of nursing (6). The purpose of these interviews was to assess the overall strengths and weaknesses of the programme from the perspective of the other staff involved in the running of the programme.

Information was collected through the use of a semi-structured interview guide. (See Appendix 9 for details.) Providers supplied contact details, and the researcher arranged to conduct telephone interviews with all those who agreed to participate. The length of interview ranged from 30 to 45 minutes.

Data analysis

Survey data from closed questions were analysed using the SAS analysis package. Open-ended survey questions and data from the key informant interviews were analysed by hand, by subject and by themes.

Response rates

New graduate surveys

At the start of the programme, questionnaires were sent to all the participating new graduate nurses (162 in total) at the pilot providers. The same number was sent at the end of the programme. The response rate from new graduates at the start of the programme was 90 percent, compared with 73 percent at the end of the programme. This was largely due to a much lower response rate at one of the sites, where half of the questionnaires were not distributed until after the programme had finished. Detailed response rates for the three providers are contained in Table 1 over the page.
Given the high response rates overall it is likely that a large proportion of the end-of-programme sample also completed start-of-programme surveys. (We cannot be certain of the exact numbers due to new graduate respondent anonymity.) Thus, although the samples do not match precisely, there is sufficient similarity to be able to make broad comparisons. This limitation should be borne in mind when reading the following findings.

**Preceptor surveys**

At the start of the programme, questionnaires were sent to all the participating preceptors (162 in total) at the pilot providers. The same number was sent at the end of the programme. The response rate from preceptors at the beginning of the programme was 48 percent, compared to only 30 percent at the end of the programme. We cannot tell how many of these also completed start-of-programme questionnaires. This should be borne in mind when assessing the comparisons between the two samples.

The low response rate limits the scope for generalising the preceptor findings. Nevertheless, these findings can provide a valuable indication of the key issues that need to be addressed.

**Table 1: Survey response rates, new graduates and preceptors**

<table>
<thead>
<tr>
<th></th>
<th>Provider X</th>
<th>Provider Y</th>
<th>Provider Z</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New graduates</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start of programme</td>
<td>93</td>
<td>86</td>
<td>93</td>
<td>90</td>
</tr>
<tr>
<td>End of programme</td>
<td>82</td>
<td>76</td>
<td>59</td>
<td>73</td>
</tr>
<tr>
<td><strong>Preceptors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start of programme</td>
<td>73</td>
<td>37</td>
<td>43</td>
<td>48</td>
</tr>
<tr>
<td>End of programme</td>
<td>50</td>
<td>24</td>
<td>25</td>
<td>30</td>
</tr>
</tbody>
</table>

Demographic details of the new graduate and preceptor respondents are contained in Appendix 2.

### 3. Literature review: the benefits of providing preceptorship

One of the key objectives of the First Year of Clinical Practice Pilot Programmes was to ensure that all new graduates had access to a supportive environment through the use of preceptorship. Analysis of the available literature on the subject highlighted that preceptorship was an essential part of the socialisation and professional development of the new graduate nurse.

It should be noted that a predominance of small sample sizes in the majority of these previous studies prevents the use of inference statistics to provide empirical data to support these overall findings. Many of the overseas studies also look at the experience of student nurses who, as unregistered practitioners, legally require a much higher level of supervision. However, despite these limitations some common findings are discussed below.
Factors that facilitated learning

Oermann and Moffit-Wolf (1997) reported the following factors that facilitate learning:

- consistent preceptors, who provide positive reinforcement and who guide the learning process
- a well-planned orientation
- hands-on experience
- role models on the unit
- self-motivation
- the opportunity to practise skills and procedures more than once.

In a study conducted by Teasdale et al (2001) there was a statistically significant difference on the personal accomplishment scale that suggested greater feelings of competence and successful achievement among a supervised group than among an unsupervised group. The study also concluded that clinical supervision can provide important support for more junior staff.

Another study, conducted by Lees (1999), concluded that there were significant differences between those nurses receiving and those not receiving clinical supervision. In relation to the amount of support participants received, 43 percent of those receiving supervision felt very satisfied compared with 30 percent of those not receiving supervision. In response to the opportunities for career advancement, 53 percent of those receiving supervision felt either very satisfied or satisfied, compared with 26 percent of those in the control group. These findings are supported by a number of studies conducted with nursing students (Clayton et al 1989 and Scheetz 1989, both cited in Dyson and Thompson 1996), which support the finding that preceptored students showed significantly greater improvement than non-preceptored students.

Length of preceptorship

It would appear that the longer and more structured the orientation, the more confident and less stressed the graduates were when taking responsibility for clients (Walker 1999). Commitment to preceptorship should extend after the initial supernumerary, or basic orientation, stage (Hancock 2002). Hancock’s evaluation of preceptorship in a neonatal intensive care unit stressed that the success of the preceptor programme relied on the support of staff – not only from the preceptors and team leaders, but also from the preceptees themselves. She stated that preceptees and preceptors needed help with self-rostering to ensure an ongoing relationship.

Preceptorship programmes that extend beyond the orientation programme can be used as a staff recruitment tool (Hill and Lowenstein 1992, cited in O’Malley et al 2000; Hardy and Smith 2001).
Designated preceptors

Having a consistent preceptor was advantageous for both preceptor and preceptee (Myrick 2002; Dyson and Thompson 1996). Both Myrick’s and Dyson and Thompson’s studies highlighted that continuity with one student allowed preceptors to use their judgement in relation to the individual student’s ability, and therefore allowed them to challenge and extend the student’s knowledge base and practice further.

Students stated that inconsistent preceptoring did not promote learning. As one student stated (Myrick 2002: 10):

In the past I’ve had one nurse one day and another nurse another day, and a lot of them weren’t interested. They didn’t teach me anything. They liked the fact that I helped them make beds or I helped them to do this, but they weren’t interested in me ... I was basically on my own.

Anderson (1998, cited in Hardy and Smith 2001) stated that assigning preceptors to a specific orientee is frequently a random choice based on scheduling convenience, rotation through the role, or personal request. Often this approach results in multiple preceptors for one orientee, and orientees may become frustrated with the inconsistent messages of the various preceptors. Hardy and Smith (2001) also stress the need to match preceptees to preceptors.

Valuing preceptors

Preceptors are more likely to be committed to the role when they perceive the rewards to be personally worthwhile or professionally beneficial (O’Mara and Welton 1995, cited in Wright 2002). A number of studies (Wright 2002; Brennan and Williams 1993; Cerinus and Ferguson 1993, cited in Allen 2002) maintain that it is important to set up situations that enhance positive attitudes towards preceptorship, such as preparation for the role, support from other staff members, reduced clinical workload, and opportunities for career advancement. Wright warns that when these conditions are not in place, it can lead to extra stress for the preceptor, which can fuel anger and frustration. Often this anger and frustration is directed towards the trainee, resulting in ‘horizontal violence’, where at times the experienced nurse may be too eager to belittle the idealistic ideas of novice nurses.

Dibert and Goldenberg (1995, cited in Allen 2002 and O’Malley et al 2000) warn that increasing demands on experienced practitioners who already have extensive responsibilities increases the possibility of ‘burn-out’. Dibert and Goldenberg cite problems of lack of support from management and other staff and insufficient time to fulfil the preceptor role alongside their other duties as factors exacerbating the problems of preceptorship.
Part II: Findings

4. Were new graduate expectations for the programme met?

Overall expectations of benefit

Ninety-one percent of the start-of-programme new graduate respondents agreed or strongly agreed that the programme would ‘promote my professional development as a registered nurse’. At the end of the programme this proportion had dropped slightly, to 82 percent. Expectations at Provider X and Provider Z were very high – 97 percent of the start-of-programme new graduate respondents at these sites agreed or strongly agreed with this statement, but by the end of the programme the rating had dropped to 84 percent and 80 percent, respectively. At Provider Y, expectations at the start and ratings at the end were about the same: 84 percent compared with 81 percent agreed or strongly agreed with the statement.

Table 2: ‘The programme will promote/promoted my professional development as a registered nurse’ (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 145)</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>49</td>
<td>41</td>
</tr>
<tr>
<td>Agree</td>
<td>42</td>
<td>41</td>
</tr>
<tr>
<td>Neutral</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

At the end of the programme almost two-thirds of new graduate respondents (62 percent) agreed or strongly agreed that, overall, their expectations of the programme had been met. However, satisfaction with some aspects of the programme was considerably lower than expectations at the start of the programme. This was most evident with regard to the preceptoring relationship.

Table 3: ‘Overall the programme met my expectations’ (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>18</td>
</tr>
<tr>
<td>Agree</td>
<td>44</td>
</tr>
<tr>
<td>Neutral</td>
<td>21</td>
</tr>
<tr>
<td>Disagree</td>
<td>16</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
</tr>
</tbody>
</table>
Expectations of the preceptoring relationship

At the start of the programme 78 percent of new graduate respondents expected to have a preceptor who would recognise their learning needs. Only half (53 percent) of the end-of-programme new graduate respondents agreed or strongly agreed that this had been the case.

Table 4: ‘My preceptor will recognise/recognised my learning needs’ (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 145)</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>Agree</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td>Neutral</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>Disagree</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Don’t know/not stated</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Similarly, 76 percent of new graduate respondents at the start of the programme expected to have a preceptor who would use useful strategies to help them meet their learning needs, and only 53 percent of the end-of-programme new graduate respondents agreed or strongly agreed that this had happened.

Table 5: ‘My preceptor will use/used helpful strategies to help me meet my learning needs’ (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 145)</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>33</td>
<td>16</td>
</tr>
<tr>
<td>Agree</td>
<td>43</td>
<td>37</td>
</tr>
<tr>
<td>Neutral</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Disagree</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Don’t know/not stated</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Finally, 73 percent of new graduate respondents at the start of the programme expected that their preceptor would provide timely and appropriate feedback to them, compared with 53 percent of the end-of-programme new graduate respondents who agreed or strongly agreed that this feedback had been forthcoming.
Table 6: ‘I will receive/received timely and appropriate feedback from my preceptor’ (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 145)</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td>Agree</td>
<td>46</td>
<td>37</td>
</tr>
<tr>
<td>Neutral</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>Disagree</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Don’t know/not stated</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

New graduates were supposed to have access to a designated preceptor for an agreed period of time, and 82 percent of new graduate respondents at the start of the programme expected that this would happen (ie, they agreed or agreed strongly with a statement to this effect). By the end of the programme less than two-thirds of new graduate respondents agreed or strongly agreed that this had happened.

Table 7: ‘I will have/had access to a designated preceptor for an agreed period of time’ (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 145)</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
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<tbody>
<tr>
<td>Strongly agree</td>
<td>39</td>
<td>24</td>
</tr>
<tr>
<td>Agree</td>
<td>43</td>
<td>38</td>
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<tr>
<td>Neutral</td>
<td>8</td>
<td>14</td>
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<tr>
<td>Disagree</td>
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<tr>
<td>Strongly disagree</td>
<td>2</td>
<td>3</td>
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<tr>
<td>Other</td>
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<td>3</td>
</tr>
<tr>
<td>Don’t know/not stated</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
5. The preceptor role

The assignment of new graduates to preceptors

New graduate perspective

Just over three-quarters of the end-of-programme new graduate respondents stated that they had a designated preceptor for each rotation. Ten percent said this had happened for one rotation but not the other; 12 percent stated that they had not had a designated preceptor for either rotation. Eight percent of Provider Y respondents said they had been preceptored by several different nurses. On some occasions this meant having a different preceptor every day.

Table 8: Did you have a designated preceptor assigned for each rotation? (new graduate respondents)

<table>
<thead>
<tr>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Yes for one rotation, no for the other</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

Seventy-seven percent of new graduate respondents thought that their preceptor had been responsible for no more than two preceptees (as stated in the specification). In most cases (68 percent), new graduate respondents thought that their preceptor had been responsible for only one preceptee. At Provider Z, a smaller proportion of new graduate respondents (62 percent) thought that their preceptor had been responsible for no more than two preceptees, compared with 80 percent of new graduate respondents at the other two providers.

Table 9: Perceived number of preceptees per preceptor (new graduate respondents)

<table>
<thead>
<tr>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preceptor responsible for:</td>
</tr>
<tr>
<td>1 preceptee</td>
</tr>
<tr>
<td>2 preceptees</td>
</tr>
<tr>
<td>3 preceptees</td>
</tr>
<tr>
<td>4+ preceptees</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Preceptor perspective

Three-quarters of preceptor respondents at the end of the programme stated that they had a designated new graduate for each rotation. The figures for the three pilot providers were broadly similar. The majority of preceptor respondents (82 percent) stated that they had been responsible for one or two preceptees; 12 percent had been responsible for three or more preceptees. There were no marked differences on this issue between preceptor respondents at the three providers.
Table 10: Number of preceptees per preceptor (preceptor respondents)

<table>
<thead>
<tr>
<th>Preceptor responsible for:</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 preceptee</td>
<td>35</td>
</tr>
<tr>
<td>2 preceptees</td>
<td>47</td>
</tr>
<tr>
<td>3 preceptees</td>
<td>8</td>
</tr>
<tr>
<td>4+ preceptees</td>
<td>4</td>
</tr>
<tr>
<td>Don't know</td>
<td>6</td>
</tr>
</tbody>
</table>

Did the clinical workload allow time for preceptorship?

New graduate perspective

At the end of the programme less than half the responding new graduates thought that their clinical workload had allowed time for preceptorship throughout the year. Nine percent thought that this was the case for one of their rotations, but not the other, while a further 5 percent stated that their workload had sometimes allowed time for preceptorship.

Table 11: Did clinical workload allow time for preceptorship? (new graduate respondents)

<table>
<thead>
<tr>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Yes for one rotation, no for the other</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Don’t know / not stated</td>
</tr>
</tbody>
</table>

At the end of the programme over a third of new graduate respondents stated that their clinical workload had not allowed time for preceptorship in either rotation. Over half of this group (20 percent of all new graduate respondents) said that heavy workloads and other time constraints had meant that there was little if any time for preceptoring. For example: ‘Preceptorship gets lost in the ward environment – all senior nurses had to be available to help’.

Half of this group (18 percent of all new graduate respondents) gave the reason for the lack of preceptoring as being that they had rarely or never been rostered together with their preceptor after the initial orientation period. It is interesting to note that this comment was also made by some of the new graduate respondents who said that there had been time for preceptoring. As discussed further in the section below (‘What did preceptorship consist of?’), 17 percent of new graduate respondents described their preceptoring as occurring predominantly, if not exclusively, in the orientation period, and did not appear to expect anything more beyond that time.

In total it appears that 35 percent of new graduate respondents did not have much, if any, contact with their preceptor after the orientation period. There was little variation between the three providers on this issue.
Other reasons given (by between 2 percent and 4 percent of all new graduate respondents) for the lack of preceptoring included:

- little or no allocated time off ward
- did not have a preceptor
- only had a preceptor for a few days
- preceptor had other responsibilities
- preceptor changed from day to day / no continuity.

For example:

On the first rotation the ward was too busy. No-one really wanted to precept me and when I finally got a preceptor, she was never around. I received minimal input from the charge nurse and after three days was told by staff that my preceptoring was over. I had to have my own patient load for four days. I cried each day and hated nursing. I asked for more preceptoring and the staff had presumed I was with the other new grad on the ward who had already had two weeks preceptoring.

**Preceptor perspectives**

Only 41 percent of preceptor respondents at the end of the programme thought that their clinical workload had allowed time for preceptorship. A further 33 percent thought that there had been time for preceptorship on some occasions, but not consistently. Over a quarter of preceptor respondents stated that their clinical workload had not allowed any time for preceptorship.

<table>
<thead>
<tr>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>No</td>
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</tbody>
</table>

**Programme co-ordinator perspective**

The majority of programme co-ordinator respondents thought that the clinical workload of new graduates had been reduced to facilitate their practice development, but that this reduction rarely extended beyond the orientation period.

Most programme co-ordinator respondents felt that there had been some reduction in preceptors’ workload to facilitate preceptorship. Some areas were more supportive than others in this respect. Preceptors were also under pressure to respond to clinical need, and this took precedence over preceptoring time.
Suggestions for ensuring that workloads were reduced included:

- a blanket mandatory agreement that this should occur for a specified time
- more release time
- highlighting the preceptor’s and new graduate’s names on the roster as a reminder that they need a reduced workload.

**What did preceptorship consist of?**

**New graduate perspective**

Those new graduate respondents who said that their workloads had allowed time for preceptorship at least some of the time (61 percent) were asked what this consisted of. Over a quarter of this group (17 percent of all new graduate respondents) described preceptorship as predominantly, if not exclusively, happening in the orientation period for each rotation. Other descriptions of preceptorship by new graduate respondents included:

- support and guidance from their preceptor, including reflection and feedback (10 percent)
- on-the-job explanations and teaching clinical skills (10 percent)
- rostered time off ward together – activities in this time included working on competencies, discussing and evaluating progress, reflection assessments, and planning the next steps (8 percent)
- informal contact with their preceptors when workloads allowed; for example, during quiet times) (7 percent).

**Preceptor perspective**

Preceptors were asked what preceptorship had consisted of. Just over a fifth (22 percent) of all preceptor respondents mentioned supernumerary time (ie, when the preceptor and the new graduate shared a workload at the start of the rotation) lasting for several weeks. As one preceptor described this time:

> Often we would take a load and work together on the care of clients. This enabled the rationale to be discussed with the nurse. Or cases that the new graduate had confidence in I would allow them to complete and just assess.

Fourteen percent mentioned supporting and teaching the new graduate in the work environment. Only 10 percent mentioned time out of the ward environment for one-to-one teaching. One preceptor described her role as follows:

> Working through the PDP book, orienting to the unit, supervising, checking, teaching, teaching by example, thinking of things that she didn’t know that she didn’t know, being available and approachable.

However, such a thorough approach did not seem to be achievable in many cases. Over half (53 percent) of all preceptor respondents said that they had often been too busy to provide adequate preceptoring. Staff shortages, low skill mixes, heavy workloads, high patient acuity, the extra responsibilities of being a senior nurse – including the need to supervise bureau staff – all contributed to the pressure on preceptors, resulting in little if any time to support the new graduates and reflect on their practice.
The most useful aspects of preceptorship

New graduate perspective

New graduate respondents were asked at the end of the programme which elements of preceptorship had been most useful to them. The most common theme related to the preceptor as a source of knowledge of clinical issues as well as hospital and ward procedures and cultures: 42 percent of new graduate respondents reported that having access to this knowledge had been very useful. Thirty-nine percent cited the support and guidance provided by the preceptor.

Thirty-eight percent of new graduate respondents thought that it was important to have one specific person who they knew that they could turn to for support. Comments related to the benefits of continuity, of having someone who was taking an active interest in their development, someone who understood them and their abilities and limitations, and someone in whom they felt safe in confiding. Two new graduates reported these benefits as follows:

- Always knowing I had the support of someone extra caring there for me and someone who was genuinely interested in my progress and always wanted to see that I had the best experiences and learning opportunities available.
- Having a designated person to confide in and reflect without feeling self-conscious or concerned re that info being talked about with other staff.

Preceptor perspective

At the end of the programme, preceptors were asked to identify the aspects of preceptorship that they thought had been most effective with regard to developing the new graduates’ clinical practice. Around a quarter of all preceptor respondents thought that the opportunity to provide role modelling and teaching in a clinical setting was an effective means of developing the new graduates’ clinical practice. Eighteen percent felt that it was important to have time to step back from day-to-day clinical issues to allow for reflection, goal setting and evaluation, and assessment of learning needs. For example, the preceptor ‘knows where the new graduate is at, and knows where to help them develop more’.

Sixteen percent of preceptor respondents thought that close supportive guidance from the preceptor made a valuable contribution to the new graduates’ development. Twelve percent mentioned the importance of regular access to the new graduate (through working together where possible). In this way, a relationship of trust could be built up, and the new graduate could feel safe to ask questions and seek support:

- Having one or two senior nurses consistently working with the nurse in her initial period of orientation: the relationship formed encourages an on-going environment for learning and encourages the mentoring process to continue after the initial orientation.
Programme co-ordinator perspective

Programme co-ordinator respondents also commented on the contribution that preceptorship made to the development of the new graduates’ clinical practice. The most useful aspects of preceptorship were seen to be as follows:

- providing non-threatening clinical support
- joint release time to go over clinical skills, work through competencies, etc
- consistent support throughout the placement
- training and support for preceptors.

As one respondent stated: ‘The relationship between these two cannot be underestimated in its importance’.

The least useful aspects of preceptorship

New graduate perspective

New graduate respondents were asked which aspects of preceptorship had been least useful to them. Over one-third (35 percent) of respondents made comments related to having limited time with their preceptor due to not being rostered together, having no off-ward time together, or having heavy workloads that did not allow time for preceptoring. Some respondents said that they rarely saw their preceptors; others said that the preceptor was always too busy.

Eleven percent of respondents were not happy with the quality of preceptoring, even when they did have time together. Comments focused on preceptors not being aware of the new graduates’ abilities (‘telling you things you already knew’), being judgemental, or clearly not wanting to be preceptors. Ten percent of Provider Y new graduate respondents (5 percent of all new graduate respondents) said that they had had regular changes in preceptor, and found the resulting lack of continuity to be the least useful element of preceptoring.

Preceptor perspective

Preceptors were then asked to identify the aspects of preceptorship that they thought had been least effective with regard to developing the new graduates’ clinical practice. Just under half of the preceptor respondents commented on this issue. Eighteen percent mentioned a lack of time together (ie, not working the same shifts) as contributing to less than effective preceptoring. Eighteen percent reported that even when they were rostered together, the ward was too busy to allow any time for teaching, explanations, supervision or reflection. A small number of preceptors (4 percent) commented on the lack of consistent follow-through over the rotation.

Programme co-ordinator perspective

Preceptorship was seen not to function effectively when the preceptor and the new graduate did not have the opportunity to work together much. Programme co-ordinator respondents thought that this was due either to a lack of rostered time together, or to the workload pressures on the ward even when preceptors were working the same shifts as the new graduate.
How could preceptorship be improved?

New graduate perspective

New graduates were asked to suggest improvements in the way preceptorship was provided in this programme. The main area of comment (mentioned by 41 percent of all new graduate respondents) related to spending more time with their preceptor. These included:

- having more rostered time together (15 percent)
- reducing the preceptor’s patient load to allow more time for preceptoring (13 percent)
- having allocated time off the ward together (9 percent)
- having a longer period of preceptorship (4 percent).

As one respondent stated, ‘Extra time off ward to discuss progress with preceptor and have a better understanding of how I was doing and the goals I needed to aim for’.

Eleven percent of new graduate respondents (including nearly one in five of Provider Y new graduate respondents) thought that the new graduate should not have more than one preceptor, to ensure continuity. Eleven percent also made suggestions related to the treatment of preceptors. These included rewarding them, not using the same preceptor each time (to avoid burn-out), and making sure that preceptors were willing to undertake the role beforehand. For example: ‘Rewards for preceptors to acknowledge their vital input to the graduate, and acknowledge appreciation for their time and commitment’.

Other suggestions included:

- more education and guidance for the preceptors regarding the preceptor / new graduate relationship (7 percent of new graduate respondents)
- ensuring that preceptors are senior nurses (4 percent).

Preceptor perspective

Preceptors’ suggestions for improving the way in which preceptorship was provided in the programme included:

- more paid time out of the ward together to ensure that the preceptor and new graduate could reflect on the new graduate’s practice, discuss issues and goals, or undertake appraisals and evaluations (20 percent of respondents)
- lighter workloads to enable preceptors to undertake more supervision of the new graduate’s practice (12 percent)
- more information on the programme before they started preceptoring – including more notice that they were going to be preceptors (8 percent)
- the need to be rostered together with the new graduate (4 percent)
- the need for a longer or supernumerary time (4 percent).
Programme co-ordinator perspective
Programme co-ordinators made the following suggestions for improving the process used to select staff to become preceptors.

- Preceptors should only be selected if they are motivated and willing candidates – they will be more effective if this is the case.
- There should be a formal process, with a job description.
- The positive aspects of preceptorship need to be highlighted (eg, professional development), and recognition for the hard work needs to be provided if more nurses are to be encouraged to become preceptors.

Ideal qualities and experience of preceptors
At the end of the programme, preceptor respondents identified the following personal qualities and experience that they thought a preceptor should have to make a difference to the clinical practice of new graduates:

- experienced nurses with good clinical skills (63 percent of preceptor respondents)
- patience (53 percent)
- communication and interpersonal skills (53 percent)
- mentoring skills, such as the ability to constructively critique, empathy, supportiveness, being non-judgemental, the ability to encourage to improve, the ability to reflect (41 percent)
- good teaching skills (24 percent)
- a desire to undertake the role (18 percent).

One preceptor summed up the desirable experience and qualities as follows:

You need the experience to know that you never stop learning and that learning comes from many sources and you need to remain open to these sources. A preceptor must be confident in their practice but not overbearing, encouraging without taking over, open-minded.

Key informant perspectives on the preceptor role
Supernumerary time
Key informants were asked how effective they thought the supernumerary period (when the preceptor and the new graduate shared a patient load at the start of each rotation) had been in developing the clinical practice of new graduates. The vast majority (87 percent) thought that this time had been very effective. It was seen as a very important, if not essential time. The reasons given for this were as follows:

- New graduates have an opportunity to settle in to the new environment without the pressure of a workload – they can learn by observing and gradually build up the confidence to take on their own patients (36 percent of respondents).
- New graduates can familiarise themselves with ward layout and routines, and what is expected of them (36 percent of respondents).
- New graduates can learn key procedures (10 percent of respondents).
• Preceptor and new graduate can start to build a relationship (5 percent of respondents).
• Preceptor can assess the new graduate and identify areas for development (5 percent of respondents).

The effectiveness of this period was made very clear to one respondent when a new graduate failed to have any supernumerary time:

One new graduate didn’t get it (supernumerary time). The lack of continuity affected her development and blew her confidence.

The length of supernumerary time varied, mainly from two to six weeks. One-third of key informants noted that the supernumerary time had been flexible to allow for differing needs, and to make sure that the new graduate felt safe. This was to everyone’s benefit in the long term. As one key informant respondent stated:

They have as long as they need until they are safe. The first two [new graduates] had six weeks each and were amazing after that. It might cost a bit up front but it’s so worthwhile. It should be at least a month for both rotations. After two weeks, they were petrified, but after six weeks they were wonderful. It paid dividends. (Clinical charge nurse)

A further 18 percent of key informants had not observed this flexibility, but thought it was essential for those who might need more support, as discussed above. It might also be appropriate to shorten it if a new graduate is clearly ready.

Designated preceptors

Key informants were asked for their views on the contribution that designated preceptors made to the development of new graduate nurses’ clinical practice. Virtually all (92 percent) of the key informants thought that preceptorship was a very effective means of developing new graduate nurses’ clinical practice. Several respondents (predominantly from one pilot area) noted, however, that preceptorship was not always undertaken by one designated preceptor.

The majority of key informants commented on the benefits of having one preceptor for each rotation. Nearly half (49 percent) of key informants made comments connected with the stability provided by having one designated preceptor. New graduates knew that there was someone there for them whom they could approach for support. Having someone available whom they could trust removed much of the anxiety of their new roles.

One-third of key informants thought that continuity was very important in preceptorship. A designated preceptor could take an overview of the new graduates’ development, monitor progress, identify strengths and weaknesses and set goals for future work. Having only one preceptor also meant that repetition could be avoided.

Just over a quarter (28 percent) of key informants highlighted the benefits for new graduates of being able to develop a relationship with one person over a period of time. This was likely to improve communication and learning.
At Provider Y, several key informants mentioned that after the supernumerary time it was not always possible to designate one particular preceptor to a new graduate, mainly because of staffing pressures. In these cases there was always a senior nurse on the shift who had responsibility for the new graduate. Other individuals – such as the team leader, the clinical nurse educator or the programme co-ordinator – took an overview of the new graduate’s development. The following comments highlight the tensions between the needs of the service and the preceptoring needs of the new graduate:

All senior nurses should do it [preceptoring] – it’s more sustainable if it’s a shared responsibility, but it’s harder to work out if it’s happening. In an ideal world it would be fabulous [to have one designated preceptor], but we need flexibility to deal with the real world.

The team offers preceptorship day to day, including the Clinical Nurse Educator and the Clinical Charge Nurse, but one person would be the preferred model.

6. Clinical practice

Expectations of the clinical environment

General expectations

Around three-quarters (78 percent) of new graduate respondents at the start of the programme agreed or strongly agreed that ‘each clinical environment (would) provide opportunities to develop knowledge and practice without risk to patients and/or self’. A similar proportion (70 percent) of the end-of-programme new graduate respondents agreed or strongly agreed that this had been the case. The equivalent figures for the three sites were broadly similar, with one exception: Provider Z new graduate respondents expectations at the start of the programme were much higher, with 92 percent agreeing or strongly agreeing with this statement.

Table 13: ‘Each clinical environment will provide/provided opportunities to develop knowledge and practice without risk to patients and/or self’ (new graduate respondents)

<table>
<thead>
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<td>Don’t know / not stated</td>
<td>1</td>
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</tbody>
</table>

Did new graduates’ clinical workload enhance their learning?

Three-quarters of new graduate respondents at the start of the programme expected a clinical workload that would enhance rather than interfere with their learning experience. By the end of the programme only 62 percent of new graduate respondents agreed or strongly agreed that their workload had enhanced rather than interfered with their learning.
Table 14: ‘My clinical workload will enhance/enhanced rather than interfere(d) with my learning’ (new graduate respondents)

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</tr>
<tr>
<td>Don’t know / not stated</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

The responses from the three sites were quite different. At Provider Z, 95 percent of new graduate respondents agreed or agreed strongly with this statement, but by the end of the programme this figure had dropped to 59 percent. A similar proportion (56 percent) of Provider Y’s end-of-programme new graduate respondents thought that their clinical workload had enhanced their learning, but in this case, expectations had been at a similar level (57 percent). At Provider X, both the expectations and the final rating regarding this statement were higher than average (87 percent and 71 percent, respectively).

Rotations

Choice of clinical areas

Most new graduate respondents (88 percent) said that they had two clinical placements in a hospital setting during the course of the programme. A further 5 percent had two main placements, plus a one-week community placement, while 4 percent of new graduate respondents reported only one clinical placement. Most (83 percent) of the new graduate respondents said that they had input regarding the choice of clinical areas for their rotations.

Over half of new graduate respondents had been allocated their preferred areas for both rotations, and a further 27 percent had been assigned their preference in one of their rotations. There was little variation across the three providers on this issue.

Table 15: Were you allocated your preferred clinical area? (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>58</td>
</tr>
<tr>
<td>Yes for one rotation, no for the other</td>
<td>27</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
</tr>
<tr>
<td>Not stated</td>
<td>3</td>
</tr>
</tbody>
</table>
Among those new graduates who had at least one placement in a clinical area that was not their initial preference, the majority (9 out of 10) thought that the experience gained in these areas was still useful to them. This was generally the case across all areas, although to a lesser extent in Provider X (8 out of 10), compared with 9 out of 10 of this group of Provider Y new graduate respondents, and all of this group at Provider X.

Table 16: Were the experiences gained in areas that were not initial preferences still useful? (new graduate respondents)

<table>
<thead>
<tr>
<th>% End-of-programme respondents who worked in a clinical area that was not an initial preference (n = 46)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Not stated</td>
</tr>
</tbody>
</table>

Most useful aspects of rotations

New graduate respondents were asked what was most useful about having rotations. Three-quarters welcomed the opportunities to learn different skills, and to have broader and more varied clinical experiences. Fourteen percent commented on the value of being exposed to different nursing perspectives and ward cultures. Eleven percent thought that rotations helped with decisions about their future career by exposing them to more possibilities. Five percent of new graduate respondents appreciated the challenge of having to adapt to a new environment: ‘Learning continues as you are still on your toes/active, without there being a chance to become too comfy in one area’.

Least useful aspects of rotations

In contrast, 54 percent of new graduate respondents thought that the least useful aspect of rotations was having to move on just as they were starting to feel confident and useful, and knew how things worked in their first placement: ‘At six months you began to just feel basic skills are developed and you feel comfortable and comfortable in the ward’. The challenge of change was not welcome, and was seen as disruptive and stressful. These respondents did not appreciate ‘having to start all over again’.

Four percent of respondents thought that the rotations had been too short (the second rotation had been 10 weeks long for most of these respondents). Four percent thought there had been insufficient support.

How could rotations be improved?

There were relatively few suggestions for improving the rotation system: only 25 percent of new graduate respondents made comments. Eight percent of respondents thought that more support was needed, 4 percent wanted more involvement in the choice of rotations, and 4 percent wanted longer rotations. Other suggestions included (made by one respondent each):
• define learning objectives/expectations more clearly
• make the study day tie in with rotation (i.e., surgical day for people who are doing surgical placements at the time)
• start orientation book for the second rotation during the first rotation
• talk to other graduates who have been where you are going.

Programme co-ordinator perspective on rotations
All of the programme co-ordinator respondents thought that the rotations were useful in developing the clinical practice of new graduates, and identified the following benefits:
• broadening of clinical experience and skill
• consolidation of undergraduate knowledge
• having placements that complement each other
• exposure to different ward environments, cultures and management styles
• increased confidence among new graduates
• negotiating with the new graduate to meet their longer-term goals.

The main perceived problem associated with rotations was the transition between the two placements. Programme co-ordinator respondents commented that some new graduates were reluctant to move on once they were settled in their first placement: ‘They don’t want to go back to being the new person’.

Rotations did not work well if a clinical area experienced difficulties with skill mix and support structures. It was not always possible to roster the new graduate with the preceptor, thus limiting the time that they could spend together.

Programme co-ordinators suggested the following improvements to the planning and management of rotations.
• Have dedicated new graduate vacancies that the co-ordinator can fill.
• Confirm both rotations at the start of the programme.
• Ensure that placements complement each other.
• Encourage new graduates to take annual leave between placements.
• Improve communication with charge nurses and managers.
• Provide ongoing training for preceptors and charge nurses.
• Raise awareness of the programme throughout the hospital, particularly with regard to the importance of all staff being part of the process, not just the preceptor.
Key informant perspective on rotations

The vast majority (87 percent) of key informants thought that rotations had been an effective way of developing the clinical practice of new graduate nurses. The reasons for this were as follows.

- Rotations provided a broad range of clinical experience (56 percent of respondents).
- New graduates had to step out of their comfort zones – many didn’t want to go at first, but most enjoyed it once they had made the move (33 percent).
- New graduates had the opportunity to put theory into practice in different areas, and to consolidate knowledge (21 percent).
- In the second rotation new graduates needed much less support, settled more quickly and became effective sooner (21 percent).
- Rotations helped with career decisions and future flexibility (18 percent).

As mentioned above, most new graduates had two rotations, and the majority of these were similar in length (around five to six months). Some new graduates were placed in a home ward and had a 10–12-week rotation in another ward. Fifty-six percent of key informants thought that six months was an adequate length for rotations, although most thought that this was a minimum length. New graduates were only just starting to settle in to the team and become confident at around three months, and needed the rest of the time for consolidation.

A small number of respondents had some criticisms of rotations.

- In some highly complex areas (such as intensive care units) it would be better to stay for the whole year, as there is too much to learn in any shorter period. If new graduates are to spend only six months in such areas, this should not be the first rotation (8 percent of respondents).
- Other team members lose new graduates just as they are becoming effective (8 percent).
- Some areas are broad enough to provide a range of experiences – in these cases, rotations are not necessary (5 percent).
- Six months is not long enough to consolidate skills (5 percent).

Study days

Virtually all new graduate respondents (99 percent) stated that the programme offered regular study days (one day per month in two areas, and one day per fortnight in the third area). According to the programme co-ordinators, these were rostered in at the beginning of the year, so that there was no question of nurses not being released to attend them. Just under one-third of new graduate respondents did not state whether they had been released to attend these days. This could be because it was not necessary to negotiate this time. Of those who did reply (69 percent), almost all (67 percent) said that they had been released to attend these days.

Just over a quarter of new graduate respondents (28 percent) mentioned that they had been released to attend other teaching sessions (such as ward teachings). This figure rose to 42 percent in Provider X and dropped to 13 percent at Provider Z. Twenty-seven percent of Provider Y new graduate respondents mentioned the availability of clinical release for other teaching sessions.
There was little difference between the expectations at the start of the programme and the rating at the end of the programme regarding the availability of clinical release time for educational purposes. Eighty-seven percent expected that this would happen, and 85 percent agreed or strongly agreed that it had. There were no marked variations across the three sites regarding this issue.

Table 17: ‘I will receive/received clinical release time to attend educational components/formal tutorials/assist with guided self-assessment’ (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 145)</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>45</td>
<td>46</td>
</tr>
<tr>
<td>Agree</td>
<td>42</td>
<td>39</td>
</tr>
<tr>
<td>Neutral</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

Most new graduate respondents (84 percent) found the teaching sessions useful. From the nature of the comments regarding this issue, it appears that the vast majority of these respondents were referring to the formal study days (rather than any other teaching sessions) when answering this question. New graduate respondents were asked why the teaching sessions were useful. The main reasons given were:

- the opportunity to gain new knowledge and skills (31 percent of new graduate respondents)
- being able to relate the knowledge acquired at these sessions to their practice (18 percent)
- the opportunity to refresh or consolidate knowledge (10 percent).

Table 18: Were the teaching sessions useful? (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>86</td>
</tr>
<tr>
<td>Sometimes</td>
<td>6</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
</tr>
</tbody>
</table>

Negative comments (made by only 11 percent of new graduate respondents) related mainly to the perception that study days were repeating previous learning or were too basic (8 percent), or were irrelevant to their practice (3 percent).

**Key informant perspectives on clinical release time for educational purposes**

Two-thirds of key informants thought that clinical release time for study days had been an effective means of developing the new graduates’ clinical practice. It was seen as essential to be able to step back and assess experiences. For example: ‘If they don’t have this, they get sucked into doing without focusing on the reasons for doing’.
The other main benefits of the study days were:

- learning new knowledge and clinical skills
- being able to relate new knowledge and skills to a practical work setting
- peer support and networking
- a forum for questions and exchanging ideas.

Clinical release time for study days was guaranteed and had been rostered in from the start of the programme. Release time for other educational purposes (such as reflection sessions or time off the ward with their preceptor) was less uniformly available, as already noted. Several key informants thought that release time of this nature was far more vulnerable to the day-to-day pressures of the ward. For example:

- new graduates might feel guilty about leaving their patients
- other staff might make a fuss about their going
- release time would be planned, but would be the first thing to be cut in times of service pressure.

7. Conflict resolution and cultural safety

Conflicts and complaints

New graduate perspective

Thirteen percent of new graduate respondents stated that they had been involved in a conflict or complaint. Only one-third of these related to the new graduates’ interactions with other staff. For example:

- Staff personalities (vertical violence) and unfair allocation of workload. Discussed with the Charge Nurse at times, otherwise it was left alone.
- Moving to a ward that didn’t really appear to want new grads or new staff although they were extremely short-staffed. I spoke to the charge nurse and programme coordinator.

Preceptor perspective

Sixteen percent of preceptor respondents stated that they had been involved in a conflict or complaint. Preceptors described the complaints and how they had resolved them as follows:

- Conflict of new graduate with other staff member. Discussed and set as a goal for improvement and better team/colleague working together.
- Very minor, re person’s general approach, the professionalism upheld. Discussed how to see both sides of what was happening and mediate.
- New graduate felt orientation was inadequate (due to busy ward and lack of senior staff). Charge Nurse handled situation so new graduate was aware of lines of authority, therefore individual performance plan initiated.
Other staff expressed concern as to ‘team spirit’ potential of one of the new grads. I was able to identify the fact that new grad needed assistance in prioritising care – was rushing to do everything and thus had been perceived as working only for her patients. Put in place strategies to help.

New graduate obvious feelings of not coping/stress after a busy weekend duty. Talking with new graduate, encouraging confidence in own abilities.

**Cultural sensitivity and support**

**New graduate perspective**

Seventy-one percent of new graduate respondents said that they had been given access to information and resources to help them meet the needs of Māori patients and their whānau. Only 42 percent of new graduate respondents at Provider X stated this to be the case, compared with 85 percent at Provider Y and 75 percent at Provider Z. The main stated sources for this information were study days (mentioned by 25 percent of new graduate respondents) and various forms of written information such as leaflets, ward folders and policies (mentioned by 18 percent).

All of the 10 new graduates respondents who identified as Māori had been offered cultural support in their role as a registered nurse. Details of this support (where reported) were as follows:

- invited to meetings (two respondents)
- met with cultural facilitator (one respondent)
- met with Māori support group (three respondents)
- had cultural supervision study day (two respondents).

The main perceived benefit of cultural support was the availability of a supportive environment in which to discuss concerns. Other comments about benefits included: ‘Easily contactable and approachable and interested in improving the system’, and ‘I could provide better care’.

Two respondents reported that they did not access the support that they had been offered. Two respondents mentioned that the cultural support only became available towards the end of the programme.

Suggestions for improving the provision of cultural support included:

- raising the profile of cultural support (three respondents)
- ensuring that cultural support is in place at the start of the programme (three respondents)
- provide cultural support more regularly.
**Preceptor perspective**

Sixteen percent of preceptor respondents stated that they were given access to information and resources to help them meet the needs of Māori new graduates. By provider, the proportions were: 26 percent at Provider Y, compared with 11 percent and 9 percent at Providers X and Z, respectively. Fifty-seven percent of preceptor respondents said they were not provided with any such information or resources because they had not preceptored any Māori new graduates (53 percent at Providers X and Y, and 73 percent at Provider Z).

**Cultural supervisor’s perspective**

For all three providers, structured cultural support was being offered to Māori new graduates for the first time. The support models and processes were therefore being developed as the programme progressed.

At Provider X the new graduates who identified as Māori were offered cultural support, but none took up the offer. They had been offered cultural supervision, the opportunity to meet and/or work with other Māori staff, and mentoring. Clinical release time had been available for these activities.

At Provider Y the cultural supervisor:

- held a monthly meeting with Māori new graduates
- negotiated clinical release time as required
- ensured that Māori new graduates were aware of Māori events
- talked regularly to each Māori new graduate
- arranged organisational support (such as e-mail)
- was available to give advice or answer queries.

At Provider Z a monthly meeting was held with the Māori new graduates. At first there was no dedicated time for cultural support within the programme. This meant that meetings in the first half of the year took place in the lunch hour. In the second rotation Māori new graduates had a study day together, during which they drafted recommendations for improving cultural support within the organisation.

Cultural supervisors identified the following benefits of cultural support for Māori new graduates:

- the knowledge that there is someone to turn to for support
- support in dealing with other people’s expectations that they will know about all Māori issues
- identifying and networking with other Māori nurses
- peer support
- the opportunity to debrief, share experiences and find solutions to problems
- the opportunity to discuss and plan for professional and career development.
Cultural supervisors highlighted the following problems associated with the provision of cultural support:

- lack of dedicated time for cultural support activities
- lack of understanding of what cultural support is and why it is important.

The cultural supervisor at Provider Z outlined the key recommendations of the study day for Māori new graduates:

- provides clinical and cultural support for Māori new graduates to ensure safe and competent practice and to retain their identity and integrity as Māori
- puts strategies in place so that Māori nurses are able to support Māori new graduates in the clinical setting and reduce feelings of isolation
- puts strategies in place to enable Māori new graduates to feel culturally safe in the clinical setting and the wider organisation.

8. The participants assess the pilot programme

The new graduates’ assessment

Level of confidence

New graduates’ confidence in their own nursing practice was markedly higher at the end of the programme compared with at the start of the programme. As Table 19 below shows, the vast majority (87 percent) of new graduate respondents rated their confidence as either good or excellent at the end of the programme, compared with only one-third of the start of the programme. Only 13 percent of new graduate respondents at the end of the programme rated their confidence as average (neither good nor bad) compared with over half of the new graduate respondents at the start of the programme. None of the new graduates rated their confidence as poor at the end of the programme. The equivalent figure for the start of programme was 9 percent.

The overall trend was similar in all three sites, although there were some marked differences. At the start of the programme just over a quarter of new graduate respondents in Provider Y rated their confidence as good or excellent, compared with 43 percent of Provider X and 39 percent of Provider Z new graduate respondents. At the end of the programme confidence was much higher in all three providers. At Provider X, almost all new graduate respondents (97 percent) rated their confidence as good or excellent. The equivalent figures for Providers Y and Z were 83 percent and 84 percent, respectively.
Table 19: New graduates’ level of confidence in their clinical practice, start and end of programme

<table>
<thead>
<tr>
<th>Rating</th>
<th>% Start-of-programme respondents (n = 145)</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>Good</td>
<td>32</td>
<td>73</td>
</tr>
<tr>
<td>Average</td>
<td>52</td>
<td>13</td>
</tr>
<tr>
<td>Poor</td>
<td>9</td>
<td>0</td>
</tr>
</tbody>
</table>

The reasons given for the confidence ratings at the end of programme included:

- the availability of good support and guidance, and knowing how and when to access this support (about half of those who rated their confidence as ‘excellent’, and one in five of those who rated their confidence as ‘good’)
- practice had improved greatly over the course of the programme: ‘I know what I’m doing and why’ (just over one in three of those rating their confidence as ‘excellent’, and two in five of those who had rated their confidence as ‘good’)
- there is still a lot to learn: ‘It takes time to develop confidence, and I will always be adding to it’ (around one in four of those who had rated their confidence as ‘good’).

A small number (4 percent) of new-graduate respondents rated their confidence as good, but stated that various aspects of the programme had interfered with their learning. These included a lack of orientation, insufficient preceptor support, a very heavy workload and the need to start all over again in the second rotation.

The most useful aspects of the programme

At the end of the programme new graduate respondents were asked to identify which aspects of the programme had been most useful for developing their practice. Some respondents mentioned more than one aspect of the programme. Over half mentioned the study days. Being released from ward duties to look at specific topics relating to clinical practice was seen as very beneficial – whole days away from the ward were seen as more useful than a few hours at a time.

One-third of new graduate respondents thought that the support they received contributed greatly to the development of their practice. Half of this group (17 percent of all new graduate respondents) specifically mentioned support from preceptorship. Respondents appreciated the guidance, feedback, reflection and teaching provided by their preceptors. The remainder of this group (also 17 percent of all new graduate respondents) commented on the support of the programme in general, or from other individuals or groups, including their peers, the programme co-ordinators, clinical nurse educators and clinical charge nurses.

Thirteen percent of new graduate respondents stated that the hands-on clinical practice had contributed to their development.
Least useful aspects of the programme

New graduate respondents were asked to comment on the elements of the programme that had been least useful to the development of their clinical practice. Less than half (44 percent) of them answered this question. Just under one-third (30 percent) commented on study-related issues. Half of this group thought that the study days had been the least useful aspect of the programme. Some thought that they repeated work that had been covered by their degree; others commented that they were too basic or irrelevant to their practice: ‘We have just finished a three year degree programme and the information was really nothing new. I would like to be extended in my learning’. The other half of the group thought that the written assignments and extra study constituted too much extra work.

Six percent of new graduate respondents thought that their clinical workload was too heavy, and a further 6 percent commented that there had not been enough support, including feedback on and evaluation of their progress.

Next steps

Nearly three-quarters of new graduate respondents planned to stay working for the DHB where they had undertaken the programme. Over two-thirds of this group (52 percent of all new graduate respondents) stated that participation in the programme had influenced their decision to stay. The two main reasons given for this decision were:

- the programme allowed new graduates the opportunity to try out different areas and identify where they wanted to work (16 percent of new graduate respondents)
- the new graduates had felt supported and had had positive experiences during the programme (10 percent).

Table 20: Do you plan to continue working at this District Health Board? (new graduate respondents)

<table>
<thead>
<tr>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Don’t know</td>
</tr>
</tbody>
</table>

Just under a quarter of new graduate respondents were not planning to continue working for the DHB where they had undertaken the programme. Most of these (16 percent) were planning to go overseas. One respondent was taking a break to reassess, and one was planning to leave nursing altogether. Half of those planning to leave the DHB (10 percent of all new graduate respondents) stated that participating in the programme had influenced their decision to leave. For those going overseas, some mentioned that the programme had given them the confidence to follow their plans and a better idea of the field they wanted to work in.
Table 21: Did participating in the programme influence your decision? (new graduate respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents deciding to stay at DHB (n = 85)</th>
<th>% End-of-programme respondents deciding to leave DHB (n = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>71</td>
<td>48</td>
</tr>
<tr>
<td>No</td>
<td>28</td>
<td>48</td>
</tr>
<tr>
<td>Not stated</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

The preceptors’ assessment

Overall expectations of the programme

At the end of the programme around 60 percent of preceptor respondents agreed or strongly agreed that their overall expectations of the programme had been met. The equivalent proportions at Provider X were much higher than those of the other two providers: 79 percent of Provider X preceptor respondents agreed or strongly agreed that their overall expectations of the programme had been met, compared with 42 percent of Provider Y preceptor respondents and 55 percent of Provider Z preceptor respondents.

Table 22: ‘The programme met my overall expectations’ (preceptor respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>6</td>
</tr>
<tr>
<td>Agree</td>
<td>53</td>
</tr>
<tr>
<td>Neutral</td>
<td>20</td>
</tr>
<tr>
<td>Disagree</td>
<td>14</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>6</td>
</tr>
</tbody>
</table>

Effectiveness of the programme

Nearly all (95 percent) of the preceptors surveyed at the start of the programme agreed or strongly agreed that the programme was a safe and effective way to support new graduates to develop competencies in clinical practice. The proportion of respondents who either agreed or agreed strongly with this statement was very similar across the three providers, although there were differences in the strength of agreement. At Provider Y, 41 percent of preceptor respondents agreed, and 55 percent strongly agreed with this statement, compared with 68 percent of Provider Z respondents who agreed and only 26 percent who strongly agreed with this statement.
Similarly, most preceptors surveyed at the end of the programme (86) agreed or agreed strongly that the programme was a safe and effective way to support new graduates to develop competencies in clinical practice (55 percent and 31 percent, respectively). The findings were more positive at Provider X, where 95 percent of preceptor respondents agreed or agreed strongly with this statement, and less positive at Provider Z, where 73 percent of preceptor respondents agreed or agreed strongly with the statement.

**Table 23:** ‘The programme is/was a safe and effective way to support new graduates to develop competencies in clinical practice’ (preceptor respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 77)</th>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>42</td>
<td>31</td>
</tr>
<tr>
<td>Agree</td>
<td>53</td>
<td>55</td>
</tr>
<tr>
<td>Neutral</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

At the end of the programme 86 percent of preceptor respondents agreed or strongly agreed that the clinical practice of the new graduates had improved as a result of preceptorship. There was no marked difference on either of these issues at the three providers.

**Table 24:** ‘The clinical practice of new graduates improved as a result of preceptorship’ (preceptor respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>33</td>
</tr>
<tr>
<td>Agree</td>
<td>53</td>
</tr>
<tr>
<td>Neutral</td>
<td>4</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know / not stated</td>
<td>8</td>
</tr>
</tbody>
</table>

**Opportunities to practise leadership and teaching skills**

The vast majority (93 percent) of preceptors surveyed at the start of the programme agreed or strongly agreed that the programme would provide an opportunity for them to practise their leadership and teaching skills. The combined figures for ‘agree’ and ‘agree strongly’ were broadly similar across the three providers. The proportion who strongly agreed with the statement, however, was greater at Providers Y and Z (63 percent and 66 percent respectively) than at Provider X (45 percent).
Table 25: ‘The experience will provide/provided an opportunity to practise my leadership and teaching skills’ (preceptor respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 77)</th>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>57</td>
<td>45</td>
</tr>
<tr>
<td>Agree</td>
<td>36</td>
<td>51</td>
</tr>
<tr>
<td>Neutral</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

This view was echoed at the end of the programme, when 96 percent of preceptor respondents agreed or strongly agreed with this statement. At Providers X and Z, all of the preceptor respondents agreed or strongly agreed with this statement. The equivalent proportion at Provider Y was slightly lower (90 percent), but this was still a large majority.

At the end of the programme the majority (84 percent) of all preceptor respondents agreed or strongly agreed that their skills and abilities as preceptors had increased as a result of the programme.

Table 26: ‘My skills and abilities as a preceptor have increased as a result of the programme’ (preceptor respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>33</td>
</tr>
<tr>
<td>Agree</td>
<td>51</td>
</tr>
<tr>
<td>Neutral</td>
<td>10</td>
</tr>
<tr>
<td>Disagree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4</td>
</tr>
</tbody>
</table>

Other benefits for preceptors

At the end of the programme preceptors were asked what else they thought they had gained from participating in it. Only 49 percent made any additional comments. These are summarised below.

- Benefits to their own nursing practice: for example, the programme had given them the opportunity to reflect on and question their own practice and to consolidate their knowledge. Some commented that their confidence had increased as a result of being a preceptor, and that their profile within the team had been raised (33 percent of preceptor respondents).
- Satisfaction of passing on knowledge and skills to the new graduate: they found the experience rewarding and interesting (14 percent).
- Learning from the fresh ideas and knowledge of the new graduates (10 percent).
There were only two negative comments (4 percent of preceptor respondents). These related to the added workload and stress, and the lack of rostered time with their preceptee.

**Information provided to preceptors**

At the start of the programme only 51 percent of preceptor respondents thought that the information given to them made them feel confident about their role as preceptors. Opinions at the different providers varied quite widely. At Provider X, 66 percent of preceptor respondents agreed or strongly agreed with this statement, compared with only 37 percent at Provider Z and 45 percent at Provider Y.

Twenty-two percent of preceptor respondents did not think that the information given to them at the start of the programme made them feel confident about their role. Only 7 percent of Provider X preceptor respondents disagreed that the information given to them made them feel confident about their role as preceptors, compared with 32 percent of Provider Z respondents and 31 percent of Provider Y respondents who disagreed or strongly disagreed.

**Table 27:** ‘The information given made me feel confident about my role as a preceptor in the First Year of Clinical Practice Programme’ (preceptor respondents)

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 77)</th>
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</thead>
<tbody>
<tr>
<td>Strongly agree</td>
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<tr>
<td>Agree</td>
<td>38</td>
</tr>
<tr>
<td>Neutral</td>
<td>25</td>
</tr>
<tr>
<td>Disagree</td>
<td>18</td>
</tr>
<tr>
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<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
</tr>
</tbody>
</table>

At the end of the programme, 59 percent of preceptor respondents agreed or agreed strongly that the programme co-ordinator had provided them with adequate information about the programme. Sixty-eight percent of Provider X preceptor respondents agreed or strongly agreed with this statement, compared with 53 percent and 55 percent of preceptor respondents at Providers Y and Z, respectively. Nearly one-fifth (18 percent) of all preceptor respondents disagreed or disagreed strongly with this statement.

Very few preceptor respondents made suggestions about any further information about the programme that would be helpful. Suggestions included:

- feedback from preceptees about preceptors
- contact details of other preceptors for networking purposes
- more specific information about paperwork requirements.
Table 28: ‘The programme co-ordinator provided me with adequate information about the programme’ (preceptor respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>18</td>
</tr>
<tr>
<td>Agree</td>
<td>41</td>
</tr>
<tr>
<td>Neutral</td>
<td>20</td>
</tr>
<tr>
<td>Disagree</td>
<td>14</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>4</td>
</tr>
<tr>
<td>Not stated</td>
<td>2</td>
</tr>
</tbody>
</table>

Did training prepare preceptors for their role?

At the end of the programme two-thirds (65 percent) of preceptor respondents agreed or strongly agreed that the preceptor training had provided them with adequate information about their role. At Provider X, 58 percent of preceptor respondents agreed or strongly agreed with this statement, compared with 73 percent of Provider Z respondents and 69 percent of Provider Y respondents. Only 8 percent of all preceptor respondents disagreed or disagreed strongly with this statement.

Table 29: ‘Preceptor training provided me with adequate information about my role’ (preceptor respondents)

<table>
<thead>
<tr>
<th></th>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>14</td>
</tr>
<tr>
<td>Agree</td>
<td>51</td>
</tr>
<tr>
<td>Neutral</td>
<td>20</td>
</tr>
<tr>
<td>Disagree</td>
<td>6</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know / not stated</td>
<td>4</td>
</tr>
</tbody>
</table>

Forty percent of the preceptor respondents took the opportunity to make suggestions as to what should be included in the preceptor training programme. Suggestions included:

- behaviour management, including performance management, managing challenging behaviour, and conflict resolution (14 percent of preceptor respondents)
- how to undertake appraisals and assessments, and goal-setting (10 percent)
- more information about the expectations of the programme (8 percent)
- workload management strategies (8 percent).
Nearly two-thirds (64 percent) of key informants thought that preceptor training made an effective contribution to the development of new graduates’ clinical practice. The main benefits highlighted were that:

- the training had provided an opportunity for preceptors to develop or consolidate teaching and learning skills (36 percent of key informant respondents)
- preceptors gained a better understanding of what was expected of them (10 percent).

A small number (8 percent) of key informants thought that the training had been too basic or too generic, and needed to be tailored to the needs of new graduate nurses. Eight percent of key informants noted that preceptors also learned a great deal about preceptoring by actually doing it.

Support for preceptors

The majority of preceptor respondents (86 percent) thought that other team members had supported them in their role as preceptor. This proportion rose to 95 percent and 91 percent at Providers X and Z respectively, and fell to 74 percent at Provider Y. The majority of preceptor respondents (86 percent) also thought that clinical charge nurses had supported them in their role as preceptor. There was little variation between providers on this issue.

Support from programme co-ordinators was less evident, with just over half of preceptor respondents (53 percent) feeling that the programme co-ordinator had provided support. This proportion rose to 79 percent at Provider X, and fell to 26 percent at Provider Y. Forty-one percent of preceptor respondents thought that the programme co-ordinator had not supported them in their role. This perception was most common at Provider Y, where 63 percent of preceptor respondents felt that they had not been supported in their role by their co-ordinator, compared with only 16 percent of preceptor respondents at Provider X.

The programme co-ordinators’ perspective

The majority (five out of six) of programme co-ordinator respondents stated that they had been adequately supported in this role. Providers of support included:

- director of nursing
- senior managers/nurse leaders
- professional development co-ordinator
- regional programme coordinator
- other programme co-ordinators
- clinical nurse educators
- clinical nurse specialists
- clinical charge nurses.

One respondent noted that it had taken much consultation and careful communication to gain ‘buy-in’ from the clinical charge nurses.
Programme co-ordinators made the following suggestions for improving the way in which their role was supported:

- regular meetings with directors of nursing, other senior nurses, and other co-ordinators, to discuss issues and promote understanding of the role
- more time and resources.

**Overall perceived benefits of the programme**

**Benefits for new graduates**

The vast majority (86 percent) of preceptor respondents, most programme co-ordinator respondents and all key informants commented on the benefits of a structured and supportive environment. The programme provided, for example:

- a safe environment in which the new graduates could start to apply theory to practice with the support of senior nurses
- the opportunity to make the transition safely from student to registered nurse
- increased support while they were building confidence and consolidating their skills
- essential knowledge for those working in paediatrics that was not covered at undergraduate level.

As one respondent stated:

> It provides a safe working environment for nurses who are beginning practitioners. It encourages their independence in problem-solving, research, reflective practice, also setting them up to succeed in all the skills and competencies they will need to become expert. (Preceptor respondent)

Key informants commented, for example, that learning was more likely to occur in such an environment, and that support was not dependent on the good will of the ward.

Eighteen percent of all preceptor respondents commented on the preceptor relationship. They felt that the new graduates had benefited from the individual attention and support from their preceptor, and from the continuity of that support. New graduates had been able to observe and learn from the preceptor, and develop their practice with one-on-one support. One preceptor respondent commented:

> If preceptor/graduate relationship is good, this method provides strong support for the new graduate and a safe place to discuss concerns and express ideas without fear of appearing foolish, while developing their own nursing skills and style.

Eighteen percent of preceptor respondents and one-third of the key informants mentioned that the educational opportunities had been of benefit to the new graduates. The knowledge gained from study days was also seen as valuable for other team members. Programme co-ordinators identified increased study leave, structured study days and self-directed learning as benefits of the programme for new graduates.
Twelve percent of preceptor respondents, half of the programme co-ordinator respondents, and one in four key informants mentioned the sound clinical skills and a broad knowledge base that new graduates had developed through participating in the programme.

**Benefits for preceptors**

Just over one-third of key informants thought that participation in the programme challenged the clinical practice of preceptors in a beneficial way. It encouraged preceptors to formalise their thinking and update their skills. Having to teach someone else meant that they had to be very clear about what they were doing and why.

One-third of key informants and half of the programme co-ordinator respondents thought that the programme provided good personal development opportunities for preceptors. For example, they were able to acquire or improve their teaching and leadership skills. Other benefits mentioned included:

- training and support for preceptors
- formalising and officially recognising the preceptor role – their work was more likely to be acknowledged and valued, thus improving morale
- the satisfaction of contributing to the new graduate’s development and growing confidence
- learning from the new graduate, and extending and consolidating their knowledge and skills.

**Benefits for other team members**

About one in five (18 percent) of preceptor respondents and one-third of key informants thought that other team members had benefited from the new ideas and fresh perspectives of the new graduates. Programme co-ordinator respondents also commented that new graduates contributed new experiences to the team from their previous rotation.

Twelve percent of preceptor respondents and 20 percent of key informants thought that the programme provided opportunities for other team members’ knowledge base and professional standards to be challenged, thus extending their nursing practice and their way of thinking. One-third of programme co-ordinator respondents made similar comments.

Twelve percent of preceptor respondents and 20 percent of key informants thought that the formal support structure for new graduates was helpful for other team members too. For example, there was less pressure on them, and they knew whom to approach if there were any problems. One programme co-ordinator respondent commented that other team members were reassured that appropriate support and teaching was being provided to new graduates.

Twelve percent of preceptor respondents and 15 percent of key informants thought that other team members had gained a better understanding of the new graduates’ situation, needs and abilities. Twelve percent of preceptor respondents and 10 percent of key informants thought that the new graduate had become an effective team member more quickly because of the support they received, thereby easing the pressure on other team members.
Other benefits of the programme for other team members mentioned by a small number of key informants included:

- an opportunity to observe the new graduates’ development (13 percent of respondents)
- an opportunity to assess the new graduate for future employment possibilities (10 percent).

**Benefits for patients**

Nearly one-third (31 percent) of preceptor respondents and a quarter of key informants made comments relating to the new graduates’ enthusiasm, fresh outlook and willingness to spend more time with the patient. For example:

They have a nurse fresh in their practice, still being supported and guided in their practice, looking after them. (Preceptor respondent)

Half of the programme co-ordinator respondents also commented on the benefits to patients of motivated and enthusiastic nurses.

The second most common theme related to patient safety. Twenty-two percent of preceptor respondents, half of the programme co-ordinator respondents and two in five key informants highlighted the benefits to the patient in this area. The support from the programme had meant that the new graduate could practise with more confidence and provide safer, higher-quality healthcare. As one key informant respondent noted, ‘The patient is protected from inexperienced decision-making’.

On a similar theme, 10 percent of preceptor respondents and one in five key informants thought that patients would have been reassured by the existence of formal support for the new graduate. One programme co-ordinator respondent also mentioned access to the most up-to-date nursing theory as a benefit to patients.

**Benefits for the health service**

The two main perceived benefits were recruitment and retention. Thirty-five percent of preceptor respondents thought that new graduates would be more likely to stay working at the DHB (or in New Zealand nursing positions generally) if they had felt supported and valued in their first year of clinical practice. Most of the programme co-ordinator respondents mentioned the positive impact of the programme on the retention of nurses within the health service.

One-third of preceptor respondents felt that the programme helped with recruitment. It provided a pool of experienced, skilled and confident nurses to choose from, in a shorter time frame than would have been the case without the programme. Some programme co-ordinator respondents mentioned that the programme was a good investment in future staffing. For example: ‘New graduates are the future Clinical Nurse Leaders, Managers, Educators and experienced practitioners’.

As with the other two groups of respondents above, key informants identified the main perceived benefits of the programme for the health service as being the positive impact on recruitment and retention. Four-fifths of key informants made comments on this theme, echoing the comments of preceptors. For example: ‘Without the programme they will flounder and leave’.
Overall perceived negative effects of the programme

Negative effects for new graduates

Twenty-nine percent of preceptor respondents, 10 percent of key informants and one programme co-ordinator respondent thought that preceptoring difficulties might have had a negative impact on new graduates. Respondents highlighted, for example, insufficient preceptoring after the initial supernumerary time due to being on separate shifts or being in pressured, understaffed environments. In some cases preceptoring after the initial orientation period was not occurring at all. If the new graduate’s preceptor changed, the lack of continuity was seen by some to be unhelpful. Settling in time was seen as inadequate in some cases.

Sixteen percent of preceptor respondents and 10 percent of key informants thought that the study workload had been too intensive, on top of the pressures of starting work. It was suggested that too much was expected, especially straight after a degree. The fact that the academic component of the programme was not nationally recognised was thought by some to make it less valuable for new graduates.

Some new graduates seemed to find it hard to move to their second clinical placement, although most appeared to appreciate the move once they had done it (13 percent of key informants and 4 percent of preceptor respondents).

Programme co-ordinator respondents also mentioned that some new graduates had unrealistic expectations of themselves and the clinical placements they wanted, and that there had been increased stress to achieve competencies and other programme requirements.

Negative effects for preceptors

Programme co-ordinators’ and key informants’ views on the negative effects of the programme for preceptors mainly related to the increased workload and increased demands on the preceptors’ time. Half the programme co-ordinator respondents and nearly half the key informants made comments along these lines. Preceptors had to cope with their own patient load as well as being responsible for the new graduate. As one key informant respondent stated:

It’s stressful, especially if you’re not very senior yourself – you have responsibility for a new practitioner as well as your own practice. It’s tiring – you put in a lot of effort, and relationships are not always straightforward.

A connected issue was preceptor burn-out. Thirteen percent of key informants made comments on this theme. The stress of preceptoring could reduce the future pool of possible preceptors, and put even more pressure on those remaining to undertake more, and eventually burn out.

Preceptors were perceived as experiencing some frustration if they were unable to perform their role as they saw it, as a result of pressures on the clinical floor, poor skill mixes, sickness, etc. This impaired their ability to pick up problems as they occurred.
Negative effects for other team members

The main area of comment here related to the extra pressure of having to support new graduates on top of a heavy workload. Thirty-nine percent of preceptor respondents made comments of this nature (58 percent of Provider Y respondents, compared with 26 percent of Provider X and 27 percent of Provider Z respondents), as did half of the programme co-ordinator respondents and two-fifths of key informants.

Respondents mentioned, for example, that other team members had to take on increased workloads until the new graduates were up to speed. Supporting new graduates was seen to be very time consuming for other team members, especially when the preceptor was not on the same shift. Staff shortages and low skill mixes exacerbated these difficulties. As one programme co-ordinator respondent noted: ‘Sickness, skill mix, annual leave and study leave can impact on enthusiasm for sharing clinical knowledge’.

Negative effects for patients

Only 22 percent of preceptor respondents commented on any possible negative effects of the programme for patients (32 percent at Provider Y, compared with 16 percent and 18 percent at Providers X and Z, respectively). Only a quarter of key informants made comments about negative effects on patients.

Fourteen percent of preceptor respondents and 10 percent of key informants thought that new graduates’ lack of confidence and limited people skills could make patients feel nervous. A minority of preceptor respondents (6 percent) thought that patient safety could be affected if adequate support was not available. Five percent of key informants thought that patients might be adversely affected if the new graduate didn’t ask when unsure about something: ‘The new graduates who seek help are the safest. The ones who don’t seek help are a risk’ (Key informant respondent).

None of the programme co-ordinator respondents thought that there had been any negative effects of the programme for patients.

Negative effects for the health service

Only 18 percent of preceptor respondents made any comments about possible negative effects of the programme for the health service itself. The main perceived adverse effect was that the new graduates would go overseas after the programme (8 percent of preceptor respondents).

No programme co-ordinator respondents thought that there had been any negative effects of the programme for the health service. One respondent commented that this was due to the funding provided: ‘Without funding the impact would be huge’.

Just over half the key informants thought that there had been no negative effects of the programme for the health service. The main perceived negative effect mentioned was cost. Fifteen percent of key informants (in two of the three pilot areas) raised financial issues. One area had received CTA funding for only 40 percent of its new graduate nurses but had provided the programme for all of them. The second area had provided more study days than had been required by the programme specification.
A small number of key informants raised the following issues:

- the difficulty in planning for future programmes, with no certainty about future funding, and the loss of momentum if programmes cannot continue (8 percent of respondents)
- the staffing pressures to cover supernumerary time and study days, when bureau staffing is in short supply – especially in winter (5 percent of respondents)
- the investment in new graduates who then leave to go overseas (5 percent of respondents).

**Overall perceived effectiveness of the programme**

**Programme co-ordinator perspective**

Five out of the six programme co-ordinator respondents thought that, overall, the programme had met their expectations. The sixth respondent thought the programme had met her expectations as far as the formal education components were concerned, but felt that there had been a lack of support for new graduates in the wards. The comments made by those whose expectations had been met included the following.

- High standard of practice achieved and reflected in the nurses.
- Comprehensive programme that I can see reflected in the way in which new graduates have developed professionally over the year.
- Tremendous change in the confidence of new graduates (decision-making and articulating themselves with patients and colleagues).
- The programme provided the structure and support required to ensure that graduate nurses were able to consolidate skills and knowledge and that they could feel safe doing so.

**Key informant perspective**

Ninety percent of key informants thought that, overall, the programme had been effective in developing the clinical practice of new graduate nurses. Many respondents reiterated their answers to previous questions about particular aspects of the programme. These will not be repeated here. Some respondents gave examples of indicators that demonstrated the effectiveness of the programme, including:

- observations that new graduates had developed, gained confidence and become well-rounded practitioners who made a contribution to the team
- positive reports from new graduates themselves on how their practice had changed and developed, and on the skills and knowledge that they had gained
- other colleagues’ reports of their increasing confidence in the new graduates
- an excellent retention rate during the course of the year
- interest from the next cohort of new graduates to join the programme (and a waiting list to join in one area)
- nurses were staying on after the programme.
Clinical assessments
At this point it is worth including the results of the clinical assessments of new graduates, using the tool developed by the Nursing Council:
- at Provider X all new graduates passed all the assessment points
- at Provider Y all except one new graduate passed all assessment points
- at Provider Z all except one new graduate passed all assessment points.

Suggested improvements to the programme

New graduate perspective
At the end of the programme just over one-third (37 percent) of new graduate respondents made suggestions as to how the programme could be improved. About half of these (18 percent of new graduate respondents) commented on the educational aspects of the programme. Ten percent suggested improvements in the study days, including avoiding repetition of issues covered at degree level, linking the study days to clinical skills and applications, and running separate study days for those doing surgical and those doing medical placements. Eight percent wanted fewer written assignments (eg, case studies or portfolio work).

Thirteen percent of new graduates thought that the programme would be improved by increasing the amount of support available. This included more allocated time with the preceptor, more support from the programme co-ordinators, and strategies for dealing with the stress of shift work and study.

Preceptor perspective
About one-third of preceptor respondents made suggestions as to how the programme could be improved. Twelve percent of respondents wanted more guaranteed release time with new graduates (eg, for evaluation, performance reviews, questions and special skills). Eight percent identified a need for greater clarity on the expectations of the preceptor, including a formal structure/definition for the preceptor/preceptee relationship over the whole period of the rotation.

Programme co-ordinator perspective
Programme co-ordinator respondents made the following suggestions for improving the programme:
- more preceptor training and support
- more joint release time for the new graduate and preceptor
- ensure there is adequate time to reflect on practice and experience as new graduates move through the programme
- more time for the programme co-ordinator role.
Key informant perspective

The main area for improvement raised by key informants related to support for new graduates. A quarter of key informants made suggestions of this nature, including:

- more supernumerary time
- an unrostered day for the preceptor and new graduate at the start of each placement
- more protected time with the preceptor
- more time for debriefing, reflection and clinical supervision.

Fifteen percent of key informants made suggestions related to study days, suggesting:

- fewer study days
- more clinical/hands-on study days
- more emphasis on tutorial and reflection time.

Other suggested improvements included:

- increased training, support and recognition for preceptors (10 percent of respondents)
- further development of the primary health care aspect of the programme (10 percent)
- national standardisation of the programme to allow for transferability and to link it to a nationally recognised qualification (5 percent)
- employ the new graduates to the programme rather than each clinical area, so that staffing numbers on education days are not affected (5 percent).

Differences between the pilot programme and previous new graduate programmes

All three pilot providers had some form of provision for their new graduates’ first year of clinical practice. Key informants were asked to comment on the main differences between the current and previous programmes. The difference mentioned most frequently by key informants (26 percent) was the extent of the programme. In two of the pilot areas the pilot programme was now being run across the DHB in a co-ordinated way, instead of being in one hospital only or having different systems in different hospitals, as had happened previously. The fact that it was part of a national programme had increased its profile.

Eighteen percent of key informants mentioned a change in the provision of educational support. The number of study days had increased, along with an increase in funded release time. Fifteen percent of key informants also noted that the pilot programme was more formalised and structured than previous programmes. Thirteen percent of key informants commented on a strengthened preceptor role, including more training and formal recognition.
Final comments

New graduates

About one-third of new graduate respondents took the opportunity to make final comments. Half of these commented positively, and half negatively. On the positive side, respondents talked about a great, well-organised programme with good support. For example:

This is an excellent programme – I have had lots of support from teams from each ward and Clinical Nurse Educators, and programme co-ordinator.

I enjoyed the programme – knowing and associating with colleagues, sharing similar experiences in first year of practice is invaluable.

On the negative side, respondents thought that there was not enough support. For example:

I was led to believe when I joined the programme that our transition to RN would be supported. Instead, I’ve found that we are basically on our own and some of us have been left to flounder. This hospital in particular does not provide enough support for working parents. I’ve found my first 10 months very stressful and I’ve felt unsupported much of the time.

Preceptors

About two-fifths of preceptor respondents took the opportunity to make final comments. The vast majority of these were positive. For example:

I think the course is a great thing – a positive learning experience for both the new graduate and the preceptor. It challenges me as a preceptor to examine my practice more critically to ensure I am an effective role model, nurse and colleague, and this is a good thing.

Very effective programme – filling in a gap in the transitional stage from theory to clinical that was previously an unmet need.

Great to have the programme – it made a difference to the level of care being provided.

Some of the preceptors made comments about suggested improvements; for example:

I’m looking forward to the New Graduate Programme with more 1:1 RN : New Graduate ratio, so my preceptoring ability can be developed better. It’s difficult to accurately assess a preceptee if more than one or two nurses are responsible for the new graduate. The new graduates are the RNs of the future and I’m all for encouraging their development for their personal satisfaction and for staffing levels at the hospital.

Recognition of and reward for preceptors’ considerable time and energy commitment is needed.

I think new graduates should spend their first year in clinical practice in a more general ward area. As this area is a specialty, it doesn’t give new graduates enough time to consolidate their learning.
Programme co-ordinators

Only two of the programme co-ordinators made any final comments:

The First Year of Clinical Practice Programmes are essential for graduate nurses, employers and clients to provide support and high-quality care and to ensure a safe environment for staff and clients.

I believe that what I do makes a difference to the transition of the graduated nurse to the practising registered nurse role, and that has an impact directly on patient care, quality, decreased risk and cost savings.

Key informants

Around one-third of the key informants made final comments, the vast majority of which were positive. Comments included the following:

This is the most beneficial and forward thinking initiative to come out of CTA.

I advocate that it continues in the strongest terms.

Great programme – I wish I could have done it when I was a new graduate.

The programme is critical to retention – to ensuring that new graduates stay in nursing.

The First Year of Clinical Practice Programme needs to be seen as an extension of training, rather than the start of work as a fully practising registered nurse.

The programme has responded to a gap but we need to address the gap from the undergraduate end too.

What are the critical elements that develop practice? New graduates need to be supported and not feel out of their depth. The named preceptor is one way but not the only way.

New graduates should be funded as extras if patient care isn’t to be affected.

It is a positive programme but we need more support to support them.
Part III: Conclusions and Recommendations

9. Conclusions

Prior to the introduction of the First Year of Clinical Practice Pilot Programme, new graduate programmes for nurses did exist in some hospitals, but the form of support varied and some hospitals did not have any such programmes. The pilot programme was run across all the participating DHBs in a co-ordinated way. At some providers, the number of study days was greater than it had been previously, and there was an increase in funded release time. The pilot programme was more formalised and structured than previous programmes had been, and had a strengthened preceptor role, including more training and formal recognition.

Many aspects of the pilot programme were implemented successfully. Rotations worked well for the most part, and feedback on their effectiveness was predominantly positive. The main difficulty with rotations was the transition period between placements. Extra support around this period may be necessary. Some highly complex areas (such as intensive care units) were not thought to be suitable for placements of anything less than a year.

Release time for study days was guaranteed, and on the whole these days were thought to be an effective way of developing the clinical practice of new graduate nurses. A small number of respondents thought that the content was too basic or not relevant. The content of some study days may need to be reviewed to ensure that they are relevant and extend learning.

Release time for other educational purposes (such as reflection) was not uniformly available. This was not necessarily a budgetary issue, but appeared to be more a function of busy environments and heavy workloads, which made it difficult for new graduates to leave the ward. Protected time off-ward with preceptors may need to be investigated as an option.

For all three providers, structured cultural support was being offered to Māori new graduates for the first time. The support models and processes were therefore being developed as the programme progressed. Cultural support was generally perceived as being helpful, but the fact that it was in a development stage meant that little was available at the start of the programme. At one provider a set of recommendations for cultural support was drawn up. These are discussed in the following section.

New graduates gained a great deal from preceptorship, but it proved to be the hardest element of the programme to implement. The difficulties appeared to relate mainly to the tension between the need to provide service in an already overstretched environment, and the need to support new graduates.

The supernumerary period at the start of each clinical placement appeared to be working reasonably well. After this time new graduates’ contact with their preceptors, either on or off the ward, was variable. As other research has concluded (Hancock 2002), commitment for preceptorship needs to extend beyond the initial supernumerary period if new graduates are to experience its full benefits. Throughout the placement new graduates need to have sufficient contact with their preceptors, both on and off the ward, to facilitate learning and development.
At one provider some new graduates did not have one designated preceptor: the preceptoring function was undertaken by several different people. The benefits of continuity and consistency, as discussed above and in the international literature (Myrick 2002; Dyson and Thompson 1996) would not be felt in these circumstances.

A substantial proportion of preceptor respondents felt that they had not received adequate support. Many felt unable to perform their role adequately because of the pressures of all their other responsibilities. Similar findings were also reported by Dibert and Goldenberg (1995, cited in Allen 2002 and O’Malley et al 2000), who warn that increasing demands on experienced practitioners who already have extensive responsibilities increases the possibility of burn-out.

At one provider, all registered nurses above a certain level were expected to be available for preceptoring. Respondents made the point that preceptors need to be willing and motivated to undertake the role if they are to be effective. They also need to see the benefits for themselves. Other research has found that preceptors are more likely to be committed to the role when they perceive the rewards to be personally worthwhile or professionally beneficial (O’Mara and Welton 1995, cited in Wright 2002). A number of studies (Wright 2002; Brennan and Williams 1993; Cerinus and Ferguson 1993, cited in Allen 2002) maintain that it is important to set up situations that enhance positive attitudes towards preceptorship, such as preparation for the role, support from other staff members, reduced clinical workload, and opportunities for career advancement.

Despite the difficulties experienced with preceptoring, the overall view was that this had been an effective programme. Clearly the support provided to many of the new graduates and preceptors could have been better. Nevertheless, it appears that many new graduates did benefit from the structured educational opportunities, the varied clinical experiences and the generally supportive environment of the pilot programmes. Confidence levels were high among new graduates at the end of the programme, and actual clinical assessments reflected this confidence.

The health service appeared to benefit too: the majority of new graduates planned to stay at the DHB where they had undertaken the programme, many of whom cited the programme as influencing their decision. The pilot programme’s positive contribution to the development of new graduate nurses is a long way from the ‘sink or swim’ environment of the past.

10. Recommendations

If the First Year of Clinical Practice Programme for New Graduate Nurses is to be extended throughout the country, certain changes are needed. The following recommendations arise out of the respondents’ own suggestions.

Rotations

The support needs of new graduates around the transition period between placements need to be assessed, and measures put in place to assist in the smooth transition from one rotation to the next.
**Educational components**

Some study days may need to be reviewed to ensure that they are relevant and pitched at the right level.

**Cultural support**

Cultural support for Māori new graduates was being developed during the course of the programme. The following recommendations were drafted by Māori new graduates at Provider Z.

- Clinical and cultural support for Māori new graduates should be provided to ensure safe and competent practice and to retain their identity and integrity as Māori.

- Strategies should be put in place so that Māori nurses are able to support Māori new graduates in the clinical setting and reduce feelings of isolation.

- Strategies should be put in place to enable Māori new graduates to feel culturally safe in the clinical setting and the wider organisation.

**Preceptorship**

Clarification is needed regarding the role and responsibility of the preceptor in the following areas.

- The preceptoring responsibility should extend beyond the supernumerary period, and last for the duration of the placement.

- New graduates should have the same preceptor throughout the placement, so that an ongoing mentoring relationship can occur.

- A minimum length should be specified for the supernumerary time, but flexibility (in both directions) should be encouraged.

- New graduates should have regular opportunities to work with their preceptor after the supernumerary period.

- There should be some reduction in workload beyond the supernumerary period for preceptors and new graduates, to allow for teaching and learning on the ward.

- There should be protected time off the ward to enable preceptors and new graduates to work together on reflection, assessment, goal-setting, evaluation, etc.

**Support for preceptors**

- Selection processes for preceptors need to ensure that only motivated and willing candidates take on the role.

- Preceptors need to be recognised and valued for the contribution that they make to the development of new graduates, and supported accordingly.

- More extensive training programmes should be developed to ensure that preceptors are well prepared for their role.
References


Appendix 1: Specification for a Pilot First Year of Clinical Practice Nursing Programme

1.0 Preamble

The Ministry of Health notes the Ministerial Taskforce on Nursing’s recommendation that a national framework for what should constitute the first year of nursing clinical practice for new graduates should be developed.\(^3\)

New graduate education needs a unique curriculum model that reflects the intent to socialise new graduate nurses into a registered nursing role and to develop their practice and thinking skills to effectively practise as a registered nurse. This requires a process, practice centred curriculum that develops confidence and effectiveness in the individual’s nursing practice, independence in clinical reasoning / decision making, and acceptance of the responsibility of the registered nurse.

Teaching and learning activities need to be grounded in practice experience. While clinical practice is the key experience required in new graduate programmes, methodologies that develop the inquiry, problem-solving ability and reasoning needed to manage clinical problems are a useful theoretical component. Case reviews and problem-based learning are examples of such methodologies. The theoretical aspects of the programme must not repeat the content learning of the pre registration programme but rather emphasise the application and use of knowledge in clinical situations.

Clinical educators and preceptors need to be skilled in accessing and influencing the thinking ability of the nurse and must recognise how knowledge is affected by contextual factors. Preparation of preceptors and clinical educators is crucial for the success of the programme.

1.1 General principles and assumptions surrounding the development of a national framework and the first year of nursing clinical practice

- Purchasing will be aligned to the DHBs rather than the hospitals so that nurses have the opportunity to practise in both the community (ie, publicly funded health services with a contractual relationship with a DHB) and hospital settings.
- All new graduates will have a reduced clinical workload. The workload will be shared between preceptor and new graduate.
- The preceptor to new graduate ratio will be no more than 1:2.
- The new graduate programme will allow for ‘timeout’ from the clinical setting equal to a minimum of two days every two months or one day per month to provide consolidation of specific areas, such as time management, ethical issues, positive cultural reflection, skill development, clinical assessment, and clinical decision-making.
- The programme will integrate the principles of the Treaty of Waitangi into practice to promote equity of outcomes for Māori and facilitate practice in a culturally safe manner with all client groups.

• The new graduates will not be prevented from concurrently participating in other graduate programmes.

1.2 Overall aims of the programme

• The first year of nursing clinical practice pilot programme will reflect a national framework on nursing workforce development.
• To ensure all new graduates have access to a supported environment in their first year of clinical practice.

The programme must be approved by the Nursing Council against the Entry to Speciality Nursing Practice Programmes (May 2001) standards and this programme specification. First Year of Nursing Clinical Practice Programmes will enable new Graduates to work in more than one specialty area.

2.0 Description of services

Programmes will be designed specifically for new graduates of New Zealand comprehensive nursing courses to develop the specific knowledge and skills required of a beginning practitioner role and include preceptorship.

2.1 Learning environment

2.1.1 Clinical placement

• A minimum of two and a maximum of three rotations in two scopes of practice, eg, child health and medicine. Areas to be negotiated between the employer and each new graduate. New graduates or DHBs who wish to complete one rotation in a scope of practice will be considered on a case by case basis.
• Preceptor and new graduate to share a clinical load for a designated period of time. This will be a graduated process determined by mutual agreement between the new graduate and preceptor. The time may also vary between service areas.
• Both community (ie, publicly funded health services with a contractual relationship with a DHB) and hospital placements to be encouraged.
• Flexibility for individual negotiation and provision of options for placement are needed (community and hospital).
• Programme to allow for ‘release from clinical practice’ which is equal to a minimum of two days every two months or one day each month to provide consolidation of specific areas, such as time management; ethical issues; skill development; clinical assessment; clinical decision-making; patient follow-ups including community visits, tutorials, and guided reflection.
• Regular clinical feedback will be provided by the preceptor and other clinical staff who may assist the new graduate in tutorials, guided reflection, etc.
2.1.2 Clinical experience

The programme will normally be of 12 months maximum duration with the possibility that some new graduates may meet programme outcomes and complete the programme earlier. It is expected that the minimum duration will be nine months.

2.2 Preceptorship

2.2.1 Clinical preceptorship

Clinical preceptorship and support will be undertaken by nominated experienced registered nurses that have undertaken preceptorship training. Preceptors will require regular and consistent access to the new graduate during clinical practice.

The preceptor will be supported within the programme by a reduced clinical load, provision of continuing education and peer review by the programme co-ordinator.

Each new graduate nurse will have a named preceptor to avoid the new graduate being left alone on shift. Characteristics of a preceptor should include:

- Registered Nurse (RCpN, RGON, RPN, RGN) with a current annual practising certificate
- an ability to apply adult teaching and learning principles, eg, facilitation of critical and reflective practice
- knowledge and understanding of concepts and applications of preceptorship
- a demonstrated commitment and willingness to support and encourage a new graduate through their role as a preceptor
- experience within a scope of practice where they are providing preceptorship
- evidence of positive role modelling
- a commitment to provide (to the new graduate) and receive (from the programme co-ordinator) peer review.

2.2.2 Tikanga tiakitanga (cultural supervision)

Cultural supervision recognises that nursing practice takes place within a social context and that for new Māori graduates there is an important relationship between the clinical application of skills and knowledge, their experience of health in a Māori context and the their cultural identity. These relationships should be explored and reconciled with the assistance of a supervisor/mentor who are both clinically and culturally competent in Te Ao Māori. The role of the supervisor is to help the new Māori graduate understand and integrate his/her role and responsibilities as a clinician and expectations regarding kawa, tikanga and te matauranga hauora.

2.3 Programme co-ordination

The programme co-ordinator will be a senior experienced nurse with recent clinical experience. Key competencies for this role include:

- recent clinical practice, ie, within the last 12 months
- clinical teaching/facilitation of clinical learning
- organisational skills
• understanding of adult teaching and learning needs
• good communication and interpersonal skills.

Programme co-ordination tasks include:
• involvement in the recruitment and selection of preceptors
• facilitation of ongoing placements for new graduates
• planning and negotiating new graduate rotations
• co-ordination of clinical teaching
• liaison with the clinical areas where new graduates are employed
• record keeping, including administration of evaluation tools
• interpersonal and group skills including mediation and relationship management between the perceptor and trainee
• development and management of a quality improvement plan
• competency assessment.

2.4 Expected outcomes

2.4.1 Trainee outcomes

Outcomes:
• to be able to practice confidently and safely as a Registered Nurse
• to meet competencies as approved by the Nursing Council Framework
• ready for Level 2 on a clinical career path (if available)
• effective teamwork:
  – learning how to work in a practice environment
  – working in a multidisciplinary team.

Vehicles to demonstrate outcomes:
• performance review process
• documentation of placement experience
• documentation of learning experiences
• a specified number of case reviews
• guided self-reflection
• regular preceptor feedback
• regular feedback from professional nurse leader in clinical setting
• a specified number of patient assessments and care evaluations
• evidence of clinical judgement
• attainment of competencies for Entry to Specialty Nursing Practice (First Year).

The new graduate will receive a Entry to Specialty Practice (First Year) certificate approved by the Nursing Council from the District Health Board.

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4 These competencies are to be developed with pilot programme providers.
2.4.2 Client/service outcomes
The new graduate will contribute to enhance client and service outcomes including appropriate and effective nursing care including:
- nursing assessment
- planning
- implementation
- evaluation of clients’ care needs
- co-ordination of clients’ care needs.

The new graduate programme will demonstrate measures taken to create a safer environment for new graduates to consolidate their practice and that will minimise risks to client safety.

The new graduate programme will encourage the retention of new graduates in the New Zealand health sector.

3.0 Eligibility
3.1 Trainee eligibility
For new graduates to be eligible for Clinical Training Agency (CTA) funding, the new graduate shall:
- have registration as a nurse from a three year New Zealand nursing programme or course congruent with the Nurses Act 1977 and subsequent amendments; and
- have evidence of a current annual practising certificate; and
- be currently employed as a registered nurse within publicly funded health services at a minimum 0.8 FTE employment; and
- have not practised as a registered nurse for longer than six months; and
- complete the programme within a minimum of 9 months and a maximum of 12 months.

3.2 Provider eligibility
The programme must be approved by the Nursing Council against the standards for Entry to Specialty Nursing Practice Programmes and this specification.

4.0 Location and setting
The clinical component will be offered predominantly within the new graduate’s employment environment.

5.0 Associated linkages
Providers will have established links with:
- patient advocates for Code of Health and Disability Services Consumers Rights and Privacy issues
- local iwi
• other relevant national professional nursing organisations.

6.0 Purchase unit and reporting unit

6.1 Purchase unit
A FTE new graduate who meets the eligibility criteria set out Section 3.1 and who is formally enrolled in the training programme.

Part-time new graduates who are funded under this specification will be funded on a pro-rata FTE basis.

6.2 Reporting unit
A new graduate’s progress in relation to the expected outcomes.

7.0 Quality standards: programme specific

This section should be read in conjunction with Section F of the standard CTA contract document, which specifies generic quality standards for all programmes provided under the contract.

7.1 Preliminary evaluation
To be developed in conjunction with the selected pilot programme providers, the CTA and the Nursing Council.

7.2 New graduate outcomes
A plan for the assessment of each new graduate’s performance and progress will be developed by the CTA and the pilot programme providers in close association with the Nursing Council, before the pilot programme commences. This will provide a base line established from the preliminary assessment of the new graduate’s entry level of clinical competence, and provide a platform for ongoing monitoring as well as final assessment and overall programme evaluation.

The assessment plan shall allow for guided self-assessment, clinical preceptor assessment, and cultural supervision where appropriate.

7.3 Programme evaluation
The evaluation criteria for the pilot first year of clinical nursing practice programmes will be developed by the CTA in close association with the pilot programme providers and the Nursing Council. The criteria will be in place before pilot programmes commence.

It is envisaged that the evaluation criteria will:
• monitor the applicability of the clinical programme and its effectiveness
• monitor and assess clinical preceptorship outcomes utilising feedback from trainees, preceptors, and programme co-ordinators
• include input from Māori, Pacific peoples, and other appropriate cultural advisors regarding demonstration of the programme’s ability to meet the cultural needs of both trainees and clients
• include input from other members of the health care team
• include additional relevant measures and variables yet to be agreed.

7.4 Client/service outcomes
A process will be implemented for measuring the effectiveness and efficiency of the programme. It will include the impact of the programme on:
• recruitment and retention of the new graduate nurse workforce
• integration within the multi-disciplinary team
• the role of the new graduate nurse in the nursing workforce
• performance against client and service outcomes as noted in 2.4.2 above
• support of new graduates in their first year of clinical practice.

8.0 Reporting requirements: programme specific
This section should be read in conjunction with Section E of the CTA contract document which specifies generic reporting requirements for all programmes provided under the contract.

Reporting formats and variables are to be developed by the CTA and the pilot programme providers in close association with the Nursing Council.
Appendix 2: Demographic Details of Respondents (New Graduate Programme Participants and Preceptors)

Table A1: New graduate demographics

<table>
<thead>
<tr>
<th></th>
<th>% Start-of-programme respondents (n = 145)</th>
<th>% End-of-programme respondents (n = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work setting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tertiary teaching hospital</td>
<td>81</td>
<td>89</td>
</tr>
<tr>
<td>Provincial hospital</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Community hospital</td>
<td>0</td>
<td>3</td>
</tr>
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<td>Not stated</td>
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<td>7</td>
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<tr>
<td><strong>Age</strong></td>
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<td></td>
</tr>
<tr>
<td>Under 20</td>
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<td>0</td>
</tr>
<tr>
<td>20–24 years</td>
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<td>25–29 years</td>
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<td>18</td>
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<td>40–44 years</td>
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<td>7</td>
</tr>
<tr>
<td>Over 45 years</td>
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<td>3</td>
</tr>
<tr>
<td>Not stated</td>
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<td>6</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>89</td>
<td>90</td>
</tr>
<tr>
<td>Male</td>
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<td>5</td>
</tr>
<tr>
<td>Not stated</td>
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</tr>
<tr>
<td><strong>Ethnicity</strong></td>
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<td></td>
</tr>
<tr>
<td>New Zealand European/Pākehā</td>
<td>77</td>
<td>73</td>
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<tr>
<td>Other European</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>New Zealand Māori</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Samoan</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other Pacific Island groups</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Southeast Asian</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Chinese</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Indian</td>
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<td>2</td>
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<td>Other</td>
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<tr>
<td>Not stated</td>
<td>3</td>
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</tr>
</tbody>
</table>
Table A2: Preceptor demographics

<table>
<thead>
<tr>
<th>Work setting</th>
<th>% Start-of-programme respondents (n = 77)</th>
<th>% End-of-programme respondents (n = 49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary teaching hospital</td>
<td>90</td>
<td>94</td>
</tr>
<tr>
<td>Provincial hospital</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Community hospital</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time working as a registered nurse</th>
<th>% Start-of-programme respondents</th>
<th>% End-of-programme respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 12 months</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>1–5 years</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>6–10 years</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>11–15 years</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Over 15 years</td>
<td>32</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First nursing qualification</th>
<th>% Start-of-programme respondents</th>
<th>% End-of-programme respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-based training (registered nurse)</td>
<td>38</td>
<td>29</td>
</tr>
<tr>
<td>Hospital-based training (enrolled/community nurse)</td>
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<td>8</td>
</tr>
<tr>
<td>Diploma of Nursing (comprehensive)</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td>Bachelor’s Degree in Nursing</td>
<td>21</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-entry nursing qualifications</th>
<th>% Start-of-programme respondents</th>
<th>% End-of-programme respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bachelor’s Degree in Nursing</td>
<td>35</td>
<td>22</td>
</tr>
<tr>
<td>Post-entry certificate (700 level)</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Postgraduate certificate at Master’s level (800 level)</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>2</td>
</tr>
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</table>
Appendix 3: New Graduate Questionnaire – Start of Programme

**We need your help!** The purpose of this questionnaire is to assess whether the New Graduate First Year of Nursing Clinical Practice Pilot Programme supports New Graduates in their role as beginning practitioner. The information will be used as part of a wider evaluation of all pilot programmes.

All information will remain strictly confidential and only be used for this purpose. Please ensure you have read the Programme Specification attached before filling in the questionnaire. Please place your questionnaire in the envelope provided. You do not need to write your name on this form.

1(a) What opportunities will the programme offer you?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each clinical environment will provide opportunities to develop knowledge and practice without risk to patients/clients and/or self</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to a designated preceptor for an agreed period of time</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>A preceptor who will recognise my learning needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A preceptor who will use helpful strategies to help me meet my learning needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timely and appropriate feedback from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• preceptor</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clinical Charge Nurse</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>A clinical workload that will enhance, rather than interfere with, my learning experience</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Clinical release time to attend educational components/formal tutorials/ assist with self-guided assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Promote my professional development as a registered nurse</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

1(b) Are there any other opportunities that the programme offers you?

**Rotations**

2(a) What preferences did you have regarding clinical areas for your rotation?

2(b) Why were these clinical areas important to you?

2(c) What clinical practice areas were offered to you? (please specify areas, eg, medical, orthopaedic, not ward numbers)

2(d) Which clinical area are you now working in? (please specify areas, eg, medical, orthopaedic, not ward numbers)
2(e) Describe how your clinical placement was arranged with the Programme Co-ordinator?

2(f) Do you feel you were able to have input into the decision about your clinical placement?
   If yes – why?
   If no – why not?

**Preceptors**

3(a) What do you expect to gain by having preceptors?

3(b) What are your needs regarding clinical supervision?

**Role as a new team member**

4 What do you need from other nursing team members (other than preceptors)?

**Cultural supervision**

5(a) Were you given access to information and resources to help you better meet the cultural needs of Māori patients and their whānau?
   If yes – please specify

*For those trainees who identify as Māori answer question 5(b)–5(d). For all other trainees go to question 6(a).*

5(b) Have you been offered cultural support in your role as a registered nurse?

5(c) What do you think should be included in cultural support?

5(d) Who should (or does) provide cultural supervision?

**Self assessment of clinical practice**

6(a) At the beginning of the programme, how would you rate your level of confidence in nursing practice:
   1 Excellent
   2 Good
   3 Average – neither good or bad
   4 Poor
   5 Very poor

6(b) Please explain why you have rated it this way.
Now some questions about you ...

As part of the report we need to know a little about the people who are included in the sample. Only summarised data will be used in the final report and it will not be used to identify any individuals. If you do not wish to answer a question, just leave it blank, and go on to the next question.

7 Are you:
- ☐ Male
- ☐ Female

8 Age
- ☐ Under 20 years
- ☐ 20–24 years
- ☐ 25–29 years
- ☐ 30–34 years
- ☐ 35–39 years
- ☐ 40–44 years
- ☐ 45 years and over

Ethnicity

9 With which ethnic group or groups do you most closely identify? (Tick as many as apply.)
- ☐ NZ European
- ☐ NZ Māori
- ☐ Samoan
- ☐ Cook Island Māori
- ☐ Tongan
- ☐ Niuean
- ☐ Other Pacific
- ☐ South East Asian
- ☐ Chinese
- ☐ Indian
- ☐ Other (please specify)...................................................................................................

10 What best describes your work setting?
- ☐ Tertiary teaching hospital (eg, Auckland Hospital, Christchurch Hospital, Waikato Hospital)
- ☐ Smaller regional or provincial hospital (eg, Greymouth Hospital, Ashburton Hospital, Thames Hospital)
- ☐ Non-governmental agency (eg, iwi provider)
- ☐ Other (please specify)...................................................................................................

Thank you for taking the time to answer the questionnaire. Please place the questionnaire in the envelope provided.
Appendix 4: Preceptor Questionnaire – Start of Programme

We need your help! The purpose of this questionnaire is to assess whether the New Graduate First Year of Nursing Clinical Practice Pilot Programme supports New Graduates in their role as beginning practitioner. The information will be used as part of a wider evaluation of all pilot programmes.

All information will remain strictly confidential and only be used for this purpose. Please ensure you have read the Programme Specification attached before filling in the questionnaire. Please place your questionnaire in the envelope provided. You do not need to write your name on this form.

1(a) What opportunities will the programme offer you? (Please rate the following areas.)

<table>
<thead>
<tr>
<th>Rating scale: 1 = strongly disagree; 2 = disagree; 3 = neutral; 4 = agree; 5 = strongly agree; 6 = don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>This programme is a safe and effective way to support new graduates to develop competencies in clinical practice</td>
</tr>
<tr>
<td>The experience will provide an opportunity for me to practise my leadership and teaching skills</td>
</tr>
</tbody>
</table>

1(b) Are there any other opportunities that the programme will offer?

Selection as a preceptor
2(a) What processes were used to select you as a preceptor for this programme?

2(b) What personal qualities and experience do you think are essential to the role of preceptor?

Training as a preceptor
3(a) Please rate the level of information you received about the programme ...

<table>
<thead>
<tr>
<th>Rating scale: 1 = strongly disagree; 2 = disagree; 3 = neutral; 4 = agree; 5 = strongly agree; 6 = don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the information given make you feel confident about your role as a preceptor in the First Year of Clinical Practice Programme</td>
</tr>
</tbody>
</table>

3(b) What training did you receive to prepare you for taking on the role of preceptor?

3(c) Have you been offered any further support/training to assist you in your role as a preceptor?
   If yes – please specify.
Initial expectations

4. What were your initial expectations regarding preceptorship in terms of:
   (a) the existing level of clinical practice of new graduate nurses in this year’s programme?
   (b) whether you would be teamed up with a new graduate for the current clinical placement?
   (c) the number of new graduates you would be responsible for?
   (d) the support from the Programme Co-ordinator?
   (e) the support from other nursing team members in your direct clinical area?
   (f) other (please specify).

Relationship with Programme Co-ordinator / Charge Nurse

5. Were you given an opportunity at the beginning of the programme to clarify your expectation of the New Graduates’ level of practice with the Programme Co-ordinator or Charge Nurse?
   If yes – please specify.
   If no – why not?

6. Which staff member would you expect to manage the following:
   (a) the relationship between Preceptor and New Graduate?
      □ Programme Co-ordinator
      □ Charge Nurse
      □ Other (please specify) .................................................................
      Please comment.
   (b) Ensuring reduced clinical workloads are achieved to enable effective preceptorship?
      □ Programme Co-ordinator
      □ Charge Nurse
      □ Other (please specify) .................................................................
      Please comment.
   (c) Provision of peer review to support you in your role as a preceptor?
      □ Programme Co-ordinator
      □ Charge Nurse
      □ Nurse Educator
      □ Clinical Nurse Specialist
      □ Other (please specify) .................................................................
      Please comment.

Cultural supervision

7. Were you given access to information and resources to help you better meet the cultural needs of Māori New Graduates, eg, access to a tikanga tiakitanga?
   If yes – please specify.
   If no – why not?
Now some questions about you ...

As part of the report we need to know a little about the people who are included in the sample. Only summarised data will be used in the final report and it will not be used to identify any individuals. If you do not wish to answer a question, just leave it blank, and go on to the next question.

8 How long have you been working as a registered nurse?
- Less than 12 months
- 1–5 years
- 6–10 years
- 11–15 years
- Over 15 years

9 What best describes your \textbf{first} nursing or midwifery qualification?
- Hospital-based training – registered nurse (all categories)
- Hospital-based training – enrolled or community nurse
- Diploma of nursing – comprehensive
- Diploma in midwifery
- Degree in nursing
- Degree in midwifery
- Other (please state) ......................................................................................................

10 Do you hold any of the following post-entry nursing qualifications? (Tick all that apply.)
- Bachelor’s degree in nursing
- Post-entry certificate (level 700)
- Postgraduate certificate at Master’s level (level 800)
- Postgraduate diploma at Master’s level
- Master’s degree in nursing
- Doctorate in nursing
- Other – please state ...................................................................................................

11 What best describes your work setting?
- Tertiary teaching hospital (eg, Auckland Hospital, Christchurch Hospital, Waikato Hospital)
- Smaller regional or provincial hospital (eg, Greymouth Hospital, Ashburton Hospital, Thames Hospital)
- Non-governmental agency (eg, iwi provider)
- Other (please specify) ...................................................................................................

Thank you for taking the time to answer the questionnaire. Please place the questionnaire in the envelope provided.
Appendix 5: Programme Co-ordinator Questionnaire – Start of Programme

We need your help! The purpose of this questionnaire is to assess whether the New Graduate First Year of Nursing Clinical Practice Pilot Programme supports New Graduates in their role as beginning practitioner. The information will be used as part of a wider evaluation of all pilot programmes.

All information will remain strictly confidential and only be used for this purpose. Please ensure you have read the Programme Specification attached before filling in the questionnaire. Please place your questionnaire in the envelope provided. You do not need to write your name on this form.

1. Please outline your key competencies/experience in the following areas that are relevant to the position of Programme Co-ordinator:
   (a) Clinical practice experience
   (b) Academic qualifications
   (c) Clinical teaching/facilitation of clinical learning
   (d) Organisational skills
   (e) Understanding of adult teaching and learning needs
   (f) Good communication and interpersonal skills.

Task of Programme Co-ordinator

Planning rotations

2. What was the process used to select the area of the rotation with:
   (a) new graduates?
   (b) Clinical Nurse Managers?

Selection of preceptors

3(a) What personal qualities and experience do you think are essential to the role of preceptor?

3(b) What was the process used to select staff intending to become preceptors?

3(c) What was the process used to assign new graduates to preceptors?

Management of the programme

4(a) What processes are in place to ensure the roster of the preceptor and trainee are aligned at the start of each placement?

4(b) What processes are in place to ensure that clinical workload is reduced to enable preceptorship to occur during the clinical placement?

4(c) What processes are in place to ensure that clinical release occurs for new graduates to attend formal tutorial or other educational supports?
4(d) What processes are in place to ensure that new graduates receive adequate and timely feedback?

4(e) What processes are in place to ensure that preceptors receive adequate and timely feedback?

4(e) What processes are in place to deal with complaints or conflicts?

Relationship building to ensure the success of the programme

5 How have you built support for the programme with:
   (a) Clinical Nurse Managers/Charge Nurses?
   (b) Clinical Nurse Educators/Specialists?
   (c) Senior Nursing Management?
   (d) Interdisciplinary teams?
   (e) Other (please specify) ........................................................................................................

6(a) What cultural support is in place for new graduates in caring for Māori patient/clients?

6(b) What processes are in place to provide cultural supervision for Māori New Graduates (e.g., tikanga tiakitanga)?

Now some questions about you ...

As part of the report we need to know a little about the people who are included in the sample. Only summarised data will be used in the final report and it will not be used to identify any individuals. If you do not wish to answer a question, just leave it blank, and go on to the next question.

7 How long have you been working as a registered nurse?
   □ Less than 12 months
   □ 1–5 years
   □ 6–10 years
   □ 11–15 years
   □ Over 15 years

8 What best describes your first nursing or midwifery qualification?
   □ Hospital-based training – registered nurse (all categories)
   □ Hospital-based training – enrolled or community nurse
   □ Diploma of nursing – comprehensive
   □ Diploma in midwifery
   □ Degree in nursing
   □ Degree in midwifery
   □ Other (please state) ...........................................................................................................
9. Do you hold any of the following post-entry nursing qualifications? *(Tick all that apply.)*
- Bachelor’s degree in nursing
- Post-entry certificate (level 700)
- Postgraduate certificate at Master’s level (level 800)
- Postgraduate diploma at Master’s level
- Master’s degree in nursing
- Doctorate in nursing
- Other – please state ...................................................................................................

10. What best describes your work setting?
- Tertiary teaching hospital (eg, Auckland Hospital, Christchurch Hospital, Waikato Hospital)
- Smaller regional or provincial hospital (eg, Greymouth Hospital, Ashburton Hospital, Thames Hospital)
- Non-governmental agency (eg, iwi provider)
- Other (please specify)...................................................................................................

Thank you for taking the time to answer the questionnaire. Please place the questionnaire in the envelope provided.
Appendix 6: New Graduate Questionnaire – End of Programme

We need your help! The purpose of this questionnaire is to assess whether the New Graduate First Year of Nursing Clinical Practice Pilot Programme supports New Graduates in their role as beginning practitioners. The information will be used as part of a wider evaluation of all pilot programmes.

All information will remain strictly confidential and will only be used for this purpose. Please ensure that you have read the Programme Specification attached before filling in the questionnaire. Please place your questionnaire in the envelope provided. You do not need to write your name on this form.

1 How would you rate the programme?

<table>
<thead>
<tr>
<th>Please rate the statements below using the following scale.</th>
<th>1 2 3 4 5 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall the programme met all my expectations</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>Each clinical environment provided opportunities to develop knowledge and practice without risk to patients/clients and/or self</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>I had access to a designated preceptor for an agreed period of time</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>My preceptor recognised my learning needs</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>My preceptor used helpful strategies to help me meet my learning needs</td>
<td></td>
</tr>
<tr>
<td>I received timely and appropriate feedback from:</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>• preceptor</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>• Clinical Charge Nurse</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>• Programme Co-ordinator</td>
<td></td>
</tr>
<tr>
<td>My clinical workload enhanced, rather than interfered with, my learning experience</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>I received clinical release time to attend educational components/formal tutorials/assist with guided self-assessment</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>The programme promoted my professional development as a registered nurse</td>
<td>1 2 3 4 5 6</td>
</tr>
</tbody>
</table>

Self assessment of clinical practice

2(a) At the end of the programme, how would you rate your level of confidence in nursing practice?

1 Excellent
2 Good
3 Average – neither good or bad
4 Poor
5 Very poor

2(b) Please explain why you have rated it this way.
Preceptorship
3(a) Did your clinical workload allow time for preceptorship?
   - Yes If yes, what did preceptorship consist of?
   - No If no, why not?

3(b) Did you have a designated preceptor assigned for each rotation?
   - Yes
   - No If no, why not?

3(c) How many preceptees (ie, new graduates, nursing students, etc) was your preceptor responsible for?

3(d) What did you find most useful about having a preceptor?

3(e) What did you find least useful about having a preceptor?

3(f) Do you have any suggestion for improvements in the way preceptorship is provided in this programme?

Educational supports
4(a) Did the programme offer any teaching sessions?
   - No
   - Yes If yes, (i) how often did these sessions occur?
     (ii) how long were these sessions?

4(b) Did you have clinical release time to attend teaching sessions and guided self-assessment/reflection sessions?
   - Yes If yes, please specify amount of clinical release time
   - No If no, why not?

4(c) Did you find the teaching sessions helpful in developing your practice?
   - Yes If yes, why?
   - No If no, why not?

Conflicts or complaints
5 During the First Year of Clinical Practice Programme, were you involved in any conflicts or complaints?
   - No
   - Yes If yes (i) please specify:
     (ii) how was the complaint or conflict handled?

Rotations
6(a) Overall, do you feel you had input regarding the choice of clinical areas for your rotations?
   - Yes
   - No

6(b) How many clinical placements did you have and in which areas (please specify area, eg, medical, surgical)?
6(c) Did you get your preferred clinical areas for your rotations?
- Yes – all rotations in preferred areas
- Yes – for only one /some of the rotations
- No – none of rotations in preferred areas  Go to 6(e)

6(d) Were the experiences that you gained in clinical areas that were not your initial preferences, still useful to you?
- Yes
- No

6(e) What did you find most useful about having rotations?

6(f) What did you find least useful about having rotations?

6(g) Do you have any suggestions regarding improvements that could be made regarding rotations?

Cultural supervision
7 Were you given access to information and resources to help you better meet the cultural specific needs of Māori patients and their whānau?
- No
- Yes
  (i) please specify what was provided
  (ii) did you find it helpful for developing your practice with Māori patients/clients?

For those students who identify as Māori
8(a) Were you offered cultural support in your role as a registered nurse?
- No
- Yes
  If no – go to Q9
  If yes, please specify what was offered

8(b) What did you find most useful about having cultural support?

8(c) What did you find least useful about having cultural support?

8(d) What could be done to improve the provision of cultural support?

Overall programme
9(a) Which aspects of the programme were the most useful for developing your practice?

9(b) Which aspects of the programme were the least useful for developing your practice?

9(c) What (if anything) could be done to improve the programme?

Plans for the next 12 months
10(a) Do you plan to stay working for this District Health Board?
- Yes
  If yes, please specify in what area.
- No
  If no, what do you plan to do?
10(b) Did participating in this programme have any impact on making decisions about your employment for the next 12 months?

☐ Yes   If yes, why?
☐ No    If no, why not?

General comments
11 Do you have any other comments you would like to make?

Now some questions about you ...
As part of the report we need to know a little about the people who are included in the sample. Only summarised data will be used in the final report and it will not be used to identify any individuals. If you do not wish to answer a question, just leave it blank, and go on to the next question.

12 Are you:
☐ Male
☐ Female

13 Age
☐ Under 20 years
☐ 20–24 years
☐ 25–29 years
☐ 30–34 years
☐ 35–39 years
☐ 40–44 years
☐ 45 years and over

Ethnicity
14 With which ethnic group or groups do you most closely identify? (Tick as many as apply.)
☐ NZ European
☐ NZ Māori
☐ Samoan
☐ Cook Island Māori
☐ Tongan
☐ Niuean
☐ Other Pacific
☐ South East Asian
☐ Chinese
☐ Indian
☐ Other (please specify)........................................................................................................................................................................
15 What best describes your work setting?

☐ Tertiary teaching hospital (eg, Auckland Hospital, Christchurch Hospital, Waikato Hospital)

☐ Community hospital (eg, Rangiora, Kaikoura)

☐ Community trust

☐ Health centre

☐ Non-governmental agency

☐ Other (please specify)...................................................................................................

Thank you for taking the time to answer the questionnaire. Please place the questionnaire in the envelope provided.
Appendix 7: Preceptor Questionnaire – End of Programme

We need your help! The purpose of this questionnaire is to assess whether the New Graduate First Year of Nursing Clinical Practice Pilot Programme supports New Graduates in their role as beginning practitioners. The information will be used as part of a wider evaluation of all pilot programmes.

All information will remain strictly confidential and will only be used for this purpose. Please ensure that you have read the Programme Specification attached before filling in the questionnaire. Please place your questionnaire in the envelope provided. You do not need to write your name on this form.

1(a) How would you rate the programme?

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall the programme met all my expectations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The programme was a safe and effective way to support new graduates to develop competencies in clinical practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The experience provided an opportunity for me to practise my leadership and teaching skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My skills and abilities as a preceptor have increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The clinical practice of the new graduates has improved as a result of preceptorship</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1(b) Do you think that you gained anything else by participating in this programme?

Impact of the programme

2 What benefits do you think the First Year of Clinical Practice Programme has had for:
   (a) new graduates?
   (b) other team members?
   (c) patients/clients?
   (d) health service itself?

3 What negative effects (if any) do you think the First Year of Clinical Practice Programme has had for:
   (a) new graduates?
   (b) other team members?
   (c) patients/clients?
   (d) health service itself?
**Preceptorship**

4(a) Did your clinical workload allow time for preceptorship?  
☐ Yes  If yes, what did preceptorship consist of?  
☐ No  If no, why not?  

4(b) Did you have a designated new graduate for each rotation?  
☐ Yes  
☐ No  If no, why not?  

4(c) How many preceptees (ie, new graduates, nursing students, etc) were you responsible for during the First Year of Clinical Practice Programme?  

4(d) Which aspects of preceptorship were the most effective with regard to developing the new graduate’s clinical practice?  

4(e) Which aspects of preceptorship were the least effective with regard to developing the new graduate’s clinical practice?  

4(f) Do you have any suggestions for improvements in the way that preceptorship is provided in this programme?  

**Conflicts or complaints**

5 Were you involved in any conflicts or complaints related to the preceptoring of the new graduate nurse?  
☐ No  
☐ Yes  If yes  
   (i) please specify  
   (ii) how was the complaint or conflict handled?  

**Selection as a preceptor**

6 What personal qualities and experience do you think that a preceptor must have to make a difference to the clinical practice of new graduates?  

**Training as a preceptor**

7(a) Please rate the statements below using the following scale:  

<table>
<thead>
<tr>
<th>Statement</th>
<th>1 = strongly disagree; 2 = disagree; 3 = neutral; 4 = agree; 5 = strongly agree; 6 = don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The preceptor training provided adequate information about my role as a preceptor</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>My programme co-ordinator provided adequate information about the programme</td>
<td>1 2 3 4 5 6</td>
</tr>
</tbody>
</table>

7(b) What issues do you think should be covered in preceptor training?  

7(c) Is there any further information about the programme itself that you think would be helpful?
Support
8 Did you think that you were supported in your role as a preceptor by:
   Please tick if yes
   □ Other team members?
   □ Clinical Charge Nurse?
   □ Programme Co-ordinator?
   If no to any of the above, why not?

Cultural supervision
9 Were you given access to information and resources to help you better meet the cultural specific needs of Māori new graduates?
   □ No If no, why not?
   □ Yes If yes, please specify what was provided

Overall programme
10 What (if anything) could be done to improve the programme?

General comments
11 Do you have any other comments that you would like to make?

Now some questions about you ...
As part of the report we need to know a little about the people who are included in the sample. Only summarised data will be used in the final report and it will not be used to identify any individuals. If you do not wish to answer a question, just leave it blank, and go on to the next question.

12 How long have you been working as a registered nurse?
   □ Less than 12 months
   □ 1–5 years
   □ 6–10 years
   □ 11–15 years
   □ Over 15 years

13 What best describes your first nursing or midwifery qualification?
   □ Hospital-based training – registered nurse (all categories)
   □ Hospital-based training – enrolled or community nurse
   □ Diploma of nursing – comprehensive
   □ Diploma in midwifery
   □ Degree in nursing
   □ Degree in midwifery
14 Do you hold any of the following post-entry nursing qualifications?
- Bachelor’s degree in nursing
- Post-entry certificate (level 700)
- Postgraduate certificate at Master’s level (level 800)
- Postgraduate diploma at Master’s level
- Master’s degree in nursing
- Doctorate in nursing
- Other – please state ....................................................................................................

15 What best describes your work setting?
- Tertiary teaching hospital (eg, Auckland Hospital, Christchurch Hospital, Waikato Hospital)
- Provincial hospital (eg, Kew Hospital, Taranaki Base Hospital)
- Community hospital (eg, Rangiora, Kaikoura)
- Community trust
- Health centre
- Non-governmental agency
- Other (please specify)...................................................................................................

Thank you for taking the time to answer the questionnaire. Please place the questionnaire in the envelope provided.
Appendix 8: Programme Co-ordinator Questionnaire – End of Programme

We need your help! The purpose of this questionnaire is to assess whether the New Graduate First Year of Nursing Clinical Practice Pilot Programme supports New Graduates in their role as beginning practitioners. The information will be used as part of a wider evaluation of all pilot programmes.

All information will remain strictly confidential and will only be used for this purpose. Please ensure that you have read the Programme Specification attached before filling in the questionnaire. Please place your questionnaire in the envelope provided. You do not need to write your name on this form.

1 What benefits do you think the First Year of Clinical Practice Programme had for:
   (a) new graduates
   (b) preceptors
   (c) other team members
   (d) clients
   (e) the health service itself

2 What negative effects (if any) do you think the First Year of Clinical Practice Programme had for:
   (a) new graduates
   (b) preceptors
   (c) other team members
   (d) clients
   (e) the health service itself

3(a) Were you adequately supported in your role as a Programme Co-ordinator?
   □ Yes   If yes, please specify by whom
   □ No    If no, why not?

3(b) What improvements (if any) would you make to the way in which the Programme Co-ordinator role is supported?

Programme Co-ordinator’s tasks

Rotations

4(a) Were the rotations useful in developing the clinical practice of new graduates?
   □ Yes
   □ No

4(b) Which aspects of the rotations worked well?

4(c) Which aspects of the rotations didn’t work well?

4(d) What could be improved regarding planning and managing rotations?
Preceptors

5(a) Which aspects of preceptorship were most useful in developing the clinical practice of new graduates?

5(b) Which aspects of preceptorship were least useful in developing the clinical practice of new graduates?

5(c) What improvements (if any) would you make to the process used to select staff to become preceptors?

5(d) What improvements (if any) would you make to the process used to assign new graduates to preceptors?

Management of the programme

6(a) Was the clinical workload of new graduates reduced to facilitate their practice development?
   - [ ] Yes
   - [ ] No

6(b) Was the clinical workload of the preceptor reduced to facilitate preceptorship?
   - [ ] Yes
   - [ ] No

6(c) What improvements (if any) would you make to the process you used to ensure that reduced clinical workload occurred?

7 What improvements (if any) would you make to the process you used to ensure that new graduates received adequate and timely feedback?

8 What improvements (if any) would you make to the process you used to ensure that complaints/or conflicts were resolved?

Cultural supervision

9(a) Which were the most useful aspects of providing support for new graduates caring for Māori patients/clients?

9(b) Which were the least useful aspects of providing support for new graduates for caring for Māori patients/clients?

9(c) What (if anything) could be done to improve the provision of support for new graduates caring for Māori patients/clients?

Overall programme

10(a) Overall did the programme meet your expectations?
   - [ ] Yes If yes, please specify
   - [ ] No If no, why not?

10(b) What (if anything) could be done to improve the programme?
General comments
11 Do you have any other comments?

Now some questions about you ...
As part of the report we need to know a little about the people who are included in the sample. Only summarised data will be used in the final report and it will not be used to identify any individuals. If you do not wish to answer a question, just leave it blank, and go on to the next question.

12 How long have you been working as a registered nurse?
  □ Less than 12 months
  □ 1–5 years
  □ 6–10 years
  □ 11–15 years
  □ Over 15 years

13 What best describes your first nursing or midwifery qualification?
  □ Hospital-based training – registered nurse (all categories)
  □ Hospital-based training – enrolled or community nurse
  □ Diploma of nursing – comprehensive
  □ Diploma in midwifery
  □ Degree in nursing
  □ Degree in midwifery

14 Do you hold any of the following post-entry nursing qualifications?
  □ Bachelor’s degree in nursing
  □ Post-entry certificate (level 700)
  □ Postgraduate certificate at Master’s level (level 800)
  □ Postgraduate diploma at Master’s level
  □ Master’s degree in nursing
  □ Doctorate in nursing
  □ Other – please state ...................................................................................................

15 What best describes your work setting?
  □ Tertiary teaching hospital (eg, Auckland Hospital, Christchurch Hospital, Waikato Hospital)
  □ Provincial hospital (eg, Kew Hospital, Taranaki Base Hospital)
  □ Community hospital (eg, Rangiora, Kaikoura)
  □ Community trust
  □ Health centre
  □ Non-governmental agency
  □ Other (please specify).....................................................................................................

Thank you for taking the time to answer the questionnaire. Please place the questionnaire in the envelope provided.
Appendix 9: Key Informant Telephone Interview – End of Programme

We need your help! The purpose of this questionnaire is to assess whether the New Graduate First Year of Nursing Clinical Practice Pilot Programme has supported New Graduates in their role as beginning practitioners. The information will be used as part of a wider evaluation of the programme and to make improvements to the programme so that it better meets the needs of new graduates in their first year of clinical practice.

All information will remain strictly confidential and will only be used for this purpose.

1 What benefits do you think the First Year of Clinical Practice Programme had for:
   (a) new graduates
   (b) preceptors
   (c) other team members
   (d) patients
   (e) health service itself

2 What negative effects (if any) do you think the First Year of Clinical Practice Programme had for:
   (a) new graduates
   (b) preceptors
   (c) other team members
   (d) patients
   (e) health service itself

3 How effective do you think the following initiatives were in developing the nursing practice of the new graduates?
   (a) Rotations – that a new graduate will experience working in a number of different areas. (Probe number/length/type of rotations.)
   (b) Reduced clinical workload – that the workload is shared between the preceptor and the new graduate for a period of time. (Probe how long workload is shared.)
   (c) Assignment of a named preceptor to new graduates
   (d) Appropriate training programme for preceptors
   (e) Release from clinical setting to attend formal tutorials, workshops, and education components, or for the purpose of guided self-reflection to provide consolidation of specific skills or areas
   (f) Other initiatives – please specify

4 Are you aware of any barriers that affected the running of the programme?

Overall programme

5 Overall do you think the First Year to Clinical Practice Programme was successful in developing the practice of new graduate nurses?
   □ Yes – why?
   □ No – why not?
6 What (if anything) could be done to improve the programme?

7 How did the pilot programme differ from previous programmes?

8 What were the benefits/disadvantages of these differences?

**General comments**

9 Do you have any other comments?

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Now some questions about you …

As part of the report we need to know a little about the people who are included in the sample. Only summarised data will be used in the final report and it will not be used to identify any individuals. If you do not wish to answer a question, we can go on to the next question.

10 What is your current job title?.........................................................................................................................................................

11 How long have you been working as a registered nurse?
  - Less than 12 months
  - 1–5 years
  - 6–10 years
  - 11–15 years
  - Over 15 years

12 What best describes your first nursing or midwifery qualification?
  - Hospital-based training – registered nurse (all categories)
  - Hospital-based training – enrolled or community nurse
  - Diploma of nursing – comprehensive
  - Diploma in midwifery
  - Degree in nursing
  - Degree in midwifery

13 Do you hold any of the following post-entry nursing qualifications?
  - Bachelor's degree in nursing
  - Post-entry certificate (level 700)
  - Postgraduate certificate at Master's level (level 800)
  - Postgraduate diploma at Master's level
  - Master's degree in nursing
  - Doctorate in nursing
  - Other – please state ........................................................................................................................................................................
14 What best describes your work setting?

☐ Tertiary teaching hospital (eg, Auckland Hospital, Christchurch Hospital, Waikato Hospital)
☐ Provincial hospital (eg, Kew Hospital, Taranaki Base Hospital)
☐ Community hospital (eg, Rangiora, Kaikoura)
☐ Community trust
☐ Health centre
☐ Non-governmental agency
☐ Other (please specify)........................................................................................................

Thank you for taking the time to answer these questions.