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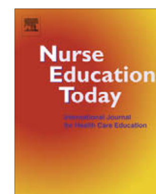

New graduate nurse practice readiness: Perspectives on the context shaping our understanding and expectations

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SUMMARY

Workforce shortages, fiscal restraint, complex healthcare organizations, increasing patient acuity, the explosion of knowledge and technology and the ever expanding role of nurses in healthcare have reinforced the importance of new graduates arriving in the work setting with the ability to move seamlessly into practice. This idea of moving seamlessly into practice is often referred to as practice readiness. Differing perspectives exist between nurses in the practice and education sector about the practice readiness of new graduates. The aim of this study was to understand the perspectives of nurses about new graduate nurse practice readiness and the underlying context shaping these perspectives. Focus groups involving 150 nurses with varying years of experience in the practice, education and regulatory sector were conducted. The findings revealed that participants' expectations and understandings of new graduate practice readiness were influenced by the historical and social context within which nursing education and professional practice is grounded. These differences centered around three main areas: the educational preparation of nurses (diploma or degree), the preparation of the technical versus the professional nurse, and the perceived responsibilities and accountabilities of the education and practice sector for the educational preparation of nurses. To shift the discourse around practice readiness, nurses from all sectors must focus on unique, innovative and cooperative solutions to ensure the seamless transition of all nursing graduates in the 21st century healthcare system.

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Background

Preparing nursing graduates who are "ready for practice" is a key concern of nurses in the education, practice and regulatory sector. A rapidly changing, ever more complex, healthcare system has contributed to ongoing tensions about the preparation of registered nurses (herein referred to as nurses). In Canada, establishing a single educational preparation at a baccalaureate level, as opposed to having either a diploma or a degree as the entry requirement for nursing, has been a national goal for the nursing profession. The change in preparation has been proposed as the solution to ensuring that nurses have the knowledge and skills required of the 21st century healthcare system (Canadian Nurses Association, 2004). In British Columbia, this goal was achieved in 2005 when all entry-level nursing education programs moved to the baccalaureate level; a move that is consistent with the majority of provinces in Canada and international directions (Pringle et al., 2004).

Although the "practice readiness" and "job readiness" discourse has long existed in nursing (Greenwood, 2000; McKenna et al., 2006), the move to baccalaureate education as the entry-level requirement for practice, coupled with a worsening nurse shortage that necessitates the need for new graduates to "hit the ground running," has increased the divide between educators and practitioners regarding practice readiness. Recognizing that this could pose a challenge to the sustainability of baccalaureate education as the entry-level requirement for practice, a coalition of nursing organizations ("the Coalition"), who focus on issues pertaining to the educational preparation of nurses, initiated an exploration of practice readiness.

An exploratory study was conducted to better understand the perspectives of nurses about new graduate nurse practice readiness. The term new graduate refers to recent nurse graduates with two years or less of experience in providing direct client care. Findings from the initial study revealed common beliefs that practice readiness entails having a generalist foundation with some job-specific capabilities, providing safe client care and having a balance of knowing, thinking and doing (Wolff and The Coalition of Entry-level

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Registered Nurse Education, 2007). However, there were also differences which may reflect nursing's unique historical and social context. Several authors have argued that the different perceptions between practice and education about the practice readiness of new graduates are grounded in the historical, social, economical and political contexts (Duchscher and Cowin, 2006; Greenwood, 2000; McKenna et al., 2006). For example, nursing is one of the few disciplines with multiple levels of education leading to the same registered nurse designation, which has resulted in characteristic class distinctions between groups within the profession. Our literature review did not identify any studies exploring the historical and social influences supporting the current perspectives about new graduate practice readiness. Insights into the context shaping the dominant values and beliefs are important to moving towards greater intersectoral collaboration in terms of the preparation, transition and integration of new graduates into the nursing workforce (Duchscher and Cowin, 2006; Greenwood, 2000).

Method

The aim of the current study was to explore the perspectives of nurses about the practice readiness of new nurse graduates and the underlying context shaping these perspectives. Focus groups were conducted throughout the province with nurses in education, practice, administration and regulation between April and June 2006. Mixed purposive sampling methods were used to recruit nurses from the educational institutions, the practice settings in regional healthcare organizations and from the provincial nursing association/regulatory body. Inclusion criteria for the study were nurses who: (a) had frequent contact with new graduates and/or fourth year nursing students, (b) were involved with new graduate initiatives (such as mentorship and transition programs), or (c) were new graduates themselves. We included nurses with varying years of experience in order to understand both the perspectives of new graduates and those who work with them. Potential participants received an electronic letter of invitation identifying the purpose of the study, the study coordinator's contact information and the focus group meeting time. Nurses who agreed to participate in a focus group received a detailed letter explaining the study and signed a consent form. The current study was part of a larger applied policy project focusing on the readiness of nurses (Wolff and The Coalition of Entry-level Registered Nurse Education, 2007) and did not require formal endorsement by a research ethics committee. However, standard research ethics were applied (Canadian Institutes of Health Research et al., 2005) including obtaining written consent from all participants, ensuring anonymity of participants (e.g., removing identifying information from transcripts and using pseudonyms), informing participants of the right to withdraw at any time and guaranteeing the privacy and confidentiality of the data.

Focus group interviews were 60–90 min in length, with the study coordinator facilitating all the focus groups to ensure consistency in data collection. Using a semi-structured interview guide, nurses were asked about the meaning of practice readiness as it pertains to new graduate nurses. Questions addressed how views of readiness had changed during the past decade, what factors influenced practice readiness and what recommendations participants had for fostering practice readiness. Digital recordings of the focus group interviews were transcribed verbatim and reviewed for errors or omissions. Using a content analysis approach (Graneheim and Lundman, 2004; Krippendorff, 1980), the first author coded each transcript, produced a summary of the themes for each focus group interview and made preliminary thematic comparisons across focus groups. Each transcript was reviewed and interview summary validated by another member of the research team. In a subsequent team meeting, the authors reached consensus on the key themes emerging from the content analysis and discussed the preliminary findings.

Findings

A total of 150 nurses participated in the 15 focus groups, which included eleven focus groups (115 nurses) in the practice sector, three focus groups (31 nurses) in the education sector and one focus group (4 nurses) in the regulatory sector. Two-thirds of participants completed their entry-level education 17–36 years ago. About 11% had graduated less than 6 years ago, which included recent graduates. Approximately 52% of nurses were from acute care hospitals and 21% from educational institutions. Most of the participants were working in an educator (34%), staff nurse/direct care (19%), or manager (18%) position.

Differing opinions about practice readiness were revealed in the findings that reflect the unique historical and social contexts within which nursing education and nursing practice has evolved. These differences were rooted in the "training" of nurses in either diploma or degree programs, in the preparation of the technical versus the professional nurse, and in the perceived responsibilities and accountabilities of the education and practice sector for the preparation of nurses.

The diploma versus the degree

Participant perspectives about practice readiness were shaped, in part, by how they were educated and the generational differences typical of that education. The prevailing perception in some of the focus groups was that diploma prepared nurses were better equipped than baccalaureate-prepared nurses to "walk into" practice settings and perform competently. Participants attributed this to the perceived differences in clinical education between the two types of education programs. Some believed that it was simply a lack of practice experience hours available to baccalaureate students; although, it was apparent that many of the participants did not know the number of practice experience hours that baccalaureate-prepared nurses received. Others believed that the nature of clinical learning was different. For example, they were critical of baccalaureate programs where students had experiences in a wide range of practice areas with little time to consolidate, or programs where students did not have practice experience in the acute care setting near the completion of their program. Participants suggested that when students were in practice settings for brief periods of time, there are limited opportunities to integrate their theoretical knowledge into practice. In other words, the breadth of knowledge provided in an entry-level baccalaureate program was a tradeoff for intensive consolidation of theory to practice. They also cited the necessity of providing students with practice experiences near the completion of their education program that offered the "realities of practice," particularly in terms of managing workloads.

The issue of educational preparation also influenced how participants viewed the socialization of new graduates, which in turn influenced their readiness to practice. Participants suggested that nurses educated in baccalaureate programs were encouraged to question orders and practices in a way that would have been unacceptable in more traditional hospital or college-based education programs. Further, some nurses educated in traditional hospital or college-based diploma programs questioned the commitment of new graduates to the workplace environment. Contemporary graduates were perceived as less likely to be committed to organizations or particular nursing units, choosing instead to embrace work/life balance. New graduates were more likely to evaluate workplace cultures in terms of their fit with that culture and to leave if the culture did not meet their ideals. Some attributed this

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to expanding roles for women, where nursing was simply one option of many available to the current generation of women. Others attributed it to the baccalaureate preparation that provided more options for students in terms of clinical placement choices, and for nurses in terms of a career track and professional goals. The impact that this perceived lack of commitment could have on practice readiness was summed up in the word of one participant, "If they're not invested in the idea of working on that floor, then maybe some of the old guard is not invested in embracing them, either."

Finally, participants spoke of the frustration of not being able to gauge the knowledge and skills of new graduates educated under diverse baccalaureate curricula. Historically, hospital-based programs expected nursing students to acquire their nursing skills while working as employees of hospitals in which they were educated. As such, new graduates were prepared according to the needs of the specific hospital and so a graduates' knowledge and skills were somewhat predictable. However, the focus group participants indicated that curricular diversity among nursing programs created confusion about the capabilities of the new graduates. As such, prospective employers had difficulty determining the types of orientation and support structures that would be required for the new graduate.

Interestingly, the debate over whether nurses were "practice ready" did not seem to be a concern to those in the community health setting. These participants had only worked with baccalaureate-prepared nurses and tended to be more comfortable allowing new graduates an extended period of transition to achieve the competencies unique to the community health setting. However, one might also argue that the seemingly less acute context of community health nursing practice permits such a transition.

The professional versus the technical nurse

The nature of practice readiness was described by the participants as either an evolving developmental process that characterized the "professional nurse" or as a tangible end-product that characterized the "technical nurse." Participants who emphasized preparing the professional nurse, viewed practice readiness as a *developmental process that evolved along a career trajectory.* From this perspective, practice readiness developed during a period of three months to two years upon entering employment. The length of transition time depended on factors such as the complexity of the practice setting, previous learning experiences (e.g., setting and length of time of clinical practicum in education program) and the availability of practice supports. Educational preparation from the professional nurse perspective entailed equipping entry-level practitioners with foundational competencies that were transferable across practice settings. The prevailing assumption was that education ought to prepare students for a variety of entry-level settings but that job-specific competencies should be obtained through on-the-job support by employers. Some of the characteristics that participants perceived as being indicative of the professional nurse were self-confidence, critical thinking, willingness to ask questions, knowing limitations and adopting a more holistic approach to practice.

Participants who emphasized preparing the technical nurse, viewed practice readiness as a *tangible end-product of nursing education* in the form of predictable outcomes conforming to pre-specified practical standards set by employers. In addition to possessing foundational competencies, the new graduates should be ready to work in a specific healthcare institution. Practice readiness was viewed as an "either/or" stance and new graduates were prepared in such a way that they had to gain the clinical skills necessary to "hit the floor running."

Participants agreed that the capacity to think critically was characteristic of the professional nurse but believed that emphasis placed on developing this capacity may result in technical deficiencies. The perceived deficiencies most often commented on in the focus groups were performing basic nursing skills, managing client workload, setting priorities and making appropriate clinical judgments. However, there was no agreed upon set of "basic" skills that all new graduates should be able to perform. These basic skills were typically derived from the practice context. For example, in some cases basic skills referred to hygiene, in other cases it referred to central line management.

Contextual knowledge was discussed as a key distinguisher between the preparation of the technical and professional nurse. Graduates of hospital programs, and often diploma programs in educational institutions, became familiar with one organization, gaining knowledge specific to that particular context. This included knowledge of organizational policies and procedures and more intricate social knowledge (e.g., physician preferences or who to contact to access required resources). Participants emphasized how important it was for new graduates to have familiarity with specific hospital policies to practice safely. Further, participants discussed how ongoing exposure to one practice setting contributed to new graduates' sense of belonging, which resulted in a level of comfort and confidence in their abilities to provide care. With the move of nursing programs to educational institutions those social bonds were disconnected and much of the contextual knowledge was lost. However, some participants still expected new graduates to possess this organizational specific knowledge which in turn led to the perception that baccalaureate-prepared nurses were not "practice ready."

Education versus practice accountabilities

Focus group discussions about practice readiness revealed inconsistencies around beliefs about who is ultimately accountable for the preparation of new graduates. Some held the perspective that it was the responsibility of the education sector to become more accountable to the practice sector. Others believed it was the responsibility of the practice sector to become accountable for adequate orientation of nurses to the specifics of the workplace. Participants expressed concern and frustration around their perceptions of a mismatch between the standards by which educational programs were being evaluated and the actual requirements of healthcare employers. Threaded throughout this discussion was the idea of the education sector being accountable to the public; although, how public accountability was understood differed. In some cases, it meant being accountable to the needs of clients as determined by the employers, in other cases it meant being accountable to a new vision of healthcare rather than simply meeting the needs of the current illness oriented healthcare system.

Issues of accountability also surrounded the practicum component of nursing education. In the face of a nursing workforce shortages, educators talked about the pressure of admitting more students to their programs without knowing whether they could find quality practice placements to support those students. From the perspectives of those in the education sector, they sought a system whereby the practice sector would be accountable to the education sector by providing the learning opportunities for their future employees. Participants suggested that mutual accountability between the practice and education sector needed to be re-established.

Issues of accountability were discussed in relation to the perceived causes of practice readiness challenges, namely the changing nature of nursing education and the increasingly complex healthcare environments. Some participants attributed the cause to changes in nursing education from a technical to a liberal arts focus. They perceived that the goal of a liberal arts education was not necessarily individual practice competence but social and organizational change, and the "political savy" to negotiate

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such change. The liberal arts curriculum was criticized for neglecting technical skills; what some described as the "art" of nursing. For some participants there was a sense that nursing education philosophies had moved too far away from the actual competencies required of the realities of practice.

Other participants emphasized the changing nature of healthcare as being the greatest contributor to practice readiness challenges. Participants described how new graduates were being prepared to begin their practice with stable and predictable patient situations, however, this contradicted the current situation in acute care facilities where most patients who are acutely ill are assigned to registered nurses, and those that are more stable are typically assigned to licensed practical nurses. Chronic staffing shortages and a mobile workforce where even the "senior" nurses on the unit may have less than five years of practice experience meant that traditional mentoring and support structures were absent. Despite the desire for a transitional period, new graduates were being confronted with full patient loads of acutely ill individuals, amidst the removal of key practice support structures such as educators, nurse managers and supervisors. Constrained healthcare budgets also meant that orientations available to new nurses were often limited. Many participants believed that current conditions in acute healthcare made it difficult for even seasoned nurses to do their job well, and so it was unrealistic to expect that new graduates should be able to enter those conditions with confidence. Senior nurses spoke of not having the time to monitor and mentor novice nurses to ensure that client care was safe. This sense of responsibility, without the corresponding resources to fulfill that responsibility, created a sense of moral distress.

One participant astutely synthesized the groups' thoughts by describing what she thought was a pivotal moment in the history of nursing. She described how nursing education moved away from hospital programs at the same time that healthcare downsizing and restructuring removed the critical support structures that permitted such a transition. Students were becoming less familiar with hospital cultures at the same time that key individuals, responsible for mentoring new graduates into those cultures, were being removed. An analogy was used of expecting new graduates to "fly 747s solo" without having any training on smaller "planes" that would lead logically to that capability. The technical orientation of the analogy is an interesting comment in itself on the perceived nature of practice.

Discussion

Findings from the current study reveal some of the historical and social contexts which shape nurses' perspectives of new graduate practice readiness. The ongoing debate about whether new graduate nurses are practice ready is profoundly shaped by the educational model under which nurses have been prepared and by the idea one carries about whether readiness is a process as embodied by the professional nurses, or a product as embodied by the technical nurse. Further, with the movement away from the shared accountabilities between the education and practice sectors, it is no longer clear who plays what role in ensuring that nurses are practice ready.

The historical influence of diverse levels of preparation for nurses has been documented in the nursing literature. The move of nursing education from hospitals to post-secondary institutions during the 1970s, and the more recent move to baccalaureate education as the entry-level preparation for registered nurses, have fueled long-standing debates about the level of education required for registered nurses (diploma or degree), where registered nurses should be educated (hospital or educational institution) and whether degree or diploma nurses are better prepared for the realities of practice (Bartlett et al., 2000; Clinton et al., 2005; Greenwood, 2000; Lofmark et al., 2006; McKenna et al., 2006). Duchscher and Cowin (2006) suggested that new graduates entering the nursing profession are educated in a system that values critical thinking and questioning, are committed to the profession (rather than the employer), and are intolerant of patriarchal and subservient healthcare systems. As new graduates are socialized to the practice setting, discrepancies exist between the values of new graduates and their experienced co-workers who "may have accepted the socio-culturally and politically oppressive context of acute care nursing as normative, and desensitized themselves to the impropriety of some of their assimilated, or even abandoned core nursing values" (Duchscher and Cowin, 2006, p. 156). It is some of these differences between the educational backgrounds of new graduates and experienced nurses that may fuel the practice readiness discourse.

The disparate views expressed in these focus groups about readiness as process or product really brought to the forefront the question of "ready for what?" For some, particularly those focus group participants working in the practice sector, new graduates were expected to have the specific knowledge and skills of a particular practice context. Ironically, this expectation has not changed even though practice contexts have become highly specialized, and students are now educated within multiple organizational and practice contexts. This expectation created a profound degree of tension for both the new graduates and the experienced nurses. Numerous studies exist that have sought to assess the clinical competence and performance of beginning practitioners from diploma and degree programs (Bartlett et al., 2000; Clinton et al., 2005; Girot, 2000; Lee et al., 2002; Lofmark et al., 2006; Schlüdt Håård et al., 2008; Walker and Bailey, 1999), and to identify the skills and competencies required of new graduates in a variety of settings (Bramadat et al., 1996; Stephens, 1999; Sweeney et al., 1980; Utley-Smith, 2004). Walker (1995) argued that the competency movement has fallen short as a solution to guide the preparation, and to assess the performance, of new graduates in practice. The development of competency-based models places emphasis on performance outcomes (which are reductive and mechanistic) rather than the learning process, which results in the avoidance of the active, critical, emancipatory and reflective component of the learning process (Milligan, 1998; Walker, 1995). Moreover, research focusing on the evaluation of the outcomes of new graduates from degree and diploma programs has perpetuated the belief that one type of program is better than the other, as opposed to the recognition that both contribute to the short-term and long-term preparation of nurses in different ways. Indeed, Greenwood (2000) and McKenna et al. (2006) argued that given the dynamic and expanding role of nurses, increasing patient acuity, technological advances, and the explosion of knowledge in the 21st century, nurses who would have graduated in the mid- to late 20th century would be equally unprepared to function in the current healthcare context.

Finally, the question of who's accountable for ensuring practice readiness was a compelling one in the data. Historically, nursing education programs were accountable to service, which in most cases was a single institution such as a hospital (Pringle et al., 2004). Whether or not education sector is accountable to the practice sector for the preparation of new graduates depends on the purpose of academic institutions and agreement about the preparation of nurses to act beyond the level of mere competence to be capable of adapting to unfamiliar circumstances in unfamiliar contexts (Watson, 2006). Currently, shared accountability lies with provincial governments, regulatory bodies, educational institutions and healthcare organizations. The challenges of these multiple accountabilities are wide ranging including ensuring that there are adequate numbers of nurses for the workforce, that there are sufficient clinical experiences, and that there is an appropriate

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transitional plan between the end of the experience and first employment. The sense of moral distress that nurses felt in being unable to adequately support new practitioners in their transition suggests that focused attention on sorting out who is responsible for what is critical. Understanding the complexity of the issues may provide some basis upon which to move toward greater intersectoral collaboration in the preparation, transition and integration of new graduates (Duchscher and Cowin, 2006; Greenwood, 2000).

Our findings, while reflective of the educational and healthcare service context in British Columbia, may not necessarily reflect the experiences of other countries where educational and service models differ. Additional study within other jurisdictions is required to determine the relevance of these findings in other contexts.

Conclusion: A delicate balancing act

Findings from the focus groups supported our initial hunch that although the term practice readiness is commonly used; the term is understood differently by nurses. The idea of practice readiness bears little meaning apart from the specific context within which the new graduate begins practice. These focus group participants clearly revealed the complex matrix of factors that contribute to the conceptualization of practice readiness. Views about the readiness of new graduate nurses are, to some extent, predicated upon the diploma–degree and professional–technical nurse debates. With potential practice environments ranging from community health to highly specialized acute care units, to rural health where a generalist model still exists, the time has come to focus more on transitional plans rather than a discourse about practice readiness that too easily becomes a politicized debate about responsibilities and accountabilities. For a profession that has been characterized as "eating its young," we need to expose the practice readiness discourse for what it is – a divisive and outdated debate that serves little purpose in a maturing profession.

Workforce shortages, fiscal restraint, complex healthcare organizations, increasing patient acuity, the explosion of knowledge and technology, changing educational policies and the ever expanding role of nurses in healthcare all influence the successful preparation, transition and integration of new graduates. We cannot afford to hide the complexity of practice readiness with simplistic solutions that belie the degree of cooperation that will be required among the sectors in envisioning unique and innovative transitional strategies. Such strategies also need to acknowledge that the capacity of new graduate nurses to move beyond stable, predictable, and familiar practice comes with experience and lifelong learning. The depth of emotion expressed by participants in the focus groups indicates that the need for this transitional plan is urgent to not only minimize the transition needs of new graduates and, therefore, the transition "strain" of experienced nurses in the practice sector but also to retain nurses. One group of participants, in a somewhat humorous tone, referred to the focus group as a support group, alluding to the stress they were experiencing facilitating new graduate transitions. As one participant poignantly commented, "practice readiness in the current healthcare climate means brave."

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