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Readiness for practice: The views of New Zealand senior nursing students

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ABSTRACT

The concept of 'readiness to practice' of nursing students is not well understood even though being 'ready for practice' is the focus of undergraduate programs. The aim of this study was to critically explore senior student's views about their readiness to practice as a registered nurse. This study was undertaken in a school of nursing in the South Island of New Zealand. The participants included all senior nursing students assigned to their final clinical practicum from five cohorts across two and half years.

The response rate for the survey across five cohorts was 46% (n = 245). The majority of students were New Zealand European females aged 30 years or younger. Students felt they were confident with their professional responsibilities and considered that they had prepared well for the profession. They agreed that they were confident with their communication skills. Areas of concern were; caring for a dying patient and caring for more than four patients at one time. This study suggests that senior nursing students feel they are work ready.

1. Introduction

The concept of 'readiness to practice' of nursing students is not well understood even though being 'ready for practice' is the focus of undergraduate educational programs. Ortiz (2016) observed that professional confidence and preparedness, is an "essential trait for new graduate nurses to possess (p. 19)" especially given the complex nature of the health care environment. Consequently, it is imperative that academia prepare students to be ready to perform the nursing role (Laschinger, 2012; Twigg and McCullough, 2014).

2. Literature review

It is the responsibility of undergraduate education programs to prepare nursing students to be safe, confident and competent registered nurses (RNs) (Nursing Council of New Zealand, 2010, 2012a; 2012b). However, the move from senior student status to that of a novice/advanced beginner RN has been noted to be a stressful period, especially the first three months (Casey et al., 2011; Casey et al., 2004; Fink et al., 2008; Jamieson, 2012; Kramer, 1974; Reagor, 2010; Unruh and Zhang, 2013). The phenomenon of 'reality shock' occurring for new graduate nurses was first documented in 1974 (Kramer, 1974). The theory of Transition Shock, developed by Duchscher (2009), which built on Kramers's work, confirmed that many graduate nurse's experience stages of shock (stress) as they navigate their new professional role. Although many measures, such as more undergraduate clinical time and transition programs, have been put in place to mitigate the shock, this period of transition continues to be a challenging time for new graduates (Jamieson, 2012; Kelly and Ahern, 2008; McKenna and Green, 2004; Newton and McKenna, 2007; Pellico et al., 2009).

Due to these challenges many new graduates begin to question their choice of career and as a result either exit the profession within their first year of practice or indicate intent to do so (Casey et al., 2011; Jamieson, 2012; Rudman et al., 2010; Tangitu, 2010). It has been noted that it takes approximately one year for new RNs to become competent practitioners (Institute of Medicine, 2011). Many new RNs enjoy a 'honeymoon period', however New Zealand research of 358 registered nurses under the age of 30 years noted that by one year post graduation many RNs are beginning to question their commitment to a long term nursing career (Jamieson, 2012). By contrast, a five-year longitudinal Swedish study of 1702 students-to-registered nurses noted no statistical significance of occupational preparedness and intention to leave in the first year of practice. However, burn out related to study exhaustion as an undergraduate student, was a significant indicator of intention of initial level to leave the profession one year post graduation (Rudman et al., 2013).

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Given the importance of preparing nursing students to become RNs little published literature was located that explored the student's perception of their 'readiness to practice' as an RN. However, there is a plethora of information about the experience of the first year of practice (Casey et al., 2004; Chang and Hancock, 2003; Clark and Springer, 2012; Dyess and Sherman, 2009; Evans et al., 2008; Johnstone et al., 2008; Kelly and Ahern, 2008; Newton and McKenna, 2007; O'Shea and Kelly, 2007; Oermann and Garvin, 2002; Pellico et al., 2009; Rudman et al., 2013; Spector and Echternacht, 2010; Zinsmeister and Schafer, 2009).

Readiness to practice is defined by Reagor (2010, p. 1) as "the ability as a graduate nurse, to assume the roles of a provider of care, designer/manager/coordinator of care, and member of the nursing profession". Reagor's (2010) doctorial research undertaken with 483 senior American undergraduate nursing students, using the Casey-Fink Readiness for Practice Survey © 2008, noted that although senior undergraduate nursing students assume that they are graduating as advanced beginning practitioners they in fact lack confidence in their preparation. Another study undertaken by Casey et al. (2011) with 429 American senior baccalaureate nursing students noted that only 3% of respondents felt that they were independent with 47 self-identified skills and procedures such as urinary catheter insertion, wound care and assessment. Skills and procedures that caused the most concern included responding to an emergency, chest tube care and tracheostomy care (Casey et al., 2011). Although it could be argued that skills such as chest tube care, and tracheostomy care, are advanced skills specific to particular areas of practice that need to be learnt, and mastered, in the workplace. Further, while participants felt confident with their abilities to communicate with members of the interdisciplinary team, patients and their families as well as problem solving and using current evidence to make clinical decisions they did not feel confident communicating with doctors or caring for dying patients (Casey et al., 2011).

The notion of readiness to practice and the associated 'theory-practice gap' for beginning practitioners in not confined to the nursing profession. Cheng et al., (2010) report that "the gap between the theory and practice of teaching is an issue of concern in teacher education" (p. 91). Likewise, O'Leary et al. (2014) agree that the theory-practice gap for under graduate physical education teachers is problematic. Stone et al., (2011) note the challenge of work readiness for osteopath graduates who wish to work in a country other than the one they educated in. Similarly, Malek (2018) suggests that bioethics philosophers also struggle with readiness to practice was they try to "bring the theoretical insights of philosophical work and methodology to practical dilemmas affecting a diverse group of stakeholders" (p. 1).

There is a dearth of New Zealand literature on the topic of readiness for practice for senior nursing students. This is not an exceptional situation, few international studies about nursing students self-reported readiness to practice have been undertaken (Cantley et al., 2017; Raines, 2009). To date, the focus of New Zealand literature has been the validity and reliability of Nurse Entry to Practice Programs to support new graduate RNs with an emphasis on how best to offer mentorship via the preceptorship model of clinical teaching and learning (Atherfold, 2008; Haggerty, 2000; Haggerty et al., 2012, 2013; Haggerty et al., 2009; New Zealand Nurse Educators Preceptorship Subgroup, 2010). One opinion piece written by a senior New Zealand nursing student noted that the transition period from student to RN was a stressful time with first year nurses prone to burnout (Tangitu, 2010).

The aims of this study were to add of the body of literature about readiness for practice of senior nursing students and to validate the Casey-Fink Readiness for Practice Survey © 2008 in the New Zealand context. The research question was: How do senior New Zealand nursing students perceive their readiness to practice as registered nurses?

3. Method

3.1. Design

A cross sectional survey design, using the Casey-Fink Readiness for Practice Survey ©, was utilized to described the phenomena of readiness for practice of senior New Zealand nursing students.

3.2. Population

All senior nursing students, (n = 529), enrolled into their final third year clinical practicum (Transition to Practice course), from one nursing school, and across five semesters were invited to participate. Students repeating the practicum were excluded to avoid the duplication of replies. Students were allocated to clinical areas that used either the Dedicated Education Unit (DEU) model of clinical teaching and learning or the Preceptorship model to support students.

3.3. Ethical considerations

Ethics approval was granted from the institution that the students were enrolled with. Submission of the completed on-line survey was taken as consent.

3.4. The instrument

Permission to adapt the Casey-Fink Readiness for Practice Survey © for the New Zealand context was received by its creators (email communication with Kathy Casey and Regina Fink, 17 September 2013). Minor adaptations were made to language, such as changing; physician to doctor, electronic record to patient notes, and clinical instructor to clinical lecturer. To ensure face validity in the New Zealand context the survey was tested with ten randomly selected senior students. No changes were made. The adapted survey consisted of two sections. Section one collected demographic data as well as information about the clinical practicum. The focus of section two was on clinical and relational skills, firstly asking students about the top three skills they are most uncomfortable doing. Secondly, students were asked to rate their confidence of managing patient care for two –four patients, on a five point scale of not confident to very confident. Thirdly, students were asked to rate 20 statements about practice skills using a four point Likert scale (1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree). Section two also asked one open ended question; why did you choose nursing as a career. Section three asked an additional open ended question: What could be done to help you feel more prepared to enter the nursing profession?

3.5. Data collection and analysis

Data was collected via an on-line survey from five cohorts of students from 2014 to 2016 at the end of each semester; cohort 1 semester 2 2014, cohort 2 semester 1 2015, cohort 3 semester 1 2015, cohort 4 semester 2 2015 and cohort 5 1 semester 2016.

Quantitative data were analyzed via R software (R Core Team, 2018) while NVivo 11 (QSR International, 2018) was used as a text management system to code free text data obtained from the open ended questions. The open text data were analyzed using concepts as described by Graneheim and Lundman (2004). Findings from the five data sets were combined for analysis.

3.6. Validation of the instrument

The instrument was validated in the New Zealand context by replicating the steps used by Casey et al. (2011) as follows:

1. An exploratory factor analysis was conducted for the 20 items in the

Table 1
Confirmatory factor analysis.

Item	Professional Responsibilities Subscale	Professional Preparation Subscale	Communication Subscale
I feel confident communicating with physicians (doctors)	0.115	0.183	**0.748**
I am comfortable communicating with patients from diverse populations	0.266	< 0.10	0.244
I am comfortable delegating tasks to others	0.122	0.375	**0.330**
I have difficulty documenting care in the patient notes	−0.409	< 0.10	−0.130
I have difficulty prioritizing patient care needs	−0.587	< 0.10	< 0.10
My ALN[a]/clinical lecturer provided feedback about my readiness to assume an RN role	0.294	0.357	< 0.10
I am confident in my ability to problem solve	**0.543**	< 0.10	0.285
I feel overwhelmed by ethical issues in my patient care responsibilities	−0.444	−0.211	< 0.10
I have difficulty recognizing change in my patient's condition	−0.618	−0.164	< 0.10
I have had opportunities to practice skills and procedures more than once	0.108	**0.467**	< 0.10
I am comfortable asking for help	0.294	0.245	0.213
I use current evidence to make clinical decisions	**0.361**	0.273	0.207
I am comfortable communicating and coordinating care with interdisciplinary team members	**0.394**	0.280	**0.432**
Simulations have helped me feel prepared for clinical practice	< 0.10	0.393	< 0.10
Writing reflective journals/logs provides insights into my own clinical decision-making skills	0.135	0.265	0.116
I feel comfortable knowing what to do for a dying patient	0.285	0.238	< 0.10
I am comfortable taking action to solve problems	**0.543**	0.201	0.178
I feel confident identifying actual or potential safety risks to my patients	**0.548**	0.145	0.167
I am satisfied with choosing nursing as a career	< 0.10	**0.652**	< 0.10
I feel ready for the professional nursing role	0.286	**0.472**	0.120
Cronbach's alpha for subscales**	0.67	0.56	0.63
Omega for subscales**	0.68	0.57	0.63

Bold figues indicate factor loadings.
[a] An ALN is the Academic Liaison Nurse from the education provider who supports student when they undertaking their practicum. **Cronbach's alpha and Omega scores account for 75% and 78% of the total variance.

questionnaire for the pooled sample of 245 respondents. This extracted three factors of interest using the principal components method. The three factors were named; Professional Responsibilities, Professional Preparation and Communication.
2. Based on the theoretical understanding and the loading of the items on the different factors a confirmatory factor analysis was conducted and tested where the factors were allowed to covary.
3. Cronbach's alpha was estimated for the whole questionnaire and based on the factors, as was the composite reliability of each of the proposed factors.

As some items were scored on five point Likert scales, and other items were scored on 4 point Likert scale responses, no assumption was made that the items were tau-equivalent. Therefore, both inter-item reliability using Cronbach's alpha and composite reliability omega were reported for the entire scale as well for each subscale (Peterson and Kim. 2013), see Table 1 for details.

4. Results

The overall response rate across the five cohorts was 46% (n = 245).

4.1. Demographics

The majority of participants were female (n = 222, 90%), thirty years of age or younger (n = 177, 73%) who identified as being New Zealand European (Table 2). Most, 60% (n = 148) completed their final clinical placement in a Dedicated Education Unit. The Transition to Practice course offers students an extended period of clinical experience. By the end of this placement students would have completed the minimum number of 1100 clinical hours for the entire programme, as required the by Nursing Council of New Zealand (NCNZ), prior to sitting the NCNZ state exams to become a RN (Nursing Council of New Zealand, 2017). Clinical placements included all areas of nursing practice such as; adult medical-surgical, mental health and primary/community care services.

Table 2
Demographics.

Demographic	n = 245
	n(%)
Age	
< =20	18(7)
21–25	115(47)
26–30	44(18)
31–35	14(6)
36–40	16(7)
41–45	15(6)
46–50	21(9)
> 50	2(1)
Gender	
Female	222(90)
Male	23(9)
Ethnicity	
New Zealand European	209(85)
Maori	4(2)
Pasifika	2(1)
Other	30(12)
Model of clinical teaching and learning	
Dedicated Education Unit (DEU)	148(60)
Preceptorship	92(38)
Not sure	5(2)

4.2. Skills and procedures

Four of the participants (1.6%) considered they were independent in all skills. The top ten skills and procedures senior student were most uncomfortable performing are detailed in Table 3.

5. Preparedness subscales

Detailed results are noted in Table 4.

Table 3
Top 10 Skills/Procedures that cause discomfort in Senior Practicum Students.

Skill/Procedure	n(%)
Bladder catheter insertion irrigation	119(49)
Chest tube care	59(24)
Assessment skills	22(9)
ECG Telemetry monitoring and interpretation	13(5)
NG tube care	9(4)
Responding to an emergency changing patient condition	9(4)
Charting documentation	5(2)
Giving verbal report	1(0.4)
IV therapy monitoring	1(0.4)
Tracheotomy care	3(1)

5.1. Professional responsibilities

The majority of respondents (97%–99%; n = 237–243) agree or strongly agree that they are confident and comfortable asking for help, using evidence to support their clinical decision making, problem solving and were able to identify patient safety risks. An area of concern was caring for a dying patient, with 38% (n = 93) noting that they were uncomfortable with this. The majority of respondents (89%–94%; n = 218–231) were not overwhelmed by ethical issues, had no difficulties about prioritizing patient care or documenting in the patient notes and few difficulties recognizing a change in the patient condition.

5.2. Professional Preparation

The results for the Professional Preparation subscale are similar to the Professional Responsibilities subscale. The vast majority of respondents (96%–98%; n = 235–239) feel confident to problem solve as well as agreeing or strongly agreeing with their choice of career. Furthermore, they agreed or strongly agreed that they had received feedback from both their clinical lecturers about their readiness to be a registered nurse. These factors appear to have contributed to the respondents feeling ready for the professional nursing role. As preparation for the professional role the majority of respondents 88% (n = 218) agreed or strongly agreed that they had opportunities while on their practicum to practice clinical skills more than once. For many respondents (191%; n = 78) writing reflective journals had been considered a helpful endeavor to prepare them for clinical practice while for others (175%; n = 71) simulations had helped them feel prepared for clinical practice.

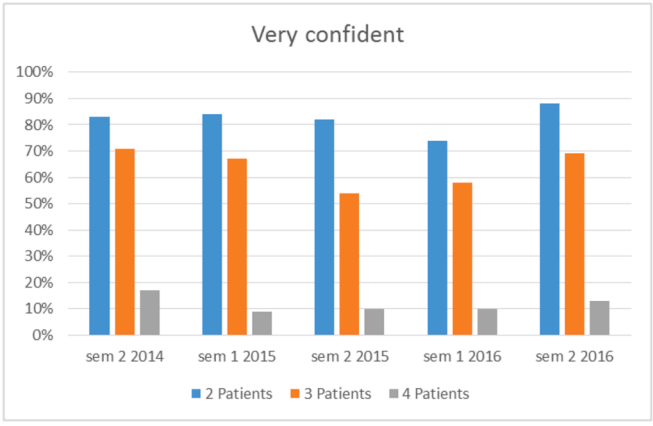

Fig. 1. Confidence levels managing patient allocation.

5.3. Communication

The communication subscale mirrors the results of the previous two subscales. The majority of respondents (85–98%; n = 209–241) agreed or strongly agreed that they were confident and comfortable coordinating care with interdisciplinary team members, communicating with patients form diverse populations, communication with doctors and delegating tasks to others.

5.4. Confidence levels caring for two, three or four patients on an adult medical/surgical unit

As shown in Fig. 1 results across the five cohorts is reasonably consistent. In general participants are confident working with two to

Table 4
Preparedness subscales.

	Agree/Strongly Agree	Disagree/Strongly Disagree	no response
	n(%)	n(%)	n(%)
Professional Responsibilities *9 Items*			
I am comfortable asking for help	243(99)	–	2(1)
I use current evidence to make clinical decisions	241(98)	4(2)	–
I am comfortable taking action to solve problems	237(97)	8(3)	–
I feel confident identifying actual or potential safety risks to my patients	237(97)	3(1)	5(2)
I feel comfortable knowing what to do for a dying patient	151(61)	93(38)	1(1)
I have difficulty prioritizing patient care needs	13(5)	231(94)	1(1)
I feel overwhelmed by ethical issues in my patient care responsibilities	21(9)	221(90)	3(1)
I have difficulty documenting care in the patient notes	24(10)	218(89)	3(1)
I have difficulty recognizing change in my patient's condition	3(1)	241(98)	1(0.4)
Professional Preparation *7 items*			
I am confident in my ability to problem solve	239(98)	5(2)	–
I am satisfied with choosing nursing as a career	238(97)	7(3)	–
My ALN[a]/clinical lecturer provided feedback about my readiness to assume RN role	234(96)	11(4)	–
I feel ready for the professional nursing role	235(96)	10(4)	–
I have had opportunities to practice skills and procedures more than once	218(88)	30(12)	–
Writing reflective journals/logs provides insights into my own clinical decision-making skills	191(78)	53(21)	1(1)
Simulations have helped me feel prepared for clinical practice	175(71)	68(27)	2(1)
Communication *4 items*			
I am comfortable communicating and coordinating care with interdisciplinary team members	241(98)	2(1)	2(1)
I feel comfortable communicating with patients from diverse populations	240(98)	3(1)	2(1)
I feel confident communicating with physicians (doctors)	229(93)	16(7)	–
I am comfortable delegating tasks to others	209(85)	34(14)	2(1)

[a] An ALN is the Academic Liaison Nurse from the education provider who supports student when they undertaking their practicum.

three patients in the acute adult care setting however they do not feel confident caring for four patients at one time. There was no correlation between confidence levels and age or gender.

6. Why did you become a nurse?

All participants (100%, $n = 245$) replied to this question. Four categories were evident.

1) *Altruism.* The most important reason noted by 131 respondents for becoming a nurse was Altruism. This category had two clear subcategories; 'caring for others' (85 students) and 'working with people' (46 students). The desire to nurse was strengthened by their desire to care; *"enjoy the selfless act of caring for others in their time of need", "being able to help and support others in their time of need"*. For others nursing offered the opportunity to work with others; *"I find people interesting and I enjoy learning from their wisdom and experience", "passion to work towards health and wellbeing for individuals and whanau (family) especially in the pacific island community"*.
2) Ability to use bioscience knowledge. Many respondents (n = 42) noted that they loved the 'sciences'; "love the science aspect of nursing", "enjoy learning about the human body", "interest in anatomy and physiology of the human body".
3) *Career strength.* A few respondents ($n = 25$) shared that their observations of nursing work had inspired them to become a nurses themselves; *"paediatric nurses were amazing to my daughter when she was in hospital-inspiration"* or due to inspirational role models; *"my grandmother was a nurse", "father was a community mental health nurse, always respected what he did in his role"*.
4) Overseas travel/work opportunities. For some (n = 21) the ability to travel and work overseas was a compelling reason to become a nurse; "I want to travel and work overseas", "can be a nurse all over the world".

6.1. What could be done to help you feel more prepared to enter the nursing profession?

Comments were received from 214 participants. Many ($n = 38$) commented that nothing more could be done to prepare them to enter the nursing profession; *"all the* support *I received prepared me", "lecturers have prepared me very well", "I feel I am ready for a professional nursing role"*. However, there were two clear categories, respondents wanted *more clinical* (63 comments) and *more simulation* (61 comments). In terms of *more clinical* comments were evenly divided between wanting longer time on placements versus wanting more diversity of placements. For simulation, the students view was that *more simulation* across all topics would be very beneficial.

7. Discussion

It seems clear from these results that these senior New Zealand nursing students feel that they are appropriately prepared to enter the nursing profession. This view is contrary to Reagor's 2010 study which suggested that senior students are highly likely to lack confidence. The students in this study were mostly allocated to clinical areas that utilized the DEU model of teaching and learning to support students. It is also important to note that throughout their program of study the majority of their clinical placements areas would have utilized this model rather than Preceptorship. The DEU model of teaching and learning is based on all staff in a clinical area offering support and learning opportunities to students rather than relying on one-to-one preceptorship (Jamieson et al., 2008). A key finding of a research study undertaken in 2016–2017 found DEUs mimic nursing, whereas a preceptorship model mimics the nurse (Sims et al., 2018). This was not the case in the Reagor (2010) study, nor the Casey et al., (2011) study. It is possible that the DEU model in some way contributes to better preparedness for practice, however this possibility warrants an in-depth targeted investigation to establish the veracity of this statement.

The skills that they were most uncomfortable performing independently mirror results from other studies (Casey et al., 2011; Reagor, 2010). Given the serendipitous nature of the clinical experience for undergraduate students these result do not seem surprising. Moreover, Reagor's (2010) in-depth study concluded that regardless of the number of clinical hours senior students completed there were a variety of clinical skills that they felt unable to perform independently. However, the vast majority of students stated they felt comfortable asking for help, and taking actions to solve problems, therefore it seems reasonable to assume that they will be proactive in seeking help when performing clinical skills that they are not familiar with. Of interest, although the students felt very confident caring for two patients in the adult acute care setting, and to some extent felt comfortable with three, they expressed concern that they felt unable to care for four patients at once. These results also mirror Casey et al.,'s. 2011 study. It is interesting to note the global nature of these concerns given that participants in Casey et al.'s study were from three different programs located in the western part of the USA while these students were from one program in New Zealand. Does this reflect patient acuity? Alternatively, is it that staff are reluctant to offer student a 'full patient load'? Or, is this an unrealistic expectation for a senior student.

In terms of clinical problem solving these senior students rate themselves as confident with their abilities to communicate with others and to be evidence based practitioners as well as problem solvers. At this stage of their program their key concern is their inability to confidently care for a dying patient. This was also noted as a concern by Casey et al. (2011). This level of confidence may be a reflection of their under graduate Bachelor of Nursing program whereby communication skills and evidence based practice are core theory topics. In addition, these elements are examined in practice as they are deemed core competencies for RN practice. By contrast, care of the dying patient, is covered in less depth and could be argued as being a specialty set of skills that students will develop as graduates depending on their area of practice.

While many students felt simulations and reflective journals had helped them prepared for clinical practice a significant number did not. Student access to simulation learning resources is a requirement of all New Zealand nursing programs (Nursing Council of New Zealand, 2015). While the NCNZ does not stipulate how many hours of learning should be provided via simulation it is very clear that simulation hours are over and above the compulsory 1100 clinical hours. Given that this view was consistent across the five cohorts of students it seems timely to reconsider the number of hours of simulation scenarios on offer to ensure that this learning modality is contributing as well as it can to the preparation of graduates.

Of interest, when asked why they had become a nurse, replies were almost an exact match to the categories observed by Casey et al. (2011) with the exception of the perceived portability of a nursing qualification and the ability to travel and work overseas. Similar results have been reported elsewhere (Jamieson, 2012). It could be argued that those who wish to become nurses, regardless, of gender, age, ethnicity and location share a similar set of personal values and expectations. The concept of travel and work could be considered a 'rite of passage' for New Zealanders (Radio New Zealand: New Zealand on Air, 2014).

The students clearly stated that there were two factors that could help them feel more prepared: more clinical time and more simulation. The total number of clinical hours per program is set by the Regulator, the Nursing Council of New Zealand, and is unlikely to change in the near future. However, it seems timely to reconsider the placement and length of clinical practicums through the three-year program alongside additional simulation hours.

Overall, the students expressed few concerns and were very confident that they had chosen the right career for them at this time. This reflects Jamieson et al.'s., (2012) work however a degree of caution

needs to be considered because many studies have demonstrate that the honeymoon period for graduate nurses is rather short lived. It seems prudent for employers to be mindful of this so that supports are in place to nurture and sustain graduates for the long haul. In turn, academic staff must constantly review curricula to ensure that students are being adequate prepared for the clinical environment of tomorrow.

7.1. Limitations

This exploratory study represents the views of students from one nursing program in New Zealand so results are not generalizable to student in other programs. None-the-less, it does go some way to address the dearth of New Zealand literature in this area.

7.2. Recommendations

To gauge the level of perceived readiness of senior nursing students across the country a national survey is recommended. This would provide substantial evidence that would be useful for planning purposes across both the education and health sectors to ensure that students continue to be well prepared for the realism of the workplace.

8. Conclusion

This study suggests that senior nursing students feel they are work ready. A longitudinal study with this cohort of students tracking their experiences as graduate nurse across their first year has just been completed. Findings should reveal if this sense of preparedness was accurate. Meanwhile, it behooves educators to continue to ensure that educational programs nurture and develop highly employable graduates.

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Conflicts of interest

No conflict of interests declared.

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