The Preceptor Experience:
The preparedness and support of registered nurses preceptoring international nurses for whom English is a second language.

A thesis submitted in partial fulfillment for the degree of
Master of Nursing
at the
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ABSTRACT:

The purpose of this research was to establish whether preceptors perceive they are adequately prepared and confident to assess internationally registered nurses for whom English is a second language (IRNs-EASL), and to ascertain the level of support they receive when undertaking the role. The changing economic and nursing environment was also considered an important component in this study.

A questionnaire was developed in Survey Monkey™ and sent via New Zealand Nurses Organisation (NZNO) e-newsletter to approximately 26000 recipients. This gave the study broad representation geographically and clinically. Using descriptive quantitative analyses, preceptor training, workload, understanding of ethical and legal accountability and perceived organisational values, support and attitudes were evaluated.

The results indicate that a proportion of preceptors do not meet Nursing Council of New Zealand (NCNZ) standards and that some work environments require nurses to preceptor IRNs-EASL against their wishes. The role is not valued by indicators of formal recognition or within job descriptions despite the high work load requirements of the position. Training increases preceptor confidence and preparedness for clinical assessment but more research is required to comprehensively evaluate preceptor understanding of ethical and legal accountability.

The establishment of a register of preceptors could provide a platform to develop audit and quality assurance principles, ensuring adequate education and preparation of preceptors. Formal recognition in the form of financial recompense, workload reduction and professional development recognition would increase preceptors perceived level of support and organisational value.
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Chapter 1

INTRODUCTION:

“Nurses practice at the intersection of public policy and personal lives; they are, therefore ideally situated and morally obligated to include sociopolitical advocacy in their practice”.

(Falk-Rafael, 2005, p. 222)

1.0 Introduction

To overcome the serious nursing shortage of the previous decade, New Zealand has relied on, and actively recruited, internationally registered nurses (IRNs), including international registered nurses for whom English is a second language (IRNs-EASL). These nurses are reliant on New Zealand registered nurses for preceptorship and transition to New Zealand nursing practice. With numbers of IRNs-EASL continuing to increase (Nursing Council New Zealand, 2010a) it is timely to undertake research which explores whether preceptors feel adequately prepared and supported to preceptor IRNs-EASL, and identify attitudes towards the preceptor role in the current nursing environment.

1.1 Background:

Nursing shortages in developed countries have, historically, increased the demand for foreign nurses to fill vacancies. In 2001 the International Council of Nurses (ICN) (International Council of Nurses, 2001) issued a position statement on ethical nursing recruitment, recognising the right of individual nurses to migrate. The ICN commented that career mobility enables nurses to achieve personal career goals and increase their clinical competency (ICN, 2007).

The resulting flow of internationally educated nurses, and, accelerated nurse migration, has generated much debate on the effect of migration on both the source and the host countries (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Gerrish, 2004; Kingma, 2004). There is an extensive body of literature on nurse migration which demonstrates the
complexity of the phenomenon and the international, national and individual factors which contribute to it (Kline, 2003; Waters, 2001).

Literature suggests that nurse emigration is motivated by economic instability, poor wages and a poorly funded health care system in the home country; personal, socio-cultural and family factors; a search for learning and professional development opportunities; and, a desire for a better quality life (Kingma, 2001; World Health Organisation, 2006). Two common underlying assumptions about nurse migration are, firstly, that nursing migration is natural and can be expected to intensify (Aiken, 2004; Buchan, 2001; Kingma, 2001), and secondly, that migration flows largely from developing to developed countries (McElmurry et al, 2006).

The World Health Organisation (WHO) (2006) states that highly trained and skilled health workers from developing countries continue to emigrate at an increasing rate thereby weakening the health systems in the country of origin. Migration, however, has generated billions of dollars in remittances (the money sent back to home countries by migrants) to low income countries and has been associated with a decline in poverty (World Health Organisation, 2006). Nurses from the Philippines and doctors from India account for the largest share of migrant health workforce in the Organisation for Economic Co operation and Development (OECD) countries (Woodbridge & Bland, 2010). The World Bank (2009), as cited in Woodbridge & Bland (2010), reported that India is the top receiver of remittances from immigrant workers abroad with US 17.4 billion dollars flowing into that country in 2003 alone.

The 2008 global recession has had a significant impact on the economies of all the OECD nations. Real growth domestic product (GDP) fell in all thirty nations making it the worst recession since the Great Depression of the 1930s (Treasury, 2010). The impact on the labour market has been significant, with unemployment rising throughout the OECD to 8.6% in the September quarter of 2009. This was the equivalent of 15 million more unemployed people worldwide (Treasury, 2010). In New Zealand this has served to reduce employment opportunities for all registered nurses and heightened nurse anxiety around job security.

The latest NCNZ Annual Report confirms that New Zealand nurses are returning to practice with an active nursing work force which grew 3.1% in 2009 and 2.5% in 2010 after near
stagnant growth through the middle of the decade (Nursing Council of New Zealand, 2010a). Nursing Council also reported more students applying to sit final nursing examinations, indicating growth within the academic institutes teaching degrees in nursing. Statistics from the annual report (Nursing Council of New Zealand, 2010a) also note an increase from 2002 of 14.7% of non New Zealand registered nurses to 24% in 2010. In the 2008 – 2009 year, NCNZ registered 1,387 internationally qualified nurses (Nursing Council of New Zealand, 2009a) while in 2010, 1270 internationally qualified nurses were registered. Although this represented a drop in numbers of internationally registered nurses of 6.7% from the previous year, IRNs received 50.8% of all new practicing certificates issued in the year ending March 2010, (Nursing Council of New Zealand, 2010a).

In ensuring that all nurses are competent and fit to practice, NCNZ as “the statutory regulatory body” of nurses must comply with the Health Practitioners Competency Assurance Act (HPCA), 2003. The HPCA Act 2003 was introduced with the principle purpose of the Act being “to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice” (New Zealand Ministry of Health, 2003). The Act legislates what constitutes competence, fitness to practice, quality assurance and specifies the functions of the 15 regulatory authorities, including NCNZ (Vernon, Chiarella, Papps, & Dignam, 2010). In compliance with the HPCA Act, NCNZ established in 2004 a continuing competence framework to ensure nurses are competent and “fit to practice their profession”. In addition Nursing Council defined competence as “the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse” (Vernon et al., 2010).

The HPCA Act (2003) requires scopes of nursing practice to be defined. The registered nurse scope of practice defined by NCNZ, involves the use of nursing knowledge and complex judgment, independent and collaborative practice, direction and delegation and comprehensive nursing assessments which occur in a range of settings and in partnership with individuals, families, whanau, and communities. Registered nurses are required to use their expertise to manage, teach, evaluate and research nursing practice (Nursing Council of New Zealand, 2007). The scope is further delineated in to four domains of competence; professional responsibility, management of nursing care; interpersonal relationships and inter-professional health care and quality improvement.
The HPCA Act (2003) also requires NCNZ to set the requirements for programmes that lead to entry of the registration of nurses and also for the monitoring and continued competence of nurses once registered (Vernon, et al, 2010). When a nurse who is registered with an overseas authority applies to NCNZ for registration in New Zealand, each application is assessed on an individual basis and requires proof of an international nursing qualification that is equivalent to that prescribed in New Zealand (Nursing Council New Zealand, 2010b). In meeting the HPCA Act of 2003, NCNZ requires international nurses to demonstrate competency to practice through a competency assessment programme (CAP) and demonstrate the ability to communicate effectively in English.

There are nineteen such programmes run throughout New Zealand, ten based within tertiary educational institutes, five offered by district health boards, three offered through residential elder care, and one by Plunket, a New Zealand child health agency. Programme length ranges from six to eight weeks. Clinical time may be extended to permit a programme of twelve weeks if required. Demand for competency assessment programmes continues to grow, with an average twelve month waiting list from acceptance to placement (Nursing Council New Zealand, 2010a).

The largest component of these programmes involves clinical placement with a preceptor for a minimum of four weeks. Although the preceptorship model appears to be is widely used and researched in undergraduate nursing programmes, there is no research in New Zealand around the needs of the preceptors of IRNs-EASL. It is also timely that such research is undertaken as NCNZ has identified that the percentage of new practicing certificates issued to IRNs is increasing (Nursing Council of New Zealand 2010a). International nurses are also over represented in NCNzs statistics for competency review (complaints about nurses) with 29% of nurses under review having trained overseas (personal communication, Maureen Kelly 28th July 2011).

It is therefore important to identify the needs of the preceptors, to ensure optimum benefit for all stakeholders involved in transitioning international nurses as well as those in need of their expertise and care. There needs to be recognition by employing agencies, preceptors and training faculties that there are academic, legal and ethical responsibilities to ensure that graduates of CAPs are competent in providing safe nursing practice (Billings & Halstead, 2005; Boley & Whitney, 2003; Nursing Council New Zealand, 2009b).
1.2 Researcher's Interest

Interest in this research was driven by the researcher’s role as programme coordinator for a competency assessment programme. The researcher recognized that among preceptors there was growing unease which seemed to be related to a changing New Zealand nursing environment, exacerbated by the current economic situation and the increasing demand from IRNs-EASL to migrate to New Zealand. The resulting ethical tensions challenge all nurses, particularly those involved in competency assessment programmes.

The researcher also recognized the scenario was further complicated by pressures placed on preceptors to assess clinical competency of IRNs-EASL using the NCNZ domains of competency framework in increasingly busy working environments. The researcher heard many preceptors state they believed their own registrations were at risk, if they failed to recognise an IRN-EASL who was unsafe to practice. There is a sense that any errors made by the IRN-EASL at a later time (once registered) may reflect poorly on the preceptors own practice. This weighs heavily on all preceptors and reflects the responsibility and accountability within the role. The researcher believes that preceptor support is vital to ensure safe assessment of IRNs-EASL in an environment that should embrace cultural diversity while maintaining high standards. Without supported preceptors there can be no guarantee of “safe passage” for IRNs-EASL choosing to migrate to New Zealand.

1.3 Significance Of The Study:

The study is significant as there is limited research which considers the pressures faced by preceptors in the current economic environment, their preparedness to confidently assess IRNs-EASL and the support which they receive while undertaking the role. The study is broad, both geographically and clinically. The breadth of the research will clarify attitudes throughout New Zealand and include Registered Nurses who preceptor IRNs-EASL from a variety of clinical placements. This will contribute to the recognition of gaps in preceptor training and support and encourage cultural understanding with the ultimate outcome of increased patient and public safety.

1.4 Aims Of The Research

The objectives of the research are to: establish whether preceptors perceive they are adequately prepared to confidently assess IRNs-EASL; to establish the perceived level of
support for preceptors of IRNs-EASL; to establish the preceptors understanding of ethical and legal accountability, and to establish the perceived organisational attitudes toward IRNs-EASL in the changing nursing environment.

1.5 The Research Question
Are preceptors adequately prepared and supported to confidently assess Internationally Registered Nurses for whom English is a second language, undertaking a Competency Assessment Programme in the current nursing environment?

1.6 Definitions
For the purposes of this study an Internationally Registered Nurse (IRN) is defined as a nurse who has been educated in nursing and registered as a nurse in a country other than New Zealand or Australia.

An internationally registered nurse for whom English is a second language (IRN-EASL) is defined as a internationally registered nurse who has been educated in nursing and registered in a country other than New Zealand or Australia and where English is considered a second language.

A preceptor is defined as a registered nurse who, supported by the clinical placement coordinator and programme coordinator, assesses the IRN-EASL while he/she is completing the clinical component of a CAP. The preceptor also completes NCNZ Domains of Competence assessment documentation in association with the programme coordinator at the conclusion of the clinical experience in accordance with NCNZ standards for competence assessment programmes (Nursing Council New Zealand, 2008b).

1.7 Nursing Council of New Zealand Requirements
The Health Practitioners Competence Assurance Act (2003) requires NCNZ to ensure the continuing competence of practitioners to protect the health and safety of the public. Competence assessment is one of the tools used by the Nursing Council to ensure initial and continuing competence to practise.

Competence assessment is used to assess the students at the completion of New Zealand nursing programmes, overseas-educated nurses who undertake competence assessment
programmes before registration to practise in New Zealand, nurses who wish to return to the workforce after five or more years away from practice, nurses who hold annual practising certificates but do not meet the continuing competence requirements, nurses who are selected for the recertification audit of their continuing competence and nurses required to demonstrate competence under a competence review process.

Nurses are assessed against the Council’s competencies for their scope of practice by the programme co-ordinator in association with the preceptor at the conclusion of the clinical experience” (Nursing Council NZ, 2008, p.6). Preceptors complete NCNZ documentation of the Domains of Competence (supported by the programme coordinator of the CAP) which fulfil the requirements of The Health Practitioners Competence Assurance Act (2003). All IRNs-EASL are allocated (preferably) one preceptor at the commencement of their clinical placement for CAP.

Nursing Council New Zealand (2008) Standards for competence assessment programmes require that the student is allocated a preceptor with appropriate skills and qualifications, that the preceptor is a registered nurse with a minimum of 3 years experience and will have completed a preceptor’s/assessor’s programme. The preceptor, supported by the programme coordinator is responsible for the assessment of the student. The preceptor must have recognised clinical skills in the area of practice and be able to provide one to one supervision of the nurse. The preceptor is also responsible for providing feedback to the IRN-EASL (Nursing Council of New Zealand, 2008).

1.8 Justification Of The Research
Despite the increasing demand for preceptor services and more IRNs-EASL migrating to NZ, no New Zealand research has been published on how preceptors are supported and prepared for their role as assessors of clinical competency for IRNs-EASL. Limited research has been published on the challenges faced by preceptors of IRNs-EASL. Previous research has focused on cultural differences and integration into nursing practice in New Zealand.

NCNZ statistics in the 2010 Annual Report (Nursing Council of New Zealand, 2010a) note that over the last 3 years approx 50% of new Practicing Certificates have been issued to International Nurses and that in 2010, 24% of all registered Nurses in New Zealand were
internationally educated. Unfortunately it is also recognized that IRNs are over represented in Nursing Councils competence review process.

Despite the dearth of New Zealand publications, international literature has highlighted gaps in preceptor education and preparation for IRNs-EASL, preceptor understanding of ethical and legal accountability and preceptor support and organisational recognition of the role.

1.9 Thesis Outline

Chapter One: This chapter will discuss the background to the research including the global nursing workforce and current economic environment. An overview of the thesis is provided and the researcher’s special interest in the topic is discussed. The chapter examines the significance and justification for the research, identifies the aims of research and articulates the research question. It also identifies NCNZ requirements of preceptors and international nurses seeking registration in New Zealand and provides relevant definitions used within the study.

Chapter Two: Literature Review - This chapter discusses the need for a narrative synthesis approach due to the lack of quantifiable research around the preparedness and support of preceptors of IRNs-EASL undertaking a competency assessment programme. The chapter discusses search strategies employed and how critiquing the literature occurred. The literature review defines the preceptor role, discusses accountability, barriers, rewards and attitudes toward the role, and considers preceptor education.

Chapter Three: Methodology – The research design is a descriptive quantitative study which is non – experimental. The rationale for selecting this design is discussed as well as the sample size and data collection tool. Ethical issues and principles of validity and reliability related to this research will also be discussed. The chapter will also discuss data analysis and management.

Chapter Four: Results– The findings of the research will be grouped into logical sections that reflect the objectives of the research and the results will be presented as Tables and Figures and in discussion.
Chapter Five: Discussion:
The demographics of preceptors will be discussed and whether the requirements of NCNZ are met. Preceptor training programmes will be identified and preparedness and confidence assessed. Ethical and legal accountability and understanding will be analysed and support of preceptors will be assessed through organisational recognition for the role and work load requirements.

Chapter Six: Conclusions and Recommendations – In this final chapter, the researcher will summarize what is already known about the topic and what this thesis adds. The strengths and limitations of the study will be examined and recommendations for future research, education and practice will be made.

1.10 Summary
The global economy is currently unstable increasing demand both locally and internationally for nursing work. This pressure changes societal attitudes to immigration as New Zealand nurses compete for limited nursing positions. Demand for CAPs outweighs availability with IRNs waiting approximately twelve months between acceptance from Nursing Council of New Zealand and a CAP placement.

IRNs-EASL usually commence programmes as soon as they enter the country using a student visa. They have no experience of New Zealand culture or New Zealand nursing practice and therefore face a multiplicity of challenges. Many of these challenges occur when they enter the clinical environment. Preceptors are faced not only with the task of clinical assessment and safety to practice but also with introducing the IRN-EASL to New Zealand culture and offering pastoral care. It is thus timely to research the preparedness and support preceptors receive when preceptoring IRNs-EASL in the current nursing environment.
Chapter 2

LITERATURE REVIEW

“More racial-ethnic and gender diversity must be actively pursued so that a workforce is created that is better able to meet the demands of a diverse population across the life span, and nurses are better able to provide culturally relevant care”.

(Stowowski, 2011, p. 3)

2.0 Introduction

According to Minichiello, Sullivan, Greenwood & Axford (2004) a literature review is “a verbal picture about what is known about a particular topic or issue and what gaps exist in this knowledge base” (p. 11). Schneider, Whitehead, Elliot, Lobiondo-Wood & Haber (2007) state “a review of literature is a systematic and critical review of published papers on a particular topic of interest in a discipline” (p.47). This study is original New Zealand research and required current literature to be examined and evaluated to gather a broad background and understanding of nurse migration (and immigration) in the current economic environment. It was followed by a more focused approach on the specific and unique transition to practice needs of IRNs-EASL and the preparedness and support that the preceptors of IRNs receive. The literature identified transition challenges for both IRNs-EASL and preceptors in the clinical assessment role. From the literature review, gaps in preceptor research were identified, particularly around preparedness for the role and the support that preceptors received. The aims of the study were developed to reflect these gaps in the literature and to ascertain whether preceptors perceive they are adequately prepared to confidently assess IRNs-EASL, to explore the perceived level of support for preceptors of IRNs-EASL, and to establish the preceptors’ understanding of ethical and legal accountability.
2.0.1 Literature Search Strategies

Literature search strategies used for this thesis included electronic data bases, website addresses, hand searches and written and verbal communication. Data base searching was conducted using the Eastern Institute of Technology (EIT) Twist Library access to data bases. These included the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Proquest, and Science Direct. EIT library services staff accessed Sage Publications and inter-loan articles which were unavailable through EIT’s databases. Google Scholar was also used extensively. Key words used were nurse migration, international nurses, nursing mentorship, nursing preceptorship, mentorship of international nurses, preceptor education, preceptor support, mentor education and support.

Websites were also searched for relevant online nursing journals and for information relating to the local and global economy, Acts of Parliament and international and legal aspects of nurse migration. Key words used were New Zealand economic forecast, immigration policies, and international nursing requirements. These websites included Nursing Council of New Zealand, the International Council of Nurses, the World Health Organisation, the New Zealand Nurses Organisation, the Ministry of Health, the Ministry for immigration, and the New Zealand Institute for Economic Research, Treasury and the Department of Labour.

Hand searches were conducted at EIT library for relevant journals and texts and included Kai Tiaki Nursing New Zealand and nursing management and research text books. Inter loans were accessed by library staff when requested.

Verbal communication and email correspondence included New Zealand Nurses Organisation, Nursing Council New Zealand, Auckland District Health Board, and CAP Coordinators from Manawatu, Wellington, Nelson, Waikato and Otago regions.

2.0.2 Strategies For Critiquing The Research

Critiquing the research involves systematically reading articles in a critical and objective manner to establish the strength, quality and consistency of the research (LoBiondo- Wood & Haber, 2006). Paul and Elder (as cited in Schneider et al. 2007, p. 269), describe critical reading as “an active intellectually engaging process in which the reader participates in an
inner dialogue with the writer”. There are a number of critiquing strategies however Schneider et al. (2007) provides critical review guidelines using a structured approach for quantitative studies which were appropriate for this thesis.

2.0.3 Narrative Thesis Approach To Reviewing The Literature

Narrative reviews, according to Schneider et al. (2007), are a traditional approach, which allow for a broad review of a topic. Using this approach initially, allowed for themes to be developed and focus areas to then be identified. Many of the initial researched areas were articles, editorials and commentaries on nurse migration, integration into a new nursing culture and associated challenges faced by IRNs-EASL.

There are however, some research articles on transitioning international nurses into practice which were useful but there was no New Zealand research which addressed the unique needs of preceptors for IRNs-EASL. For this reason an integrative review approach will be used to describe the literature. An integrative review approach according to Schneider et al. (2007), “enables the inclusion of studies with diverse methods, as well as theoretical and methodological papers” (p.55). Due to the limited quantifiable research available this literature review uses general themes, supposition and discussion to guide its format.

2.1 Literature Review:

Introduction

The literature review discusses both international and national research and recognises that there is a dearth of New Zealand literature. It defines the differences and similarities between the preceptorship and mentorship roles, discusses contractual accountability of preceptors when assessing IRNs-EASLs and identifies preceptors’ confusion between social responsibilities and clinical assessment. Both national and international literature identifies barriers for IRNs-EASL in competency assessment and transition programmes and identifies gaps in preceptor training particularly in regard to cultural diversity and lack of organisational recognition and support for the role.

2.2 Ethical and Legal Accountability

To ensure safe client care and ethical professional practice, IRNs-EASL, like New Zealand registered nurses, must provide care within the guidelines of the Code of Conduct (Nursing
Council New Zealand, 2009b) and demonstrate competency through the Domains of Competence (Nursing Council New Zealand, 2011). According to Luhanga et al. (2010) nurses in the preceptor role are contractually accountable for accurate clinical evaluation and have a professional and moral responsibility to the student. These responsibilities include selecting appropriate activities based on learning objectives, determining the student’s prerequisite knowledge, skills, and attitudes necessary to complete their Domains of Competency. They must also provide appropriate guidance, supervision and feedback (Cherry & Jacob, 2002; Gaberson & Oermann, 1999). Cherry and Jacob describe accountability as “an ethical duty stating that one should be answerable legally, morally, ethically or socially for ones activities” (p. 189). In nursing this accountability is “unquestionably multi-faceted” (Luhanga, Myrick, & Yonge, 2010, p. 265), with a responsibility to clients, contractual accountability to employers, and professional accountability to their governing body and society as a whole (Nursing Council New Zealand, 2008a, 2009b).

2.3 Definition Of The Preceptor Role
In researching the literature it was noted that there is a blurring of descriptions between the preceptor model and that of the mentor. There is little or no universal agreement with regards to the role and function of the preceptor/mentor (Bray & Nettleton, 2007; Huybrecht, Loeckx, Quaeyhaegens, De Tobel, & Mistiaen, 2011; Koskinen & Tossavainen, 2003). Huybrecht et al., however identify preceptorship as a short term contract which usually includes some form of assessment. Jordan (as cited in Huybrecht et al., 2011) defines mentors as “giving support, assistance and guidance in learning new skills, adopting new behaviours and acquiring new attitudes” (p. 274).

In a New Zealand context, registered nurses both preceptor and mentor IRNs-EASL through their competencies and face a duality of roles compounding the complexities of assessment with “failing to fail” an unsafe nurse and moral dilemmas due to “assessing a friend” (Bray & Nettleton, 2007). For the purposes of this literature review a preceptor may also be termed a mentor, as clearly the roles are intertwined.

2.4 New Zealand Research
Kai Tiaki Nursing New Zealand recently published an article by Bland, Oakley, Earl and Lichtwark (2011), examining barriers for transitioning students through a competency
assessment programme in New Zealand. This is the only study which has looked specifically at a competency assessment programme in New Zealand. The study explored transition to clinical practice by registered nurses on the completion from one competency assessment programme and also integrated the district health board orientation programme. The study developed three main questions involving the understanding of programme objectives, assessment of students, and whether a generic clinical orientation programme of a District Health Board prepared new employees for practice. Interviews were conducted over a six week period. The research identified that cultural expectations of both IRNs-EASL and New Zealand registered nurses needed to be recognized and “married together” (p. 18). There was an expectation that IRNs- EASL would practice in a similar way, and intensity to that of New Zealand staff nurses. They also noted that it appeared to take longer for IRNs-EASL to “integrate” into NZ nursing culture than New Zealand nurses returning to practice and that clinical expertise of IRNs-EASL was not immediately demonstrated. The research identified that both IRNs-EASL and CAP assessors failed to understand NCNZs competency assessment framework. Preceptors were unfamiliar with, and lacked understanding of the assessment language used in the competencies and were unwilling to commit to paper what they saw as accountability for their practice in signing off of IRNs- EASL as safe to practice through NCNZs Domains of Competency.

The study also identified resentment of preceptors supporting IRNs-EASL while continuing to work with a full patient quota and with no financial recognition. Multiple preceptors for IRNs and busy workloads also contributed to preceptor stress coupled with the preceptor’s perception that the time frame (four weeks) was insufficient to meet clinical competencies and that more time was required for planning and assessment. Also of concern was the issue of communication with preceptors identifying different cultural non-verbal communication styles, concerns with comprehension and verbal delivery, noting IRNs-EASL were timid and shy and found communication with doctors and answering the telephone stressful.

This timely publication was the first research in New Zealand to identify preceptor concerns within a competency assessment programme and complements this study. The limitations of the study were that the research looked at one competency assessment programme and one district health board (DHB). However, the methodology used was able to discuss in depth, issues that were specific for the participants.
2.5 Barriers For Preceptors and IRNs-EASL Within Competency Assessment and Transition Programmes.

International researchers Zizzo & Xu (2009), in their systematic literature review of transitional programmes for international nurses, noted the limited research available and were critical of institutional and managerial commitment for failing to recognize the unique transitional and adaptation needs of IRNs. Their review recognized, however, that mentorship is one of the critical factors for successful adaptation (or failure) of international nurses and that more interventional research is needed to test measures designed to facilitate transition.

Koskinen & Tossavainen (2003) noted, in their Intercultural Mentoring study using an ethnographic approach, that IRN-EASL often suffer from language problems, loneliness, isolation and home sickness in the host culture. There is adequate literature to support this finding when reflecting on studies written from the perspective of those entering the New Zealand nursing culture with English as second language. Woodbridge & Bland (2010) noted that an excess of nurses are trained in developing nations with a view to migration. There is a need to ensure that receiving countries provide comprehensive orientation to IRNs-EASL along with both technical and non technical skills so they can attain the same knowledge base as their colleagues (Woodbridge & Bland, 2010). The ICN (International Council of Nurses, 2001), states that all nurses must be given access to appropriate programmes, which support and maintain competence, and in New Zealand ongoing professional development is a requirement for maintaining a practicing certificate (Vernon, et al., 2010).

For IRNs-EASL there are many challenges during the transition into practice in a new culture. As well as physical displacement from family, cost associated with migration, adaptation to different clinical practices and climate, there is also the challenge to demonstrate competence in the use of English (Kingma, 2006). An Australian study noted that accents and the multiple meaning of words and slang can be major barriers (Walters, 2008). Misunderstandings and delays in registration due to difficulty meeting formal language requirements were major hurdles for nurses from South Asia and India (Walters, 2008). IRNs have stated that differences in pronunciation, accent and terminology led to fear of miscommunication (Xu & Kwak, 2007). These findings are supported by Bland et al.
(2011), who noted that preceptors found communication to be a barrier when mentoring IRNs-EASL.

While many IRNs-EASL are highly skilled experienced practitioners in their home countries, they may be challenged when working in different nursing environments. Nurses reported feelings of disempowerment caused by discriminatory practices, professional isolation and unrealistic expectations by local nurses (Deegan & Simkin, 2010). Deegan & Simkin interviewed 13 participants using a modified grounded theory approach. They noted that feelings of competency were affected by inconsistent levels of education and professional support and negative perceptions of prejudice. Walters (2008) noted that professional marginalization and a “sense of otherness” (p. 1) made transition difficult. Adams and Kennedy (2006) identified institutionalized racism, coping with different belief systems, negative attitudes of both staff and patients as barriers to competent and safe practice. Deegan and Simkins’ (2010) study, aptly named “Expert to novice”, noted that three cultural themes emerged – non recognition of professional skills, use of language and communication as a barrier for successful integration, and work place discrimination.

Cummins (2009), distributed 220 questionnaires to migrant nurses working in Ireland, finding forty nine percent of nurses noted differing work practices from their home countries, but that ninety six percent of nurses found the preceptoring experience beneficial despite communication barriers. This study, being quantitative in method, was unable to explore depth of feeling, and was limited to a singular (perioperative) practice setting.

2.6 Cultural Adaptation
Mentoring and preceptorship can be a way to assist IRNs to achieve their goals provided mentors, administrators and nurses are familiar with the many differences in health care systems between the East and West (Xu & Kwak, 2007). By making the transition more welcoming, and providing “safe passage” it will make it easier for IRNs to enter and learn in the new cultural environment (Woodbridge & Bland, 2010). More data is needed around cultural adaptation issues particularly the high social cost to women as displacement from family (including young children) create complex social issues, which are often reflected in practice (Buchan, 2001).
Ramsden (1993), requires nurses to examine their own cultural values and beliefs and demonstrate an open and flexible attitude to those from different cultures. As a country that embraces cultural safety, New Zealand needs to be mindful of the many cultures and cultural concepts New Zealand nurses work within (Wepa, 2005). Cooney (1994, p. 6) states “Unsafe practitioners diminish, demean and disempower those of other cultures, whilst safe practitioners recognise, respect and acknowledge the rights of others”. Hence, while nurses should be active partners in the Treaty of Waitangi (ToW), in meeting the Health Practitioners Competence Assurance Act (2003) nurses must also be culturally competent (DeSouza, 2008). Cultural competence is defined by DeSouza, as “the ability of systems to provide care to patients with diverse values, beliefs and behaviours…” (p.131). Clinical cultural competence therefore can be enhanced through staff training, workforce development, and staffing (or ethnic matching) that reflects the culture they serve (DeSouza, 2008). Cultural competence emphasizes learning about the culture of another whereas according to DeSouza cultural safety recognizes the importance of oneself as a culture and “power bearer” (p133). Given the diversity of the New Zealand community, IRNs-EASL may provide the paradigm for guidance in practice settings that can complement the implementation of cultural safety.

2.7 Rewards Of The Role
Salami (2010) examined satisfaction with mentoring based on gender and social support in Nigeria. His research noted that increased professional stressors of a struggling economy, retrenchment, increased workload, burnout and insecurity in the workplace negatively impacted on the mentoring experience particularly when the mentor and protégé have different values or attitudes. Using hierarchical multiple regression techniques he noted no significant relationship between gender and work attitudes but that social support and mentoring satisfaction were related to career attitudes. This study may reflect New Zealand preceptors resentment documented by (Bland et al., 2011) who noted heavy workload and communication as barriers. The current economy and nursing environment may also impact on this resentment. Limitations of the study may reflect the socio cultural differences, particularly with gender roles between New Zealand and Nigeria.

In Briggs and Shriner’s (2010) article they identify both intrinsic and extrinsic rewards for the preceptor role and propose the use of preceptor “recognition programmes” to raise the profile of the role within organisations. Intrinsic rewards within the programmes would
include the opportunity to teach and influence nursing practice, share and broaden one’s own knowledge base and encourage critical thinking. External rewards proposed included online educational resources, educational workshops, excellence awards and newsletters. Alspach (2003) identified the top three incentives for the preceptor role as being demonstrating the worth of nursing work, financial and career advancement and increased respect of colleagues while Benner (1995) states that “preceptors are more likely to continue and commit to the role when they perceive that the rewards are personally meaningful or professionally beneficial” (p. 102).

2.8 Preceptor Responsibilities and Attitudes

The presence of a good mentor is crucial to students’ well being and learning potential (Philips, Davies, & Neary, 1996). A number of studies also show that mentors can themselves benefit from the role if it is formally recognized and contributes to professional development (Watson, 2006). Watson’s ethnographic, mixed method study of mentor support in the United Kingdom, consisted of 994 questionnaires with a response rate of 44.6 percent which ensured reliability of the data. The study raised several areas of concern – mentors felt students were ill prepared for clinical placement, that they felt pressured into recording assessments which at times were at odds with their own judgment and that the time spent with students conflicted with time available for care delivery. Preceptors in this study also felt that they were inadequately prepared for the role of mentor. Limitations of the study are its age and the diversity of the student group represented.

Although much has been written about the qualities and attributes of what constitutes a good mentor, it would appear from the literature that there is little correlation with selection and training (Andrews & Chilton, 2000). Andrews & Chilton also noted in their qualitative study of “Preceptor perceptions of their own aptitude” that many nurses were mentors, not by choice, but as a compulsory part of their work. Mentors, as a result, often felt inadequate in their roles either because they believed their training did not equip them for current practice and/or because they did not understand the aims of the pre-registration programme.
2.9 Preceptor Education

Similarly, Bray & Nettleton (2007), whose mixed method study looked at both how mentoring is conceptualized in the health setting and the training and development needs of the mentor, identified that nursing mentors gave less priority to the assessor role than to that of the pastoral role and that there was poor formal recognition of the importance of assessment. It was recognized however, that this study achieved a low response rate of 13 percent. By contrast Huybrect et al. (2011), whose response rate was 62 percent, noted that although preceptor perceptions were generally positive, more importance needed to be placed on preceptor education. Allan (2010), in her United Kingdom study, notes similarly, that there is a lack of effective teaching of ethical practice in the context of cultural diversity within health care, further stating that mentors are ill equipped to mentor IRNs from existing mentor training programmes. Alspach (2008) concluded that preceptors receive inadequate educational preparation especially in relation to diversity of cultures and language. Alspach also noted that there was even less support for the preceptors once they had accepted the role. Yonge, Habler, Cox, and Drefs’ (2008), in their study of preceptor training noted that while approximately 50 percent believed they were prepared for the role following training, 56 percent of those attributed this preparation to previous clinical expertise.

Sandau, Cheng, Pan, Gaillard, and Hammers’ (2011) study used a mixed method approach with a quasi-experimental design to test preceptors self-reported confidence and comfort before and after preceptor training. Part one of the study used a quantitative approach and noted a significant improvement of confidence and comfort three to six months after attending a training workshop. Part two of the study using qualitative narrative noted that the primary barrier to positive preceptoring was workload issues while in the role of preceptor (Sandau & Halm, 2011). This reinforces the theme woven throughout the literature, concerning the lack of organisational support for preceptors.

2.10 Summary

Several core themes have emerged from the literature review. Firstly there is limited New Zealand literature particularly relating directly to preceptorship of IRNs-EASL. Secondly the international research suggests that, organisationally, the unique needs of IRNs are overlooked by failing to provide adequate preparation and education to preceptors which results in a lack of understanding of culture difference and diversity. This lack of
understanding often equates to disempowerment of the IRNs-EASL. Thirdly, the role of preceptor and mentor is ambiguous, with many preceptors failing to understand the concept and associated responsibilities. This is evident in the “failing to fail” and “assessing a friend” attitude which questions preceptors’ understanding of ethics and accountability. Fourthly, - preceptors are not always in the role by choice, also questioning the ethics of the employing organisation(s) and subsequent lack of education, perceived support and recognition for the role. There is confusion over accountability and evidence that accountability is multi faceted suggesting a lack of understanding and education within the role.

In light of this, research needs to occur in New Zealand which identifies current attitudes toward the role in the changing nursing environment and asks whether preceptors feel adequately prepared and supported to confidently assess IRNs undertaking competency assessment programmes.

**Chapter Summary**

This chapter has considered the search strategies for the literature review and discussed how the topic was critiqued. It has also discussed the limited research relevant to registered nurses support and preparedness when preceptoring IRNs-EASL through a competency assessment programme and the consequent use of a narrative approach. The literature review defined the preceptor’s role, discussed contractual accountability, barriers, rewards and attitudes toward the role and explored preceptor education.
Chapter 3

METHODOLOGY

“In dwelling on the importance of sound observation, it must never be lost sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort”

(Florence Nightingale)

3.0 Introduction

The literature review identified the limited New Zealand research regarding preceptors of IRNs-EASL. In this chapter the researcher will describe the research design and discuss the sample and data collection methods. The chapter will also discuss validity and reliability of the data, ethical principles and issues and discuss the management and analysis of the data.

3.1 Research Design

The research is a quantitative non-experimental descriptive/observational study. A descriptive study from a quantitative perspective involves collection of data via questionnaire and requires no interaction with participants (Schneider, et al., 2007).

For this research, a quantitative approach was used because the study was broad and the research time was limited. A recommendation for further research may be to provide qualitative research to support and provide increased depth for the findings within this report.

An invitation to participate in the research and a web link were sent to approximately twenty six thousand registered nurses via the New Zealand Nurses Organisation (NZNO) e-newsletter. This allowed for a broad representation of preceptors attitudes and perceptions and ensured anonymity. The survey commenced on 12th July 2011 with the
survey remaining open until 22nd August 2011. The purpose of the research was clearly explained and only preceptors of International nurses with English as a second language invited to participate.

3.2 Sample Size
According to Lo Biondo-Wood and Haber (2006) no single rule can be applied to sample size, although the sample size should be determined before the study is conducted. The researcher believed that a sample size of between one hundred, and one hundred and fifty participants, would benefit the study. A power analysis was unable to be undertaken as at the time of publication no data has been collected in New Zealand that identifies the number of preceptors available, the number of registered nurses who preceptor IRNs-EASL or the number of registered nurses who have completed preceptor training. One DHB claimed 13% of registered nurses within their staff had completed preceptor training (personal communication Chris McKenna April 2011). There is no way of knowing if this figure is representative of all employing organizations. Line managers hold this information but it was unavailable given the breadth both clinically and geographically of the study.

The (NZNO) e-newsletter carried a link to the Survey Monkey™ questionnaire. Of the 26,000 e-newsletters there is no way of identifying how many registered nurses (as opposed to enrolled nurses, care Assistants, managers and non working registered nurses) received the e-newsletter, and further, how many had preceptored IRNs-EASL. Participants were excluded from the questionnaire if they had not preceptored IRNs-EASL in the last five years.

3.3 Data Collection Tool
There have been no previous quantitative surveys in the literature that questioned the preparedness of preceptors to assess IRN-EASL. Therefore a questionnaire consisting of twenty nine questions was developed. The questionnaire took approximately fifteen minutes to complete and was designed to reflect the aims of the research.

A quantitative study of this design was selected by the researcher for ease of accessing preceptors from broad clinical and geographical areas therefore affording a larger sample size. Ease of administration and affordability were also a consideration.
3.4 Validity
Validity refers to the extent to which the instrument (questionnaire) measures what it is intended to measure (Bui, 2009) and is free from bias (Schneider, Elliot, LoBiondo-Wood, & Haber, 2003). Schneider et al. (2003) consider “validity to be the most fundamental consideration in instrument development” (p. 340) and notes that “a valid instrument truly reflects the concept of interest” (p. 340).

The questionnaire was piloted to assess the reliability and appropriateness of the questions and to ensure validity. According to Downs (1999) “pilot work is of critical importance to carefully conceived sampling designs, especially when there is not a substantial body of published research on the variables of interest” (p. 7). Pilot studies ensure the relative variance of the dependent variable can be estimated and allow the feasibility of the sampling plan to be evaluated (Downs, 1999). The pilot study did not assist with population size in this instance. Appropriate wording changes were made following the pilot for ease of understanding of some of the questions.

3.5 Reliability
Reliability refers to the consistency with which the instrument (questionnaire) measures what it is intended to measure (Bui, 2009). A reliable instrument is one that can produce the same results if the behavior is measured again by the same scale (Schneider et al., 2007). The pilot study was distributed to individual of preceptors who were culturally and clinically diverse and, who were all preceptors of IRNs-EASL. Reliability was not demonstrated in this study as the researcher was unable to re-contact original participants as survey participation was anonymous.

3.6 Distributing and Collecting the Research data
The researcher considered many avenues of data collection before settling on using an internet survey tool for development of the questionnaire and NZNO’s e-newsletter for distribution. The simplicity with which Survey Monkey™ linked to NZNO emails ensured data collection was uncomplicated. NZNO offered an appropriate time frame for distribution and did not require financial recompense for the service. It also ensured wide distribution both geographically and clinically as per the aims of the study.
3.7 Ethics

Schneider et al. (2007) state that the universal framework for ethical research encompasses the core principles of: respect for autonomy; respect for privacy; respect for justice; beneficence; respect for human vulnerability and integrity; and respect for cultural diversity.

3.7.1 Respect For Autonomy: refers to the right to self determination (Schneider, et al., 2007). The participant information sheet clearly stated that the response to the research is voluntary and that participation is optional.

3.7.2 Respect For Privacy: ensures that participants have complete anonymity for the questionnaire and that the researcher will be unable to identify them. Survey Monkey™ ensures confidentiality.

3.7.3 Respect For Justice: is based on the right for fair treatment (Polit & Beck, 2004). Schneider et al. (2007) state “participants should be selected for a study because they match specific and clearly stipulated criteria, not because they are conveniently available or easily exploited”. The survey/questionnaire was relevant to those participants who have been preceptors to Internationally Registered Nurses for whom English is a second language. Participants who had not preceptored IRN-EASL were exited from the survey at question six.

3.7.4 The Promotion Of Beneficence: refers to “doing good” as well as preventing and removing harm (Johnstone, 2009). The participant’s information sheet informed the participants that the research promoted “safe passage” for transitioning IRNs and promoted the interests of public safety.

3.7.5 Respect For Human Vulnerability and Integrity: although preceptors are not themselves a vulnerable group, the attitudes identified may be required to be handled sensitively and respectfully.

3.7.6 Respect For Cultural Diversity: refers to the nature of the study. The participants and theme are recognized as culturally diverse. However cultural diversity is not limited to ethnic background. According to Lederach (1995, p. 9) “culture is the shared knowledge
and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them”. According to Wepa (2005) “we must give full credence to the other cultures we encounter in research in terms of their histories, beliefs and practices”. The participants’ information sheet and questionnaire was developed in response to this knowledge.

3.8 Cultural Safety
Questions within the questionnaire were developed in consultation with Maori and demonstrate commitment to the Treaty of Waitangi and recognize tangata whenua (Māori as people of the land). The questions relate directly to the incorporation of the Principles of the Treaty of Waitangi into the preceptor/IRN-EASL relationship. Maori nurses, as preceptors of IRNs-EASL were also participants in the survey. Both the Hawke’s Bay District Health Board Māori Health Advisor (HBDHB) and an EIT Faculty of Health Sciences Māori nurse colleague were presented with potential questions which incorporated the Treaty of Waitangi and Cultural Safety. The outcome of consultation highlighted the importance of explicitly incorporating the Treaty of Waitangi Principles.

3.9 Ethical Approval
Prior to the commencement of the research approval was received from the Ministry of Health’s Multi Region Health and Disability Ethics Committee and from the researcher’s institutional Research Ethics and Approval Committee.

3.10 Quantitative Data Analysis
Descriptive analysis was performed for each question. Percentages, means and crosstabs were used to explore the data. Demographic results were graphically represented. “Such graphical and numerical techniques enable trends and differences to be noted.......and for descriptive statistics to condense or reduce large quantities of numerical information into meaningful data” (Schneider et al., 2007, p. 226).

3.11 Use, Storage and Disposal Of Data
The data will be used by the researcher for this Masterate thesis research. Findings will be published and presented ensuring anonymity of the participants.
The data will be stored electronically with pass word protection until completion of the thesis. Computer data will be retained for five years after which time they will also be destroyed. The paper copies of the data and results will be destroyed when the thesis is completed.

3.12 Summary
This chapter has reviewed the methodology for this research project. It has described the research design as well as the sample and collection methods. Ethical issues and the principles of validity and reliability were discussed. The chapter concluded with how the data will be analysed as well as managed.
Chapter Four:

RESULTS

“However beautiful the strategy, you should occasionally look at the results”.

(Sir Winston Churchill)

4.0 Introduction

This chapter will present the findings of the research in several sections that reflect the objectives of the research. The objectives of the research were:

1. To establish whether preceptors perceive they are adequately prepared to confidently assess IRNs-EASL;
2. To establish the perceived level of support for preceptors of IRNs-EASL;
3. To establish the preceptors understanding of ethical and legal accountability;
4. To establish the perceived organizational attitudes toward IRNs in the changing nursing environment.

Sections 4.1-4.3 consider who the preceptors are and whether they meet Nursing Council of New Zealand standards for competence assessment programmes.

Section 4.4 focuses on preceptor training programmes and considers whether they increase confidence and prepare registered nurses to confidently preceptor IRNs-EASL. Training programmes are also compared. The support of preceptors is discussed in relation to collegial support, support from CAP coordinators (providers) and organisational support.

Sections 4.5-4.7 discuss where IRNs-EASL have been preceptored in relation to survey respondents, assesses the general level of support for preceptors and the perceived level of reward for the role. Organisational support is evaluated through sections 4.8-4.10 which focus on formal recognition of the preceptor role, volunteer status of the role, and workload commitments including NCNZ documentation and organisational attitudes toward IRNs-EASL. Section 4.11 considers the legal and ethical requirements of preceptoring IRNs-EASL and addresses preceptor understanding of accountability, the requirements of the Treaty of Waitangi and bio-ethics which guide preceptor practice.
4.1 Response Rate and Number
An email link to the Preceptor Experience Survey was emailed to approximately 26,000 recipients of the NZNO newsletter. There is no way of assessing how many registered nurses who received the link had preceptored IRNs-EASL as there is no national register for preceptors. Thus a response rate cannot be calculated.

One hundred and fifty one nurses responded to the survey. Eight nurses exited from the survey at question 6 as they had not preceptored an IRN-EASL in the last five years. A further 18 exited the survey when asked how many IRNs-EASL they had preceptored over the last five years leaving a total of 133 respondents. Respondents were given the option of not answering several of the questions. Between 133 and 94 respondents answered each question.

4.2 Preceptor Demographics - Who Are The Preceptors?
The ethnicity of respondents is shown in Figure 1. New Zealand Pakeha (New Zealander of Caucasian descent) made up the majority of the respondents representing 44% of the total. Seventy percent of all the respondents answered “yes” to English as their first language.

![Figure 1. Ethnicities of the preceptor experience survey respondents. The number of responses is bracketed for each ethnicity.](image)

Of the 151 respondents the majority worked in a general medical or surgical ward or in a high acuity ward within a regional hospital run by a District Health Board (DHB) (Figure 2).
Statistics identified by NCNZ (Nursing Council of New Zealand, 2010c) note that 45 percent of all registered nurses work in general medical/surgical and high acuity wards within DHBs, 13 percent work in as practice nurses within primary health organisations (PHOs), 10% work as community nurses, 10 percent work in Elder Health and 1 percent as Māori health providers. The remaining registered nurses work in a variety of settings, not included in the survey demographics.

Approximately fifty percent of the respondents had achieved a postgraduate qualification (22% Post Graduate Diploma, 19.3% Post Graduate Certificate, and 9.3% Masters Degree). Thirty percent of respondents noted their highest qualification as a Bachelor Nursing while the remainder held either having a Diploma of Nursing (12%) or hospital trained certificate (Registered General Obstetric Nurse) (7.4%). Figure 3 shows the qualification spread throughout the work environments.
4.3 Nursing Council of New Zealand Standards for Competency Assessment

Nursing Council of New Zealand (NCNZ) requires preceptors to have completed a formal preceptor training programme and to have greater than three years nursing experience (Nursing Council New Zealand, 2008b). Of those who started the survey, 143 people responded to the standards of practice questions. Eight of these had never preceptored an IRN-EASL and therefore exited the survey. Of those who had preceptored an IRN-EASL (n=135), 95.5% (n=129) had been registered as a nurse for 3 or more years and of these 80.6% (n=104) had done preceptor training.

It is therefore of note that 19.4% (n=25) of the nurses registered for three or more years had not completed preceptor training and therefore do not meet NCNZ Standards of Practice. Furthermore, 4.7% (n=6) of the preceptors had been registered for less than three years; however four of these had received training. These nurses also do not meet NCNZ Standards of Practice. In total 23.0% (n = 31) of the IRN-EASL preceptors did not meet the Nursing Council’s Standard of Practice for competence assessment programmes.

The majority of the nurses who did not meet NCNZ preceptor criteria worked in a regional hospital operated by a DHB (75.9%) with 34.5 % in the general medical/surgical wards and
41.4% in the high acuity wards. Of the remainder, 17.2% worked in elder health, 3.4% worked as community nurses and 3.4% worked as practice nurses.

4.4 Preceptor Training Programmes

Training programmes attended were broken down into Institute of Technology/Polytechnic (ITP) training, employer training, don’t know and other. One hundred and eight respondents attended a preceptor training programme. Eighteen attended two or more training programmes. In total 126 training programmes were attended. Nine preceptors chose the category labeled “Other” and they predominantly specified that the training programme was run by a District Health Board (n=7) with one respondent noting university and another noting a Certificate in Adult learning and Teaching.

Areas of work and training provider attended were compared (Table 1). Most DHB preceptors (general medical/surgical and high acuity; 65%) attended training programmes run by their employer and 24% trained at an ITP. Half of the respondents working in elder health trained at ITPs. Community and practice nurses trained at both employer and ITP run courses, however representation of these groups is low and generalizations will not be made. It should also be noted Maori health providers are not represented as none of their respondents had preceptored an IRN-EASL within the last five years.

<table>
<thead>
<tr>
<th>Work Area</th>
<th>ITP</th>
<th>Employer</th>
<th>Don’t Know</th>
<th>*Other</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>General med/surg DHB</td>
<td>8.6% (n=11)</td>
<td>22.8% (n=29)</td>
<td>2.3% (n=3)</td>
<td>1.6% (n=2)</td>
<td>35.4% (n=45)</td>
</tr>
<tr>
<td>High Acuity-DHB</td>
<td>11.0% (n=14)</td>
<td>22.0% (n=28)</td>
<td>0</td>
<td>0.8% (n=1)</td>
<td>33.8% (n=43)</td>
</tr>
<tr>
<td>Elder Health</td>
<td>9.4% (n=12)</td>
<td>5.5% (n=7)</td>
<td>0.8% (n=1)</td>
<td>3.1% (n=4)</td>
<td>18.9% (n=24)</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>2.4% (n=3)</td>
<td>3.9% (n=5)</td>
<td>0.8% (n=1)</td>
<td>0.8% (n=1)</td>
<td>7.9% (n=10)</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>1.6% (n=2)</td>
<td>1.6% (n=2)</td>
<td>0</td>
<td>0.8% (n=1)</td>
<td>4.0% (n=5)</td>
</tr>
</tbody>
</table>

100% (n=127)

Of those preceptors who had attended a training programme 71.4% expressed that it had increased their overall level of confidence and the remainder felt their confidence was not increased. A preceptor is expected to complete a NCNZ assessment of each IRN-EASL under their mentorship. Approximately sixty five percent of nurses believed the training prepared them to assess IRNs-EASL using the framework of NCNZs Domains of Competencies while the remainder believed it did not.
Of those who trained with their employers, 59.2% stated the training had prepared them for NCNZ assessment documentation while 40.8% noted it did not. In contrast, of those who trained in ITPs 73.2% felt the training prepared them for NCNZ documentation while 26.8% believed it did not.

4.5 Support Of Preceptors

Overall most preceptors felt supported by their colleagues (78.9%), the Competency Assessment Coordinator (62.4%) and employing organization (62.8%)(Figure 4).

4.6 Perceived Level of Reward For The Role of Preceptor To IRNs-EASL

Respondents were asked to represent how rewarding they found their preceptor role using a Likert scale (1 = very rewarding; 4 = neither rewarding, nor unrewarding; 7 = very unrewarding). Approximately 78% of respondents expressed some level of reward (a response of 1, 2 or 3) (Figure 5). The average Likert rating was 2.73.
4.7 Organisational Support

Respondents were asked to represent how valued by their employer they felt in their preceptor role using a Likert scale (1 = very rewarding; 4 = neither rewarding, nor unrewarding; 7 = very unrewarding). Fifty six percent felt valued to some degree by their employing organisation (Figure 6). The average Likert rating was 3.24.
When considering organisational support the average Likert rating response was 2.92 for those working in general medical/surgical wards. Approximately 65% of preceptors in this work area feel valued to some degree. Those in high acuity wards felt less valued with an average Likert rating of 3.52 and with 48% feeling valued to some degree. In elder health the average Likert rating was 3.58 with approximately 42% of preceptors in this area feeling valued to some degree (Table 2).

Representation of community and practice nurses was low. Consequently generalizations and analysis will not be done for these groups.

Table 2. Likert responses to how valued preceptors felt their role was by their employer broken down by employment area. Actual number of responses is in brackets.

<table>
<thead>
<tr>
<th>Likert Scale</th>
<th>General medical/surgical ward in a DHB</th>
<th>High acuity ward in a DHB</th>
<th>Elder Health</th>
<th>Community Nurse</th>
<th>Practice Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Valued, 1</td>
<td>22.9% (11)</td>
<td>12.5% (6)</td>
<td>21.1% (4)</td>
<td>42.9% (3)</td>
<td>20.0% (1)</td>
</tr>
<tr>
<td>2</td>
<td>18.8% (9)</td>
<td>16.7% (8)</td>
<td>15.8% (3)</td>
<td>14.3% (1)</td>
<td>40.0% (2)</td>
</tr>
<tr>
<td>3</td>
<td>22.9% (11)</td>
<td>18.8% (9)</td>
<td>5.3% (1)</td>
<td>14.3% (1)</td>
<td>20.0% (1)</td>
</tr>
<tr>
<td>4</td>
<td>20.8% (10)</td>
<td>20.8% (10)</td>
<td>26.3% (5)</td>
<td>14.3% (1)</td>
<td>0.0% (0)</td>
</tr>
<tr>
<td>5</td>
<td>8.3% (4)</td>
<td>20.8% (10)</td>
<td>10.5% (2)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
</tr>
<tr>
<td>6</td>
<td>6.3% (3)</td>
<td>10.4% (5)</td>
<td>15.8% (3)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
</tr>
<tr>
<td>Very Under Valued, 7</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>5.3% (1)</td>
<td>14.3% (1)</td>
<td>20.0% (1)</td>
</tr>
</tbody>
</table>

Rating average 2.92 3.52 3.58 2.71 3

(48) (48) (19) (7) (5)
4.7.1 Formal Recognition Of The Role of Preceptor To IRNs-EASL

Respondents to the survey were asked, as an indicator of organisational value, if they received formal recognition for their preceptor role of IRNs-EASL in the form of financial recognition, workload reduction or professional development.

Financial recognition for the role was limited, with 95.7% (110 out of the 115) respondents to the survey receiving no financial reward for their preceptor role. Of the nurses who did receive financial recognition for their preceptor role, two nurses worked in a general medical/surgical ward in a DHB, one in a high acuity ward, one in elder health and one was a community nurse. Eighty six percent of preceptors did not have their patient load reduced to compensate for the time required to preceptor an IRN-EASL. Of the nurses who did receive workload reduction for their preceptor role, four nurses worked in a general medical/surgical ward in a DHB, nine worked in a high acuity ward, two in elder health and one was a community nurse. Sixty three percent of preceptors believed the organization offered formal recognition within their professional development programme while 36.9% did not.

4.7.2 Volunteer Status

In the DHBs slightly more than half did not volunteer to be preceptors of IRNs-EASL while in Elder Health, Community and Practice Nurses the opposite is true with 63% of nurses volunteering (Table 3).

Table 3. Survey respondents who volunteered to become preceptors and corresponding areas of work. Actual number of responses is in brackets.

<table>
<thead>
<tr>
<th>Employment area</th>
<th>Yes</th>
<th>No</th>
<th>Total Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Med/Surg in DHB</td>
<td>33.3%</td>
<td>39.3%</td>
<td>36.4% (44)</td>
</tr>
<tr>
<td>High Acuity Ward in DHB</td>
<td>35%</td>
<td>42.6%</td>
<td>38.8% (47)</td>
</tr>
<tr>
<td>Elder Health</td>
<td>16.7%</td>
<td>13.1%</td>
<td>14.9% (18)</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>8.3%</td>
<td>3.3%</td>
<td>5.8% (7)</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>6.7%</td>
<td>1.6%</td>
<td>4.1% (5)</td>
</tr>
<tr>
<td>Maori Health Provider</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0% (0)</td>
</tr>
</tbody>
</table>
Most survey participants had not been made to preceptor an IRN-EASL against their wishes (81.6%) although the remaining 18.4 % had been. For 32.2% (n=39) of preceptors the role was acknowledged as part of their job description, while 39.7 % (n=48) said it was not part of their job description and 28.1% (n=34) were unsure. Responses to the question “Is the role of IRNs-EASL part of your job description?” broken down by area of employment are shown in Table 4.

Table 4. Percentage of responses to the question “Is the role of IRNs-EASL part of your job description?” broken down by area of employment. Actual number of responses is in brackets.

<table>
<thead>
<tr>
<th>Response</th>
<th>General medical/surgical ward in a DHB</th>
<th>High acuity ward in a DHB</th>
<th>Elder Health Nurse</th>
<th>Community Nurse</th>
<th>Practice Nurse</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>36.4% (16)</td>
<td>23.4% (11)</td>
<td>33.3% (6)</td>
<td>42.9% (3)</td>
<td>60.0% (3)</td>
<td>32.2%</td>
</tr>
<tr>
<td>No</td>
<td>36.4% (16)</td>
<td>38.3% (18)</td>
<td>50.0% (9)</td>
<td>42.9% (3)</td>
<td>40.0% (2)</td>
<td>39.7%</td>
</tr>
<tr>
<td>Unsure</td>
<td>27.3% (12)</td>
<td>38.3% (18)</td>
<td>16.7% (3)</td>
<td>14.3% (1)</td>
<td>0.0% (0)</td>
<td>28.1%</td>
</tr>
</tbody>
</table>

4.8 Attitudes Towards IRNs-EASL
Approximately fifty one percent (n=62) of survey respondents felt that attitudes toward IRNs-EASL have not changed in the last twelve months. Fourteen percent (n=17) noted that attitudes had become more positive, 13.2% (n=16) felt that attitudes had become more negative and 21.5% (n=26) were unsure if change had occurred. Table 5 presents a breakdown of attitudes according to employment area.
Table 5. Organisational attitudes in working environments.

<table>
<thead>
<tr>
<th>Response</th>
<th>General medical/surgical ward in a DHB</th>
<th>High acuity ward in a DHB</th>
<th>Elder Health Nurse</th>
<th>Community Nurse</th>
<th>Practice Nurse</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes: Has become more positive</td>
<td>13.6% (6)</td>
<td>10.6% (5)</td>
<td>11.1% (2)</td>
<td>28.6% (2)</td>
<td>40.0% (2)</td>
<td>14.0%</td>
</tr>
<tr>
<td>Yes: Has become more negative</td>
<td>15.9% (7)</td>
<td>12.8% (6)</td>
<td>16.7% (3)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>13.2%</td>
</tr>
<tr>
<td>No: Has not changed</td>
<td>59.1% (26)</td>
<td>53.2% (25)</td>
<td>38.9% (7)</td>
<td>28.6% (2)</td>
<td>40.0% (2)</td>
<td>51.2%</td>
</tr>
<tr>
<td>Unsure</td>
<td>11.4% (5)</td>
<td>23.4% (11)</td>
<td>33.3% (6)</td>
<td>42.9% (3)</td>
<td>20.0% (1)</td>
<td>21.5%</td>
</tr>
</tbody>
</table>

Approximately thirty six percent (n=43) of survey participants believed the number of IRNs-EASL being preceptored had stayed the same, 29.8% (n=36) believed the number had increased, 19.0% (n=23) believed the numbers had decreased and 15.7% (n=19) were unsure.

4.9 Preceptor Workload

Preceptor workload was broken down into four components: pastoral care, assessing clinical skills, teaching clinical skills, and teaching the culture of nursing in New Zealand. As well as their normal nursing role, a preceptor is expected to assess clinical skills and safety to practice of IRNs although they are not expected to provide clinical training. Due to the nature of the role however, pastoral care is an inherent component when assimilating IRNs-EASL into nursing practice in New Zealand but one which is not formally recognised.

When the preceptors were asked if they had enough clinical time to adequately assess IRNs-EASL, 52.3% believed they did. A Likert scale was used to assess whether the following factors impacted positively (score of 1) through to negatively (score of 7): Cultural differences and perspectives; the IRNs-EASL nursing initiatives; the IRNs-EASL communication skills; clinical time available for assessment of the IRN-EASL. The average score were 3.03, 2.99, 3.51 and 3.61, respectively, suggesting communication skills and assessment time impact slightly negatively on their ability to assess IRNs-EASL.
4.9.1 Pastoral Care

Figure 7 shows the average percentage of time a preceptor spends each day on pastoral care with IRN-EASL. While 32.4% of the respondents spent minimal time on pastoral care, 30.6 percent spent between 10-20% of their time on pastoral care and the remainder of the respondents (36.9%) invested greater than 20% of their time.

![Pie chart showing time spent on pastoral care](image)

Figure 7. Time spent on average, on a typical day, doing pastoral care.

4.9.2 Assessing Clinical Skills

As expected, most respondents (31.8%) believed they spent >50% of their time assessing clinical skills (and safety to practice). A further 18.2% noted assessment time spent, as between 41 – 50% on average on a typical day (Figure 7).

![Pie chart showing time spent assessing clinical skills](image)
4.9.3 Teaching Clinical Skills

Both the assessing and teaching of clinical skills showed a similar workload pattern (see Figures 7 & 8). Figure 9 shows 29.7% of respondents on a typical day on average spending >50% of their time on teaching clinical skills.

4.9.4 Teaching the Culture of Nursing

The culture of nursing can be defined as nursing practice in New Zealand and includes working within a multidisciplinary team, communication, (therapeutic and collegial), nursing management and professional responsibilities. Figure 10 shows the percentage of time respondents spent teaching the culture of nursing.
4.9.5 NCNZ Documentation

The largest group of respondents, 36.9%, answered that Nursing Council New Zealand documentation required 0.5 – 1 hour/week to complete (Table 6). Over a four week period the total time to complete NCNZ documentation was therefore between 2 and 4 hours. Twenty seven percent of preceptors noted between 0 and 0.5 hours per week were spent completing NCNZ documentation while 36% of preceptors spend more than an hour a week on completing NCNZ documentation.

Table 6. Time spent completing NCNZ documentation

<table>
<thead>
<tr>
<th>Time spent hours/week</th>
<th>General medical/surgical ward in a DHB</th>
<th>High acuity ward in a DHB</th>
<th>Elder Health</th>
<th>Community Nurse</th>
<th>Practice Nurse</th>
<th>Response</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 0.5</td>
<td>22.0%</td>
<td>38.1%</td>
<td>11.8%</td>
<td>16.7%</td>
<td>40.0%</td>
<td>27.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>16</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>0.5 - 1</td>
<td>43.9%</td>
<td>31.0%</td>
<td>41.2%</td>
<td>50.0%</td>
<td>0.0%</td>
<td>36.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>13</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>1 - 2</td>
<td>19.5%</td>
<td>19.0%</td>
<td>29.4%</td>
<td>16.7%</td>
<td>40.0%</td>
<td>21.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>&gt; 2</td>
<td>14.6%</td>
<td>11.9%</td>
<td>17.6%</td>
<td>16.7%</td>
<td>20.0%</td>
<td>14.4%</td>
<td></td>
</tr>
<tr>
<td>answered</td>
<td>41</td>
<td>42</td>
<td>17</td>
<td>6</td>
<td>5</td>
<td>111</td>
<td></td>
</tr>
</tbody>
</table>

4.10 Ethical and Legal Requirements and Understanding

Registered nurses must meet NCNZ legal and ethical requirements, including the implementation of the Treaty of Waitangi and cultural safety, in order to maintain their practicing certificates and ensure safety to practice. “Cultural safety, the Treaty of Waitangi and Māori health are aspects of nursing practice that are reflected in the Council’s standards and competencies” (Nursing Council of New Zealand, 2011, p 4.) Accountability and bioethical understanding were also considered important components of assessment for preceptor’s understanding of these areas.
4.10.1 Treaty of Waitangi

In meeting Nursing Council New Zealand requirements for cultural safety and the legal and ethical implications of the Treaty of Waitangi for nurses it is reasonable to expect preceptors spend time discussing and demonstrating the requirements of the Treaty Principles and discussing cultural safety. Respondents were asked to use a Likert scale to indicate their attitude toward teaching cultural safety, (1 = very important; 4 = neither important, nor unimportant; 7 = very unimportant). Approximately 74% of respondents believed teaching cultural safety to be important or very important while 1.8% believed teaching cultural safety to be very unimportant (Figure 11). The average Likert score was 2.05.

![Figure 11. Survey respondents’ attitude to teaching cultural safety.](image)

4.10.2 Treaty of Waitangi Principles

The Treaty of Waitangi has three main principles: participation, protection, and partnership. Table 7 shows the average time spent on a typical day demonstrating/discussing the principles of the Treaty of Waitangi. When this is broken down by working environments (data not shown) there are large differences presumably related to the acuity of the patient and the patient’s ability to engage with the nurse. For example 25% of preceptors working in general medical/surgical wards spent >50% of their time demonstrating and discussing the three Treaty of Waitangi principles, whereas in the high acuity wards the percentage of preceptors that spent >50% of their time on each of
the principles was dramatically less (participation, 2.4% of preceptors; protection 4.8%; and partnership 7.1%).

Table 7. Time spent on average on a typical day demonstrating/discussing the principles of the Treaty of Waitangi.

<table>
<thead>
<tr>
<th></th>
<th>0 – 9%</th>
<th>10 – 20%</th>
<th>21 –30%</th>
<th>31 –40%</th>
<th>41 –50%</th>
<th>&gt;50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>27.30%</td>
<td>18.20%</td>
<td>13.60%</td>
<td>12.70%</td>
<td>15.50%</td>
<td>12.70%</td>
</tr>
<tr>
<td>Protection</td>
<td>33%</td>
<td>16.40%</td>
<td>12.70%</td>
<td>13.60%</td>
<td>13.60%</td>
<td>13.60%</td>
</tr>
<tr>
<td>Partnership</td>
<td>29.10%</td>
<td>13.60%</td>
<td>10.90%</td>
<td>16.40%</td>
<td>15.50%</td>
<td>14.50%</td>
</tr>
</tbody>
</table>

4.10.3 Pressure or Obligation to Record an Assessment
Approximately thirty six percent of preceptors had felt pressured or obligated to record an assessment of IRNs-EASL that they felt uncomfortable with while 63.8% had not.

4.10.4 Preceptor Ethical and Legal Accountability
Using a Likert Scale (1 = very responsible; 4 = neither responsible, nor not responsible at all; 7 = not responsible at all) survey respondents were asked to rate how responsible they felt to patients in their care, the New Zealand public, the IRN-EASL, NCNZ, the employing organisation and the CAP provider. Approximately eighty six percent of preceptors felt very responsible for the patients in their care with an average Likert scale score of 1.19; 67% felt very responsible for the New Zealand Public (average Likert scale score 1.45); 56 % felt very responsible for the IRN-EASL they were working with (average Likert scale score 1.68); 57% felt very responsible toward Nursing Council New Zealand (average Likert scale score 1.74) and 63% felt very responsible for the employing organization (average Likert scale score 1.62). By contrast only 22% felt very responsible for the provider of the Competency Assessment Programme (average Likert scale score 2.53).

4.10.5 Bio-ethics Guiding Practice
Ninety four survey participants responded to the final question “when preceptoring IRNs-EASL which bioethical principles guide your practice”. The preceptor was asked to rank the
following bioethical principles in order of priority for guiding their preceptoring practice: justice, beneficence, autonomy, and non-maleficence. Table 8 shows that 38% of respondents believe non-maleficence to be the first priority to guide their practice when preceptoring IRNs-EASL; 41.4% of respondents chose beneficence as their second priority; 32.2% selected autonomy as their third priority and 37.1% chose justice as their fourth priority.

Table 8. Priority level selected by preceptors (expressed as a percentage) for each of the guiding bioethical principles.

<table>
<thead>
<tr>
<th>Priority level selected</th>
<th>Justice</th>
<th>Beneficence</th>
<th>Autonomy</th>
<th>Non-maleficence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>17.4%</td>
<td>30.4%</td>
<td>14.1%</td>
<td>38.0%</td>
</tr>
<tr>
<td>2</td>
<td>16.1%</td>
<td>41.4%</td>
<td>26.4%</td>
<td>16.1%</td>
</tr>
<tr>
<td>3</td>
<td>29.9%</td>
<td>24.1%</td>
<td>32.2%</td>
<td>13.8%</td>
</tr>
<tr>
<td>4</td>
<td>37.1%</td>
<td>3.4%</td>
<td>24.2%</td>
<td>30.3%</td>
</tr>
</tbody>
</table>

4.11 Summary
This chapter has presented the research findings by grouping them into sections and subsections. The first section has considered who the preceptors are, where they work, and whether they meet NCNZ standards for practice. Training programmes have been evaluated in the second section for increasing support and preparedness and comparisons have been made between employer and ITP programmes.

The third section has considered the support offered to preceptors by colleagues, the CAP provider and the organization. Organisational support was measured in terms of formal recognition, job description and the preceptor’s willingness to do the role. This section has also considered the unique workload relating to preceptorship of IRNs-EASL. When the complexities of the role are understood, the support requirements of the preceptors can then be assessed.

Perceived attitudes and the numbers of IRNs-EASL being preceptored have been discussed in relation to the previous twelve months and the changing nursing environment and the final section has considered the preceptors understanding of ethical and legal requirements.
of the role. It has considered the preceptors perceptions of accountability, the requirements of the Treaty of Waitangi and reflected the bioethical principles that guide practice when assessing IRNs-EASL.
Chapter 5

DISCUSSION

Say not, “I have found the truth” but rather, “I have found a truth”.

(Khalil Gibran)

5.0 Introduction
This chapter will discuss the results of the research and they will be again grouped into the sections and sub sections identified during data analysis. Who the preceptors are will be considered, where they trained and whether the training increased confidence and preparedness. The perceived level of reward for the role will be discussed and the support offered by colleagues, CAP providers and organisations expanded upon. Workload issues will be examined in the context of value and support for the preceptorship role. The attitudes toward IRN-EASL in the current nursing environment will be reported. Finally this chapter will consider preceptors understanding of legal and ethical accountability and consider whether the results reflect accountability, confidence, preparedness and support when preceptoring IRNs-EASL.

5.1 Who Are The Preceptors?
The majority of the respondents worked in DHBs in general medical/surgical and high acuity wards with the remainder in elder health (residential care), in general family practice (GP settings) and community. The respondents were representative of the major areas nurses work in as identified by NCNZ (Nursing Council of New Zealand, 2010c). The findings were cross tabbed when appropriate to identify individual areas of interest and for comparison. Geographical areas were not included in the survey and this may have been useful when making comparisons.

Many respondents throughout the work environments had completed postgraduate training. This study may then represent a cohort of respondents who have a broader view of education and an interest in the careers of nurses. Thirty percent of respondents
identified that English was not their first language, suggesting that one third of respondents had themselves completed a competency assessment programme and now as preceptors were interested in assisting with the study. Many of the nurses who did not meet Nursing Council New Zealand’s preceptor criteria worked in general medical/surgical wards and high acuity wards within DHBs while a smaller percentage worked in elder health, community and practice nursing.

This may occur because employing organisations are unaware of NCNZ standards for competency assessment programmes and preceptor selection requirements. Alternatively, employing organizations may be aware of the requirements but be financially contracted to take IRNs-EASL without appropriate support structures to support these students, with demand for preceptors outweighing availability of nursing candidates who meet the requirements. It has been recognized that within larger organisations nursing management are often unaware of the percentage of nurses who are preceptors (C. McKenna, personal communication, April, 2011) or which registered nurses meet NCNZ standards for competency assessment and are therefore eligible candidates for the role.

5.2 Preceptor Training Programmes
The results suggest that those preceptors training through the Institutes of Technology/Polytechnics (ITPs) had increased confidence over those training through their employers. There was a significant difference between employers and ITPs in preparedness for completion of NCNZ Domains of Competence. This study, however, has also identified gaps in the training and identified the need for further understanding of legal and ethical requirements. Although training programmes are guided by the National Framework for Preceptorship Programmes (2002) it may be time to audit the framework and ensure that the needs of the IRNs-EASL and the preceptors are being met within the programmes, especially in light of the high numbers of IRNs-EASL who are registering in New Zealand and now make up a large percentage of all registered nurses.

The study of Bland et al. (2011) and this research has identified that preceptors require more comprehensive education to ensure the NCNZ documentation for the Domains of Competence are completed appropriately, with confidence and with understanding. Bland et al. highlighted the use of language and the “one size fits all” approach within the documentation as a barrier for preceptors completing assessments while this study has
highlighted the extended amount of time needed to meet documentation requirements. This is would suggest that the training preceptors receive does not adequately prepare them to meet the NCNZ requirements for documentation although the survey respondents identified an improvement in confidence and preparedness following attendance in a training programme.

5.3 Perceived Level of Reward for Preceptors
Most respondents perceived some level of reward for the role, however twenty two percent perceived no reward. This is of concern especially as this study has also identified that some registered nurses have been preceptors against their wishes. According to Baltimore (2004) the preceptor role includes role modeling, socializing and educating. In achieving these goals, preceptors are required to demonstrate patience, enthusiasm, knowledge, a sense of humor and the respect of peers. If there is no or little either extrinsic or intrinsic reward for the role it is likely there will be little enthusiasm or any other of the required characteristics.

5.4 Support of Preceptors
The study has highlighted that registered nurses believe they are well supported by their colleagues in the role of preceptor for IRNs-EASL. There are however gaps in organisational support and in the support that preceptor’s receive from CAP providers and coordinators.

5.4.1 CAP Provider Support
It is vital that the CAP providers maintain a high profile within the clinical areas in supporting both the IRNs-EASL and the preceptors as they remain the custodians of the teaching-learning process. CAP providers are also familiar with the complexities of introducing and assessing IRNs-EASL for registration in New Zealand. Sharing this knowledge with preceptors would be helpful in identifying and understanding the social support that IRNs-EASL require when on clinical placement. It is also a requirement of NCNZ that “the preceptor is supported by the clinical placement coordinator and the programme coordinator” (Nursing Council New Zealand, 2008b, p. 10) and “that the student is assessed against the Council’s competencies for their scope of practice by the programme coordinator in association with the preceptor at the conclusion of the clinical experience” (Nursing Council of New Zealand, 2008b, p. 10). It is therefore a legal
requirement that support is offered by the CAP providers in ensuring that are assessments are true, accurate and comprehensive.

5.4.2 Organisational Support

There is much that organisations can do to increase the level of support and sense of being valued that the preceptor’s receive. All employers need to be clearer in their expectation of staff and include preceptorship within job descriptions if it is an expectation within the registered nurse role. There is also a clear difference in perceived support and value between general medical/surgical wards and those who work in high acuity areas, with preceptors from high acuity areas feeling it is a responsibility that is not part of their role and one which is undervalued. Further research would identify clearly why differing attitudes exist between work environments. It is also of concern that some registered nurses are required to preceptor IRNs-EASL against their wishes as this demonstrates not only an undervaluing of the role but also of a lack of respect for the preceptors’ wishes, further reducing the sense of support perceived.

Formal recognition for the role was not demonstrated in the study. Ninety six percent of survey respondents stated they received no financial recognition for the responsibility. Formal recognition in some form must occur for preceptors to attain an increased sense of support and value. This could be achieved a number of ways. Firstly as IRNs-EASL pay to complete clinical placements, it would not seem unreasonable for a proportion of this revenue to be allocated to preceptors in recognition of their increased workload and to acknowledge the value of the role. Secondly a reduction in patient workload would recognise that preceptor responsibility carries significant contractual and professional accountability and is a time consuming role to undertake. Acknowledgement also needs to occur in all professional development reviews of performance recognising the senior level of nursing assessment and communication that is required to undertake assessments of IRNs-EASL. As noted by Alspach (2003), the top three incentives for the preceptor role are the ability to demonstrate the worth of nursing work, financial and career advancement and increased respect of colleagues.

Benner (1995) also noted that “preceptors are more likely to continue and commit to the role when they perceive that the rewards are personally meaningful or professionally beneficial” (p. 102). If organisations were to take advantage of intrinsic rewards and offer
some extrinsic rewards, preceptors would be encouraged into the job knowing that there is organisational awareness and value to the role. If organisations can be creative with the extrinsic awards they offer, for example offering excellence awards for preceptors, journal subscriptions and ongoing education, financial incentives may not be required to achieve increased perceived preceptor support.

5.5 Workload Issues – A Reflection of Organisational Value and Support?
Workload serves as a reflection of organizational value and support. When workload issues are recognised preceptors will feel their role is recognised as having value for the employing organization. There is a perceived sense that the role is undertaken in a context of goodwill rather than in the professional context it deserves.

5.5.1 Clinical Workload
Approximately half the survey participants believed they did not have enough clinical time to adequately assess IRNs-EASL. Clinical workload was also included in the survey as an indicator of organisational support and understanding. Understanding how a preceptor’s workload and roles were divided during a working day allowed the researcher to speculate on organisational support for the role and how the preceptor feels about the role.

Clinical workload was broken down to incorporate pastoral care (supporting emotional and social needs), assessment of clinical skills, the teaching of clinical skills and assisting with the culture of nursing work in New Zealand. Nurse-anthropologist, Margaret Leininger described nursing culture as “the learned and transmitted life ways, values, symbols, patterns, and normative practices of members of the nursing profession of a particular society” (Leininger, 1994, p. 19). The culture of nursing work in New Zealand may be identified through The Code of Conduct (Nursing Council New Zealand, 2009b) and include NCNZ Domains of Practice (Nursing Council of New Zealand, 2007).

Registered nurses in New Zealand are required to work multi-collegially within the multi-disciplinary team, use effective communication, (therapeutic and collegial), and be autonomous with their nursing management and in their professional responsibilities. In contrast many IRNs-EASL have worked in environments where nursing is part of a hierarchical culture and autonomy and multi disciplinary collegiality is discouraged (Personal communication, IRN-EASL nursing students, 2008-2011).
A significant proportion of preceptor time is spent preparing the IRN-EASL for nursing in a New Zealand environment (or culture) and on pastoral care. This is time not related to patient care and is supported by both national and international literature that IRNs-EASL have significant social and emotional issues impacting on them when completing a CAP. It also indicates that preceptors see their role in terms broader than simple assessment of clinical capabilities and is a valid indicator of the responsibilities and attitudes expected of the preceptors.

Participants of the survey noted they spent the majority of their time with IRNs-EASL assessing and teaching clinical skills. Assessment of clinical skills is also an indicator of the importance the preceptors place upon their role and the responsibilities they feel accountable for. It is of note that 50% of the respondents spent less than 40% of their day assessing clinical skills and safety to practice. Given the significance of assessment of clinical skills the researcher would have expected this percentage to be higher, while the role of teaching clinical skills would have required less time. There is an expectation that as IRNs-EASL have been previously registered in their countries of origin, clinical skills should be an ability already mastered in most situations.

5.5.2 Workload Related To NCNZ Documentation;
Time spent on NCNZ documentation is significant (between two and eight hours) for the respondents of the survey. Personal communication with preceptors (2008-2011) confirms this with many stating documentation is completed outside of paid clinical hours as a result of clinical workload issues. This would support the argument that it would be ethical to see individual preceptors receive some financial reward for clinical hours spent with IRNs-EASL and would also serve to compensate for work done extraneously and reduce possible work load resentment.

5.6 Organisational Attitudes towards IRNs-EASL
The study has indicated that approximately half of the respondents believed organisational attitudes have not changed toward IRNs-EASL while a small percentage, noted that attitudes have become more positive in the last twelve months. The numbers of IRNs-EASL being preceptored have stayed the same according to one third of survey respondents while a second third, believed numbers had increased over the previous twelve months.
This would suggest that the current global economy and nursing environment has not impacted on attitudes toward migrant nurses with IRNs-EASL.

5.7 Ethics and Legal Accountability within The Role

Almost forty percent of preceptors had felt pressured or obligated to record an assessment of IRNs-EASL that they felt uncomfortable with. This indicates a high level complicity (or apathy) with pressure from either the IRN-EASL, the employing organisation, colleagues or the CAP provider. This could also be an indicator of low confidence and/or inadequate training as a preceptor. Ethically preceptors have a responsibility to all stakeholders - the IRN-EASL, the patients, New Zealand public, NCNZ, the employing organization and the CAP provider to ensure that their assessments are true and just. More research is required to ascertain whether this is reflective of organisational attitudes and values, preceptor training (increased confidence and support), while keeping in mind that eighteen percent of preceptors were undertaking the role against their wishes.

5.7.1 Ethical Issues Related to Responsibilities to Patients, NZ Public, IRN-EASL, Employer, CAP.

Most preceptors felt very responsible for the patients in their care, very responsible to the New Zealand public, their employing organisation and for the IRN-EASL with whom they are working. Half the respondents felt very responsible toward Nursing Council New Zealand and one third toward the CAP provider. With the exception of the CAP provider these responses indicate a high level of legal and ethical accountability, particularly toward patients preceptors worked with and potential patients as the New Zealand public. With the preceptor role currently undertaken as good will rather than as a formally recognised skill, and with the high level of workload commitment required when assessing IRNs-EASL, CAP providers may be viewed unfavorably and with some resentment. This may also verify the findings that preceptors feel unsupported in their role by CAP providers and coordinators.

5.7.2 Preceptors Demonstration of the Legal/Ethical Requirements of the Treaty of Waitangi and Cultural Safety

The majority of preceptors acknowledged that the teaching of cultural safety was a very important component of the preceptoring role. However time spent with IRNs-EASL discussing and demonstrating the Treaty of Waitangi Principles appeared to reflect the
acuity of the patients in their care. In general medical/surgical wards in the DHB the preceptors appear to spend considerably more time discussing and demonstrating the Treaty of Waitangi principles than those in high acuity areas. This may reflect their working environment where patient acuity may impact on the perceived ability of individuals and families to actively participate in decision making. In contrast nurses working in the community and practice nursing were able to spend greater than 50 percent of their time incorporating/demonstrating Treaty Principles in their preceptor role. This may reflect the opportunity to develop very meaningful relationships with patients who are less unwell and where time is less problematic. Further research may clarify these differences.

5.7.3 Bioethics Guiding Practice

In assessing the results of bioethics guiding practice there is room for ambiguity in the responses. Overall non-maleficence was the bioethical principle guiding preceptors. However participants in the survey from medical, surgical and high acuity wards identified beneficence as the guiding bio ethic that was used most frequently. In contrast those in elder health and community nursing suggested non-maleficence was the bioethic driving assessment. Practice nursing was equally spread between, non maleficence, beneficence and justice.

The researcher would suggest justice is an objective measure by which preceptors should be assessing IRNs-EASL and better reflects preceptor responsibilities toward the patients in their care, the New Zealand public, their governing body – NCNZ, and reflect their professional obligations to the HPCA Act. More research is required to understand the bioethical principles guiding practice and to ensure greater understanding of the different working environments and their influence. Greater preceptor education may also clarify the legal and ethical requirements of the role.

5.8 Summary

This chapter has discussed the results of the research in detail and in the sections and subsections identified in the data analysis. It has questioned and sought possible explanations for participant responses and recognised areas where further research would be beneficial.
Chapter 6

SUMMARY AND CONCLUSIONS

“If nurses wish to affect outcomes in policy formation, they must be involved in politics”.

(Des Jardin, 2001, p. 8)

6.0 Introduction

In this final chapter the researcher will summarise what is already known about the preparedness and support of preceptors for IRNs-EASL and what this thesis adds. The strengths and limitations of the study will be examined and conclusions and recommendations discussed.

6.1 What Is Already Known About This Topic

An extensive literature review was undertaken to identify whether preceptors are adequately prepared and supported to confidently assess IRNs-EASL undertaking a competency assessment programme in the current economic environment. There appeared to be no New Zealand research on the support and preparedness of preceptors of IRNs-EASL. One New Zealand study explored transition to clinical practice by registered nurses on the completion of a competency assessment programme. International research identified that the unique needs of IRNs-EASL were overlooked, as there was a failure to provide adequate preparation and education for preceptors; there was a lack of understanding of legal and ethical requirements within the assessment parameters; and there was a lack of organisational support for preceptors.

6.2 What This Thesis Adds

This thesis is a New Zealand study which specifically explores preceptor support and preparedness when undertaking the preceptor role for IRNs-EASL. It provides a platform for further research on this issue. The findings reflect the literature and met the aims of the research.
6.3 Strengths Of The Study Design

The research design was a quantitative non-experimental descriptive survey. The data tool was a questionnaire linked to Survey Monkey ™ for ease of distribution and collection of the data. Distributing the data through an email link via NZNO e-newsletter allowed for broad geographic cover and for a variety of work environments to be analysed.

The questionnaire consisted of 29 questions and the survey took approximately fifteen minutes to complete and therefore required only a short time investment for respondents. Further advantages of using this design were that it was economical both in time and financial resourcing, there was no interviewer bias and confidentiality of respondents was maintained.

6.4 Limitations Of The Study Design

Limitations of the study included that there is no register of preceptors and therefore the percentage of preceptor respondents is unknown. It is also unknown how many registered nurses received the link via e-newsletter to Survey Monkey ™. Incorporating geographical areas in the questionnaire may have allowed for greater interpretation of the data. The complexity of some questions meant the attrition rate for the questionnaire was higher than expected. Depth of answers could not be gathered with a quantitative questionnaire.

6.5 Conclusions

The current global economy and nursing environment does not appear to have impacted on attitudes toward immigrant nurses with IRNs-EASL in New Zealand. Numbers of IRNs-EASL continue to remain high and be welcomed.

Some preceptors (particularly in DHBs) do not meet NCNZ standards of practice for competency assessment programmes. The selection process of preceptors needs to consider these standards and NCNZ needs to ensure that employers are meeting this obligation. This may be achieved through the development of a regional or national preceptor register. There being strength in numbers, preceptors as a national group would have a forum to discuss their educational requirements, the ability to develop quality assurance and audit guidelines and to achieve a stronger political “voice” through which their needs may be articulated.
Preceptors are not well supported by CAP providers and their employing organizations. The preceptors need to be formally recognised for the responsibilities and accountability within the role. Registered nurse job descriptions need to include the preceptorship role if it is an expectation of the employing organisation thereby increasing the value of the role. This may in turn increase the intrinsic and extrinsic rewards preceptors perceive they receive. Nursing workload also needs to be addressed when nurses are combining the roles of clinical assessment of IRNs-EASL and patient care. The demands of effective clinical assessment have been demonstrated in this study to be considerable, and this needs to be recognised by the employing organisations.

CAP providers and coordinators are required to support the preceptors in their assessment of IRNs-EASL. Coordinators of programmes must therefore increase their visibility in the support role in the clinical environment. They could also offer ongoing education and seminars for preceptors interested in increasing their knowledge of cultural diversity and/or clinical education.

Given the amount of time preceptors spend assessing IRNs-EASL it would not be unreasonable to expect strong organisational support for the role and some degree of formal recognition. This could be achieved through financial recognition, workload reduction and professional development opportunities within employing organisations. The implementation of preceptor advisory roles within employing organisations would also offer increased support and clinical supervision if required.

Preceptor training, in and of itself does not appear to adequately prepare nurses to preceptor IRNs-EASL. ITP training was considered to be more effective than training through an employer. More education of preceptors is required particularly for NCNZ documentation as it is time consuming and research has shown it to be a barrier when preceptoring IRNs-EASL. More research is required to understand if training programmes equip preceptors for ethical assessment of IRNs-EASL, especially when considering that some preceptors had been pressured into recording assessments they felt uncomfortable with. Education in the unique needs of IRNs-EASL and cultural diversity needs to be implemented into the training programmes as preceptors spend a considerable amount of clinical time doing pastoral care. Research has also shown this as an area which requires
more support for immigrant nurses to ensure safe integration to New Zealand clinical environments and demonstrate competence to practice.

It would also be prudent to review The National Framework for Preceptors and include a section specific to IRNs-EASL as they provide a high percentage of the nursing work which is currently occurring in New Zealand. NCNZ may also offer valuable insight into requirements of the programmes and ensuring that preceptors are adequately prepared for the assessment role. NCNZ also needs to highlight the expectations of the standards for competency assessment programmes and ensure all CAP providers and employers are meeting them.

The importance of cultural safety is acknowledged by almost all preceptors, thereby meeting the ethical and legal requirements of the Treaty of Waitangi. The level of patient acuity effects the time preceptors spend discussing and demonstrating the Principles of the Treaty of Waitangi. More research is required to identify differences relating to time spent discussing and/or demonstrating the Principles of the Treaty of Waitangi between work environments.

Preceptors consider they have a high degree of accountability toward patients in their care, the New Zealand public, the employer and the IRN-EASL, but little accountability to the CAP provider. This may reflect the preceptors’ perceived lack of support from CAP providers and coordinators and reiterates the need for active clinical engagement and more visibility for what should be a partnership model.

The bio-ethic that guides the preceptor most frequently is non-maleficence, followed by beneficence, justice and then autonomy. Preceptors need to view their role as a contractual responsibility and clinically assess IRNs-EASL in both an ethically and just manner. Research has shown this as an area which requires more support for immigrant nurses to ensure safe integration to New Zealand clinical environments and demonstrate competence to practice. More research is also required which considers whether training programmes equip preceptors for ethical practice.
6.11 Administrative Recommendations:
Administrative recommendations consider policy and planning options to ensure the meeting of NCNZ standards and increase preceptor recognition and support.

6.11.1 Recommendation One
Consideration should be given to formal recognition of the responsibilities undertaken and accountability within the preceptor role. This may include financial reward in recognition of the extra responsibilities preceptors accept when preceptoring IRNs-EASL.

6.11.2 Recommendation Two
Nursing workload also needs to be addressed when nurses are combining the roles of clinical assessment of IRNs-EASL and patient care. Clinical assessment has been demonstrated in this study to be considerable and this needs to be recognised by the employing organisations.

6.11.3 Recommendation Three
Registered nurse job descriptions need to include the preceptorship role if it is an expectation of the employing organisation, thereby increasing the value of the role.

This may in turn increase the intrinsic and extrinsic rewards preceptors perceive they receive.

6.11.4 Recommendation Four
CAP providers and coordinators must increase their visibility in the support role. This could be done by offering ongoing education and seminars for preceptors interested in increasing their knowledge of cultural diversity and/or clinical education.

6.11.5 Recommendation Five
Development of a preceptor register needs to occur both within organisations and nationally. Recognising preceptors as a national group would give registered nurses a forum for discussion and would encourage auditing and quality assurance measures to be developed.
Those on the register may then become eligible for extrinsic rewards such as journal membership, excellence awards and education programmes.

6.11.6 Recommendation Six
The selection process of preceptors needs to consider the NCNZ standards for competency assessment and NCNZ needs to ensure that employers are meeting this obligation.

6.12 Education Recommendations:
Educational recommendations consider how the legal and ethical requirements of preceptor assessment can be met thereby increasing confidence and preparedness for role.

6.12.1 Recommendation One
More education is required in order for preceptors to understand the requirements of NCNZ documentation and the domains of practice. This would serve to both increase preparedness for the role, and reduce barriers that previous research has identified.

6.12.2 Recommendation Two
Education in the unique needs of IRNs-EASL and cultural diversity needs to be implemented into the training programmes as preceptors spend a considerable amount of clinical time in pastoral care.

6.12.3 Recommendation Three
More education is required to ensure that assessment of IRNs-EASL is ethically sound and that legal implications of the role are clarified.

6.12.4 Recommendation Four
NCNZ needs to highlight the expectations within the standards for competency assessment in regard to preceptor requirements and ensure all CAP providers and employers are meeting them.

6.12.5 Recommendation Five
The National Framework for Preceptors needs to be reviewed and include a section specific to IRNs-EASL as they provide a high percentage of the nursing work which is currently occurring in New Zealand. NCNZ representation into the review may also be insightful.
6.13 Recommendations for Further Research:
Recommendations for research, considers gaps in research which have been identified during this study.

6.13.1 Recommendation One
More research is required to understand if training programmes equip preceptors for ethical assessment of IRNs-EASL especially when considering that some preceptors had been pressured into recording assessments they felt uncomfortable with and the guiding bioethic for assessment of IRNs-EASL.

6.13.2 Recommendation Two
Further research is required which specifically targets training programmes and preparation of preceptors to assess IRNs-EASL including the inclusion of ethnic diversity, ethical responsibilities and legal accountability including documentation.

6.13.3 Recommendation Three
Employing organisations need to undertake independent research to identify ways to offer more support and value to the preceptor role.

6.13.4 Recommendation Four
Qualitative research of preceptors would be helpful in establishing what would make the role more rewarding.

6.13.5 Recommendation Five
Research is needed which identifies differences between work environments perceptions of attitude, value and support.

6.13.6 Recommendation Six
Research needs to be undertaken that considers geographical location as this was identified as a limitation in this study.

6.14 Summary
In this final chapter, the researcher has summarised what is already known about the topic and what this thesis adds. Strengths and limitations of the study have been identified and
conclusions made. Recommendations for administration, education and further research have also been suggested.
REFERENCES


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