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Trailblazers - primary health care programme evaluation

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Trailblazers

The evaluation of new graduate programme for primary health care

Research Report

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Abstract

Trailblazers are those that forge the way to enable others to follow. This report is an evaluation of the academic journey undertaken by a group of newly graduated nurses who were sponsored by a New Zealand District Health Board (DHB) to work in a variety of primary health care nursing settings. The impetus for this pilot employment option was the Ministry of Health’s focus on primary health care nursing and workforce development for this sector and the Expert Advisory Committee for primary health care nursing’s recommendations to DHB’s regarding employment of graduate nurses and support for them to engage in post graduate study.

Evaluation participants were primarily the graduate nurses who were interviewed at the end of their first year of practice which was following programme completion then again nine to ten months later. Findings include the nurses reflections on what supported them and what acted to impede as barriers to their learning success and practice development.

The report concludes with five recommendations that can be used to ensure that the travels of future newly graduated nurses taking this pathway are supported, safe and successful.
Introduction

"Do not follow where the path may lead.  
Go instead where there is no path and leave a trail."
Ralph Waldo Emerson

Internationally, the potential for nurses to contribute extensively to primary health care, has been recognized widely since the Alma Ata Declaration of Primary Health Care in 1978 (Barnes et al. 1995; Carryer, Dignam, Horsburgh, Hughes & Martin, 1999; Cherrington, 1986; Shaw, 1986a, 1986b; World Health Organisation, 1978). Increased nurse involvement in primary health care is acknowledged as an effective way to reduce inequalities in health and improve population health in a manner that is cost effective to the country (Ministry of Health, 1998; Roe, Walsh, Huntington, 2001). Nursing is recognised as being philosophically aligned to primary health care, and is also strongly aligned with Health Promotion philosophy (Pearson,2003) espoused by the Ottawa Charter (World Health Organisation, 1986) and The Jakarta Declaration (World Health Organisation, 1997; King, 1994).

The recent enabling policy frameworks, in particular the New Zealand Primary Health Care Strategy (Ministry of Health, 2001a) He Korowai Oranga: Maori Health Strategy (Ministry of Health, 2002a) and Pacific Health and Disability Action Plans (Ministry of Health, 2002b) have reinvigorated a national quest for nurses and nursing to reach beyond their traditional contribution to client care and health outcomes. The establishment of District Health Boards and Primary Health Organisations have provided the organizational means and local oversight of, and responsibility for, implementation of these strategies.

Since the most recent primary health care focused documents were released (King 2000, 2001) the Government has supported many positive initiatives that are aimed to provide a more equitable health care system for the New Zealand population. Two of these initiatives that are most relevant to this discussion have been the formation of a Ministry of Health led Expert Advisory Committee on Primary Health Care Nursing and the Ministry of Health directives for District Health Boards (DHB’s) to develop Primary Health Organisations (PHO’s) in their regional communities.
The Expert Advisory Committee on Primary Health Care Nursing met during 2001 and developed a framework to overcome the issues that were considered to impede the development of a responsive nursing service that could fully utilise the knowledge and competence of registered community nurses. The main issues that were identified by the committee were service and funding issues, governance and leadership issues and problems related to access to education and a lack of payment related career pathways (Ministry of Health, 2003).

In 2003 the Expert Advisory Committee completed a report entitled ‘Investing in Health: Whakatohutia te Oranga Tangata that recommended that District Health Boards and Primary Health Organisations:

- identify and analyse needs and gaps in the primary health nursing workforce and develop retention and recruitment strategies with action-orientated plans to address these;
- provide opportunities for primary health care nurses to access leadership development training, recognising the priority needs of Maori and Pacific nurses;
- support the development of the primary health care nursing workforce by implementing the national framework for post–registration education development by the Nursing Council of New Zealand and supporting primary health care nurses, including Maori and Pacific and rural nurses to access post graduate education, and;
- support new graduates to transition directly to primary health care nursing practice, and experienced secondary or tertiary care nurses who wish to move into primary health care practice, through appropriate education and training programmes (Ministry of Health 2003, p. x & xi).

It is considered that these recommendations have specific relevance to this research project as the focus of the project is to examine and evaluate the journey of newly graduated nurses into primary health care practice. The impetus for supporting these nurses arose from workforce gaps identified by the DHB involved and the desire to employ Maori and Pacific nurses in community settings to reduce health inequities. The project included employment of nurses and support for them to engage in Post graduate study during their first year of practice as primary health care nurses.
Primary health care has been defined as essential health care that is universally accessible; based on practical, scientifically sound, culturally appropriate and socially acceptable methods: involves community participation; is integral to the health system and the first level of contact with the health system (World Health Organisation, 1978). Primary health care includes community participation: health improvement and disease preventative services; and both generalist, and condition specific, first level services. Primary health care nursing can contribute to reducing health inequalities, achieving population health gains, promoting health and preventing disease (Ministry of Health, 2003).

New Zealand nurses currently working in primary health care have a wide range of different employment and organisational relationships and various position titles. Positions currently include: District Nurse; Sexual Health nurse; Palliative Care Nurse; Independent Practice Nurse; Maori Health Nurse; Mental Health/Psychiatric Nurse; Pacific Nations Health Nurse; Practice Nurse; Plunket Nurse; Public Health Nurse; Occupational Health Nurse; Refugee Health Nurse; Rural Health Nurse; Family Planning Nurse; Disease-state Management Nurse, Diabetes Nurse, Asthma Nurse, School Nurse; Triage Nurse and Youth Health Nurse. The variety of organisations employing these positions include the provider arm of the District Health Board, Primary Health Organisations, Iwi and other, Ethic focussed organisations, national and local non governmental organisations (NGO’S), School Boards and private businesses. Some nurses such as District Nurses and Practice Nurses, work with all ages, while others such as the Plunket Nurse and Refugee Health Nurse work with specific population groups (Ministry of Health, 2003).

The Expert Advisory committee determined that:

Primary health care nurses work autonomously and collaboratively to promote, improve, maintain and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, and first point of contact care and disease management across the lifespan. Partnership with people – individuals, whanau, communities and populations, to achieve the shared goal of health for all – is central to primary health care.
nursing (Ministry of Health, 2002c, p.9).

Each of the employment groups for Primary Health Care nurses to date has had a different form of orientation to their role depending on their employer. Most nurses have been provided with in-house on the job training with minimal, if any mentoring from an experienced nurse leader who will often have their own case load and may be located in a different geographical area to the new staff member.

Formal education has not been readily accessible due to cost, difficulties in the release of staff including the cost of a reliever and the difficulty in finding an appropriate and available replacement, and the paucity of programmes relevant to the Primary Health Care nursing sector (Ministry of Health 2003-workforce survey). Because of the difficulties encountered by Primary Health Care nurses in accessing higher education there is a related paucity of research or evaluation of the nursing services provided or evidence base for community nursing care.

This project follows the journey of four nurses in their first year of practice who are the participants in this research project. The nurses were sponsored1 and placed within a variety of Primary Health care settings including, a Pacific Health service, the District nursing service, general practice clinics and a Marae based health clinic. Following an intensive orientation the nurses were enrolled in a full year academic nursing education programme designed for nurses new to primary health care practice.

The programme named The Postgraduate Certificate in Primary Health Care Specialty Nursing has been accredited by NZQA as a level 8 qualification equivalent to two Masters Papers and has been approved by Nursing Council of NZ as meeting specialty competencies for registered nurses (NZNC 2001).

The Postgraduate certificate originated from the Royal New Zealand Plunket Society’s education programme for nurses moving from secondary and tertiary settings into primary health care well child nursing contexts.

The programme was developed to enable primary health care nurses working in a range of settings to be supported and learn in their workplace during their first year of primary

1 Wages for the graduate were paid to the employer as supernumerary to usual staffing levels.
Health Care Nursing practice. Programme intent includes educating nurses to provide health care services that meet the needs of their clients in the community context and therefore reduce health inequities. An outcome of the programme is also to provide nurses with the opportunity to develop the skills and knowledge they need to meet the Nursing Council competencies for specialty nursing (Nursing Council of New Zealand 2001) which include:

- Demonstrates sound levels of judgment, discretion and decision-making in patient/client care.
- Demonstrates clinical nursing leadership
- Monitors and improves standards of nursing through quality improvement processes
- Develops nursing practice through research and scholarship and to gain a post graduate qualification.

The programme is accredited to Whitireia Community Polytechnic and taught by experienced Primary Health Care educators. Nurses enrolling in this programme are employed in Primary Health Care settings; attend two one week tutorials held in a central location with other students and are supported by a preceptor in their workplaces and a clinical educator, employed by the education institution. Students are provided with books of readings and they complete theoretical and clinical assessments to successfully complete the programme within one academic year.

**Literature Review**

A report on the global shortage of nurses commissioned by the International Council of Nurses (Buchan & Calman 2004) reported that research identified:

That nurses are attracted to and retained in their work because of opportunities to develop professionally, to gain autonomy and to participate in decision-making, whilst being fairly rewarded (p 34).

The engagement in continuing professional development, also linked to improved client care has been incorporated into the “magnet hospital” model (Buchan & Calman 2004). The magnet hospital concept was developed in the United States of America during the 1980’s when research aimed at determining what human resources practices and
organisational characteristics enabled hospitals to attract and retain staff during difficult labour market conditions. Key characteristics of magnet hospitals are:

- Participatory and supportive management style;
- well prepared and well qualified nurse executives;
- flexible working schedules;
- clinical career opportunities, and;
- an emphasis on in-service/ continuing education.

The concept has been further developed through a series of research studies and the development of an accreditation programme for magnet hospitals. The district health board that participated in this project is working to meet these standards and apply for magnet accreditation.

Burtenshaw (2003) reported that Collins, Hilde and Shriver (1993) had found that the opportunity to increase nursing knowledge and enhance critical thinking skills were important considerations for new graduate nurses selecting their first employment setting. Preceptorship was also considered in the selection of the initial work setting. Graduate Nurse programmes are provided in Australia to attract and educate nurses in rural and outback nursing roles, with twice the number that are accepted applying for places in these programmes (Burtenshaw 2003).

In New Zealand a Ministerial taskforce recommended that the Clinical Training Agency (CTA) an arm of the Ministry of Health, develop a national framework for new graduate nurses. Pilot programmes were run in three New Zealand District Health Board areas in 2002 and an evaluation report of the pilot was released in 2004. Preceptorship, and professional development were provided during the one- year pilot period and key findings were that more than one placement rotation was considered good for the opportunity to learn more skills. However half the participants found rotations disrupted them when they were starting to feel confident and useful in the first placement. Supernumery time to allow graduates to orientate to the environment without workload pressure was valued as was preceptorship, if time allowed for meetings with the preceptor, as it offered timely and appropriate feedback and recognition of and, strategies to help meet learning needs.
Tensions between the needs of the service and the needs for tutorial release time and preceptorship contact were identified in the pilot project. However the majority of the new graduates rated their confidence as either good or excellent at the end of the programme compared to only one third at programme start. Most preceptors considered it was a safe and effective way to support new graduates and the majority of those involved in the pilot including stakeholders considered that a structured and supportive environment had been of benefit for the new staff (MOH, 2004).

**Research Process**

The research aimed to

- To explore the experiences of new graduate nurses in the postgraduate certificate of primary health care nursing.

- To explore the experiences of faculty facilitation in the postgraduate certificate of primary health care nursing.

- To identify any issues that may need to be addressed by the institution to enhance the delivery of the programme to meet the stated aims.

**Background to the programme**

Four New Graduate nurses were sponsored by the District Health Board to participate in the population and personal health strand of the Postgraduate Certificate in Primary Health Care Specialty Nursing programme and attended tutorial weeks with students from the Well Child/Tamariki Ora strand. In addition students had a clinical educator with experience in their clinical areas to meet with once per month or as required. New graduate nurse learners were provided with some institutional support in terms of a common orientation, clinical supervision and two clinical placements rotations.
Concurrently the Director of Nursing from District Health Board conducted an evaluation of the programme from a clinical stakeholder and employer perspective. This report has yet to be published.

This programme is innovative on several levels in that traditionally new graduate nurses have not been employed in primary health care settings. Additionally new graduate nurses have not traditionally been considered as candidates for postgraduate study in their first year of practice.

**Methodology**

The question of how the new graduate nurses experienced this educational programme could be answered in a number of different ways. There are a number of quantitative methods, and a descriptive quantitative method such as a questionnaire which is the most commonly used instrument for obtaining information by self-report. This method can be valuable for investigating attitudes, values, beliefs and behaviours (Roberts & Taylor, 1998). The difficulty with such an instrument is the information obtained only relates to what is asked and the researcher may have overlooked crucial aspects worthy of inquiry. Therefore it was considered that this method would be too restrictive and only gain narrow information.

The theoretical approach of this evaluation study is both qualitative and participative. Evaluation study has been described by Trochim (1999) as "the systematic acquisition and assessment of information to provide useful feedback about some object" (p.1). The general goal is to provide useful feedback that aids in decision-making. Trochim discusses a number of evaluative research strategies (of relevance here, a qualitative model and a participant-oriented model) that place value on subjective human interpretation and participants who are users of a programme or technology. A critical theory approach is a suitable adjunct to a qualitative evaluation model (Trochim, 1999).

A qualitative method of inquiry is also descriptive and attempts to explore the relative nature of knowledge, which is seen to be unique and context dependent. Qualitative methods may be broadly thought of as either interpretive or critical. Interpretive
frameworks are about generating meaning while critical research aims to bring about change in the status quo (Roberts & Taylor, 1998). Of the critical frameworks, a participative methodology generates the kind of knowledge that has the potential to be emancipatory (Roberts & Taylor, 1998).

As a methodology, participatory research addresses how the research should be conducted, rather than the techniques used to collect the data. Henderson (1995) suggests that it may be distinguished from traditional research methodologies in the following ways:

- The people being studied are involved in all phases of the research process. A partnership exists between the researcher and those being researched.
- Value is placed on experiential knowledge.
- Incorporated within the research process is an acknowledgement and exploration of the power inequities between the researcher and those being researched.
- A goal of participatory research is to affect the lives of the participants in beneficial ways.

These points reflect the reasons a participative approach has been chosen. Although the researcher initiated the study and basic methodology, the participants were involved in subsequent phases of the research process. As participative research an emphasis on participant empowerment throughout the research process is considered vital, but as a research outcome is not always practicable.

A participative approach is particularly suited to the philosophy of Whitireia Community Polytechnic where the Treaty of Waitangi principles of partnership, empowerment and participation are inherent to the values held by the institution. These principles have direct applicability to the chosen methodology by empowering students as co-researchers, with active participation in how the research process is governed. The goal was to identify the issues that need to be addressed by the institution if this programme was to be a successful endeavour for all stakeholders.

**Method**
Participants were individually invited to participate in the research study by letter and email sent from the Postgraduate programme co-ordinator. Information sheets were made available and potential participants contacted the researcher of their own volition. Three of four of students agreed to participate and were interviewed at completion of the programme and one year later. All interviews were transcribed from either taped recordings or verbatim notes. Transcripts were returned for participant verification (member checking) and feedback. Final paper evaluation which occurs at the conclusion of all papers offered at Whitireia Community Polytechnic was included as data in the research analysis. The clinical education journaled the experience of facilitating the programme and this was incorporated into the data for analysis.

The written data from the transcribed interviews and the facilitator’s journal was examined for themes using NVivo and supported with verbatim quotes from the participants. The student evaluations were analysed using descriptive statistics of frequency distribution in order to look for patterns of response – however the small sample size (n=3) impacted on their validity and they are not presented here.

Findings

The participants were trailblazers in the sense that as individuals they marked a trail for others to follow and they have assisted in opening up a new line of research and thinking in primary health care nursing practice (WordIQ 2005). The findings here are presented in two chronological parts indicating the efforts of the trailblazers. The first part of the process has been named setting out in a promising direction with themes from the initial interview upon programme completion. The later interview held nine to-ten months later provided an opportunity for these pioneers to reflect upon their journey and to review their blazed trail.

Setting out in a promising new direction: Initial completion of programme

As the participants experienced transition from student to registered nurse initially the following themes emerged which all relate to the environment of a supported transitional experience:

- A sense of academic confidence
A sense of academic confidence

Having recently completed an undergraduate programme the participants overall felt confident in their ability to study. As one person commented

_It was actually alright because it wasn’t so scary or it wasn’t I mean in the sense of I just left school and you know how I was thinking oh I wonder what a post grad diploma or a masters degree would be like but it wasn’t so scary in a sense. And I think particularly because you’ve come straight out of school and into that your work’s on the wave. You’ve prepared yourself to do; you’re still in that mode._

This may have been at odds with other students they met at tutorials many of whom had completed their initial education for registration some years ago and were new to the concepts of Primary Health Care nursing practice and study.

There were differences that the participants noted in that they were now expected to be more independent in their learning than had been their experience during undergraduate education.

_You have to do a lot more research. It wasn’t just do that, and then right, but you had to really go out into individual, you know do your own research as well you know. I mean yeah it wasn’t like here (Whitireia) because you always have you guys to sort of rely on to direct us but out there although we have ***(clinical educator), but in here they would just have us and I think it was testing our ability to actually go out and you know being individual, being more responsible and take it all ourselves, yes._
The importance of supportive learning environment

The nurses met in their small group with the clinical educator on a regular basis. This was seen as important because the other group of students in the programme was large and it was not always possible for teaching to be interactive at whole group tutorials.

*It was a big group……and some of them were very happy. They don't want to say anything.*

However more time for separate individual tutorials would have been appreciated and was impeded by full time employment, relatively isolated workplaces and lack of manager awareness of study needs. Access to the library was a problem and the educator worked with the DBH liaison person to ensure students had a half day a fortnight to access the library and meet clinical supervision commitments.

*I mean really because you're working fulltime and doing study and I was really fortunate that where I was that I was able to have time to do my study, like to actually write my assignment and but in terms of getting to the tuts it would have been really beneficial if we had had more time sort of, because it wasn't so many tutorials.*

The importance of institutional support was highlighted with one participant commenting

*I think it's been really, really good for us because we actually have the time and the employers have understanding between the employees that you've got a way of getting on with your assignment.*

This was not consistent however with another participant commenting on the need to be firm with employers around study time requirements. A Memorandum of Understanding was signed by the employers and DHB representative as part of the sponsorship process and was seen as being important to providing a supportive framework. Upholding the MOU sometimes needed intervention by someone other than the student.
The role of clinical educator

The role of the clinical educator was seen as being very important to the student negotiating transition to registered nurse and studying in terms of clarifying expectations and support.

*First she comes over to work and see how we were going, but she’s always available if we need to ring up or ask a question, and she was always there. So it was fairly good.*

The flexibility of the educator and willingness to allow for the reality of the pressure of full time work was appreciated. Particularly valued was the flexibility of this person to meet with the participants where and when they could.

*She normally comes down to our workplace, sometimes we meet at the hospital, the ***** Hospital where everybody’s working.*

The clinical educator was seen by another participant as an advocate and a facilitator of learning.

*She provided an avenue to sort issues out and to link theory to our practice areas.*

Role transition support

The programme provided opportunity for role transition support. The assessments were seen as useful to enabling development of confidence as a registered nurse by having others acknowledge its worth.

*I might say the community analysis final was so good that I shared it with one of the staff and then when I was leaving she borrowed my assignment she said you know it’s like what she was expected to do at her new job and she saw my one, and said mine was more, you know she had got the structure in it and then she*
Another participant commented how the assignments promoted the making of links to practice. Clinical supervision was highlighted as being of importance to allow participants to process the uncertainty they experienced. The term clinical supervision is used in this context as the practice-focused professional relationship involving a practitioner reflecting on practice guided by a skilled supervisor. This process is endorsed as in the interests of maintaining and improving standards of care in an often uncertain and rapidly changing health and social care environment. (NMC 2001).

I think is very important for us new grads to have that (clinical supervision) and coming straight up and we’re scared and how do we go about that work and yeah we did all the assignments and all that.

The clinical educator and clinical supervisor supported role transition and worked with graduates to assist them in their practice issues. One issue that was identified as a problem in the first half of the year was the negative comments about their choice of work by family and friends who commented that primary health care practice was not ‘real nursing’ and from nurse colleagues who thought they should have had more hospital experience prior to their primary health care practice. Role playing responses to these comments to ensure they did not feel belittled and defensive about their choices helped them become stronger advocates for themselves and more determined that the choice they made was the right one for them.

Awareness of clinical novice status

The participants discussed a feeling of being different – there was much attention focused upon them as they were part of a pilot project. Academic study was seen by one participant as essential for her professional practice development despite the challenges.
You know we want to be nurses but we don’t want to do the extra work that makes us different from anybody else. If you want to work I think you really have to be prepared to do, to do the extra work and for the, and I also you know I mean to know when definitely to ask questions.

Some of the content of the programme did not appear to be specifically relevant to the practice areas that these nurses were engaged in – this was acknowledged by one of the participants.

Because it’s like you don’t know everything, you’re new and that there’s always the thing that a lot of stuff wasn’t actually applicable to us. I mean it is, but not so much from where we’re actually working with.

However the majority of the assessment work supported students in client care as long as they could see how it was relevant to practice.

**Reviewing the blazed trail:** *Nine-ten months following completion*

At the follow-up interview 9 -10 months later further themes were explored with the participants to provide further evaluation of the programme. The participants were asked their opinions in regard to the different practice placement models and the contribution of the programme to their development as a registered nurse in primary health care.

**Rotations/clinical placements**

There were two differing practice placement models utilized in the postgraduate programme by the District Health Board the nurses were sponsored by. For two of the participants the shape of their first year was to spend six months with one service provider area and five months in another. The other nurse experienced her whole programme from within one service provider.

Two of the participants that experienced rotations supported this approach.
I think that two places was great- it gave a good sample of what primary health involved

Interestingly the clinical facilitator had noted in her journal in relation to rotations for one of the participants

I noticed a loss of energy and they had to learn a whole new culture by shifting to a new service. It seemed far more complex than moving from ward to ward would be

The one participant who remained in situ supported that approach for her personally

I can only imagine it would have been (for me) stressful to have to work in two places in one year. Stressful in that you have to try to settle into 2 possibly quite different environments. But that's just me. When I settle in to a place, if I'm happy, I tend to want to stay and put down roots.

The contribution of the programme to development as a registered nurse in primary health care.

The participants felt overall that the programme supported their development as primary health care nurse effectively. This was reflected in their comments about the complexity of the community, the assignments and the relationship to their work.

The assignments I did on the programme have put me in good stead for report writing, documentation, client file documentation, letter writing, proposal writing and other written communications.

The programme helped me develop an understanding of how extensive the field of nursing is for primary health care nurses. That linking and co-ordinating with appropriate services is pivotal (in many cases) to help clients. And how very important it is to know what services are available to clients out there in the community, and how to link up with them, if this is what the client requires. It has
helped me to practice advocating for clients (and not only for high needs clients). I think it is an exciting time to be a PHC nurse, as the MOH are determined primary health services are to improve their linking processes so that people’s health outcomes and society in general improves.

Primary Health care is so diverse and as I was a new grad I found it a daunting field to work in initially. The course helped me to understand what the concept of primary health care was all about.

The biggest contribution that the programme had to my development was the importance of understanding how the community impacted on your work and the clients that you are working with.

Discussion

Themes that emerged from the data were similar to those reported in the literature in relation to the transition experiences of the newly graduated nurses generally. It is interesting to note that the predominance of literature that refers to new graduate nurse experiences are in hospital settings only (Maben & Macleod Clark 1996, Oermann & Moffitt-Wolf 1997, Kells & Korner 2000, Thomka 2001, Ellerton & Gregor 2003, Regan 2003, McKenna & Green 2004 and Utley-Smith 2004). One clear difference for this specific group lies in their initial clinical area of practice, and the challenges of working fairly autonomously in ever changing situations.

It has been an accepted truism in nursing in New Zealand and Australia that newly registered nurses need to spend time in tertiary acute settings before progressing to primary care (Nurses Registration Board of NSW 1997, Ministerial Taskforce on Nursing 1998). This ‘accepted’ process for newly registered nurses was an understanding that proved difficult at times in relation to other experienced nurses support of the programme. The importance of the assumptions of other nurses and resultant powerful affect that this has on the perception of support for role transition is noted clearly in the literature (Thomka 2001). This programme provided challenges to historical assumptions on several grounds.
The initial thinking may have been linked to the perception that newly registered nurses were generally in their early twenties and not ready for the higher level of interpersonal engagement that working in communities entails. In fact registered nurses under thirty years old have been a reducing group over the past seven years with this age group accounting for only 10.2 % of the workforce in 2004 compared to 15% in 1997 (NZHIS 2004). Conversely the number of nurses over 35 has risen in the same time period from 66.5% to 70.5% of the workforce (NZHIS 2004). Nurse students, specifically in our experience, are entering into education programmes with the advantage of greater life experience and with often having been employed in other occupations prior to undertaking nursing studies. This provides them with often a head start on some of the core competencies for practice.

The competencies required by new graduates to function effectively in any setting are very similar as recent research into the perceptions of nurse administrators revealed (Utley-Smith 2004). A total of 363 nurse administrators from three different American health care settings (Hospital, Home Care and Aged Care) responded to a questionnaire that asked them to rank the importance of six different competency factors. The health care competency factors were Health Promotion, Supervision, Interpersonal Communication, Direct Care, Computer and Caseload Management. Significantly for all settings, Health promotion was ranked highest by all settings though there was greater emphasis for those from home health care settings.

There has been a trend for nursing curricula in New Zealand to address the area of Primary Health care with more emphasis since the reduction of health inequalities became a Ministry of Health focus. It is interesting to note that concomitantly, nurses are primarily socialized into the profession through hospital clinical experience (Murray 1998). This combination then would support that the comprehensively prepared new graduate is equipped by education curricula to transition into the role of registered nurse regardless of setting. It is suggested that nurses who graduate with a philosophy of health promoting practice, if not supported, can quickly (within three months) transform this into a medical model of symptom management. This is a function of the nurse’s need to ‘fit in’ with the context and culture of the practice setting rather than practise their ideal conception of nursing (McKenna & Green 2004). This supports the need for a structured programme to facilitate transition into primary care nursing.
The perception may also be that nurses need time to consolidate their clinical skills in a tertiary setting with support rather than entering into the more autonomous potentially less supported primary care setting. It is undisputed that the first three months of practice as a registered nurse are a time of great anxiety and role stress. The literature has clearly identified the need for strong preceptor support in the first year of practice (Maben & Macleod Clark 1996, Oermann & Moffitt-Wolf 1997, Kells & Korner 2000, Thomka 2001, Ellerton & Gregor 2003, Regan 2003, Delaney 2003, McKenna & Green 2004 and Jackson 2004).

Strong preceptor support is found to support professional development and longevity of career in a climate where many nurses change jobs or actually leave the profession in the first year (Commonwealth of Australia 2002, Regan 2003 and McKenna & Green 2004). A recent evaluation of New Graduate First Year of Clinical Practice Nursing Programme undertaken by the Ministry of Health also supports the value of preceptorship. At the end of the pilot programme nearly all the key informants thought that preceptorship was a very effective means of developing clinical practice for the new graduate nurses (MOH 2004).

The postgraduate programme provided support in lieu of the usual workplace preceptor from the DHB liaison person, the clinical educator and the clinical supervisor. The participants valued this support. Interestingly all four nurses in this pilot are still practising in primary health care settings though not all are in their initial area of employment.

Role transition is a key theme in the literature and is alluded to by the participants in their discussion in terms of how the programme provided support for that. To role transition is to move between two relatively stable states with phases of entry, passage and exit which require life pattern changes (Kelly & Matthews 2001). Newly graduated nurses have to move from their status as student to that a registered nurse. It is suggested also that there is movement between role ambiguity as the new nurses find their place as registered nurses to role overload later in the graduate year (McKenna & Green). Certainly the participants saw themselves as confident in their role as student and yet very aware of their clinical novice status. This is not unexpected as these nurses had
spent the previous three to five years studying to become a registered nurse. The world of academia is a familiar one. Where other registered nurse students returning to study find difficulty with academic writing and researching literature these newly registered nurses had confidence. The experienced nurses in the programme were more comfortable in practice and experienced anxiety and stress with the academic demands of the programme.

As the year progressed the role overload began to develop for the participants as expectations of employers increased, with one stating

*I must say that working full time, learning a new job as a new grad, made it a heavy year with the PHC course and all that went with it. I found that by the end of October I had just run out of steam. That’s probably more to do with my age (45) than anything. But overall, I feel it was structured quite well. I am so glad I did the course and completed it.*

In response to this real concern the academic load of the programme has been reviewed and restructured so that all the assessments are more overtly part of practice development rather than on top of practice development. The assessment tasks provide real world examples and resources for the nurse’s practice such as a community assessment and analysis based in their own community. Nurses are required to focus their exploration of literature and critical reflection on real life practice issues that have meaning for them and develop a portfolio of evidence that facilitates other professional requirements such as those for competency based practising certificates. The concept of authentic assessments reflects a form of assessment in which students are asked to perform real-world tasks that demonstrate meaningful application of essential knowledge and skills (Mueller, n.d.). This approach is integral to the curriculum development of the Post Graduate Certificate and reflects strong commitment to the nursing practice focus.

Professional practice as in the applied discipline of nursing requires a work-based learning approach. Work based learning is a concept that relates to learning that is designed around a students work responsibilities. In order for this to be successful there must be a tripartite relationship between the education provider, the learner and the employing organisation (Gonczi 2002). The programme structure supports a three-way
partnership through the MOU process and the clinical facilitator support. It also provides an external advocate for the student if required as indicated the facilitator’s reflections:

_Dev eloping awareness of tensions between NG (new graduate) as student, new employee and programme participant. Meetings NG with DON seem very power over. NG unable to advocate for selves in workplace._

The level of intensity of strain produced by role transitions will vary from person to person and can be linked to the presence or absence of moderating factors (Murray 1998). Ongoing support is a critical factor to ease the transition and an education and orientation programme can be developed to moderate the role strain (McKenna & Green 2004, Murray 1998). A person under role strain may engage in instrumental acts in an effort to reduce strain (Murray 1998) which can be noted in the attraction to the clinical skills focus noted in the participants initially. Contextual factors also impact on the level of role strain and the ease of transition. The clinical facilitator noted the support that the participants drew from each other as a group both during structured meetings and informally through telephone and email conversations. Peer support can be a moderating factor for role transition stress (Murray 1998).

Role transition stress and the strength of moderating factors can vary from person to person and may be linked to individual resiliency (Murray 1998). This is evidenced in the differing views of the participants in relation to rotation of clinical areas within the first year of practice – a practice supported by the Report of the Ministerial Taskforce on Nursing (2002) and the First Year of Clinical Practice report (MOH 2004).

Overall there is no firm basis from this research for either confirming or rejecting rotations as a structure for placements in the first year of practice. The first year of practice evaluation report supported that, for hospital settings made an effective contribution to the development of new graduates’ clinical practice (MOH 2004). Conversely there is also support for the notion of transition between places creating further stress for the role development of staff (Murray 1998). However the results were mixed for this group with two students supporting the moment and one supporting staying in the one placement. The advantages of moving were around a change in environment and the opportunity to learn from other groups of staff.
The student who remained in the one place felt strongly that that was best for her and enabled her to more quickly develop confidence and autonomy in her practice. It is interesting to note that the stationary student has remained with that same service and has developed her role with a large caseload of clients. She defines her role as

*Working with clients in the community; identifying inequalities and trying to improve health outcomes for people; trying to make health accessible, appropriate, and affordable for people. I advocate for clients with WINZ often, and so have to know WINZ processes too. Work with other health professionals outside our organisation to provide care for a client. Research, read, link, network, share knowledge and resources etc, to provide quality service.*

**Conclusion**

The postgraduate programme explored through this research project has much to contribute in terms of responsiveness to key government strategies. The programme contributes to and supports Magnet hospital principles, work based learning and the primary health care strategy.

The MagnetNZ vision (MOH 2004) to improve the health of New Zealanders/Tangata Whenua through developing health care environments using evidenced based standards to improve patient outcomes, increase patient safety, and provide high quality nursing is progressed through programmes such as this one. The provision of a supportive structure for ongoing education contributes to magnetic outcomes such as demonstrated enhanced recruitment and retention of highly qualified nurses, higher rates of nurse job satisfaction, higher nursing ratings of quality of care, and significantly lower rates of nurse burnout (MOH 2004).

This programme facilitates entry to formal education through the provided structure of clinical facilitator, link liaison staff, preceptors and the curriculum. The curriculum is student-centred and contextualized for the nurses own area of practice through authentic
assessment approaches. This approach taken by the curriculum addresses a recommendation of the Expert Advisory Committee on Primary Health Care Nursing by enabling direct entry into primary health care of newly registered nurses. This Nursing Council and NZQA approved programme also supports the development of the primary health care nursing workforce through implementation of the national framework for post–registration education as developed by the Nursing Council of New Zealand (MOH 2003). A serendipitous effect of the programme is the role that participants reported as a resource for other colleagues with limited access to education.

A key purpose of this research project was to explore the experiences of new graduate nurses in the postgraduate certificate of primary health care nursing. The preparation for the transition role to primary health care registered nurse had begun for students before they graduated. This educational programme supported them to consolidate their knowledge through experience and discussion with their clinical facilitator. The integration of specialty competencies provides a strong clinical focus to the curriculum. The clinical focus of the programme enabled ‘real world’ learning for students and potentially reduced the perception of a theory-practice gap and enhanced learning transfer.

The experiences of faculty facilitation in the postgraduate certificate of primary health care nursing support the development of this role as critical to student success. The importance of this role cannot be underestimated and was commented on several times by the participants as being integral to their successful engagement with the programme and their practice through guided learning. The provision of a support person for professional development and to act as advocate if required is potentially a key moderator for role transition stress (Murray 1998).

Enhancement of the delivery of the programme would lie in the area of ensuring that the broad focus of primary health care is articulated clearly to students in tutorial and not captured by sub specialty areas. The institution that delivers this programme has a responsibility to work with its consortium partner to facilitate this. The establishment of good links between education providers and local employers is strongly supported as enabling recruitment and retention of nurses (Buchan & Calman 2004).
Arising from the research are some clear recommendations to support the transition to registered nurse practice in primary health care for newly graduated nurses:

- Academic programmes that link to ‘real world’ learning and utilise authentic assessments to ensure learning is ‘part of’ not ‘on top of’ practice
- Partnerships between education, service providers and students to ensure supportive frameworks are developed and maintained
- Provision of an external support person who is grounded in both academic and clinical practice to act as a guide for learning and an advocate when required
- Appropriate clinical workloads for newly graduated nurses to enable time for reflection and construction of practice knowledge – ideally ½ day per week or 1 day per fortnight
- Appropriate academic workloads that recognize an increasing clinical expectation as the year progresses

The Expert Advisory Committee for Primary Health Care Nursing recommended that District Health Boards and Primary Health Organisations develop retention and recruitment strategies to address nursing workforce development, provide access to post graduate education and support new graduates to transition directly to primary health care nursing practice, through appropriate education and training programmes (Ministry of Health 2003, p. x & xi).

It is considered that these recommendations have been met in this project when newly graduated nurses were supported into primary health care practice that included the successful completion of a postgraduate programme of study. These four nurses have blazed the trail that others are following in increasing numbers – putting into action a groundbreaking perspective and widening the choices for newly graduated nurses and the primary health care workforce. Development and delivery of the programme supports the need for action to effect change. This became possible because all those involved could focus on a shared vision and work together to enable something they believed in happen.

In the words of Arnold Glasgow – *An idea not coupled with action will never get any bigger that the brain cell it occupied* (Glasgow n.d).
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References


