Competency Preparedness of Baccalaureate Nursing Graduates and Practice Expectations at Entry Level as perceived by the Nursing Personnel and Nursing Leadership of the Hospitals in UAE

الاستعداد لكفاءة خريجي بكالوريوس التمريض وتوقعات ممارستهم كمبتدئين في المهنة كما يتصورها طاقم التمريض وقيادة التمريض في المستشفيات في دولة الإمارات العربية المتحدة.

by

ANNIE ROSITA ARUL RAJ

A thesis submitted in fulfilment

of the requirements for the degree of

DOCTOR OF PHILOSOPHY IN EDUCATION

at

The British University in Dubai

July 2021

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Annie Rosita Arul Raj
2015121034

A thesis submitted to the Faculty of Education
in fulfilment of the requirements for the degree of
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Thesis Supervisor
Dr Solomon Arulraj David

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ABSTRACT

Background: The competency readiness of new nursing graduate is a topic that interests nursing professionals in both academic and clinical settings. In the present era, quality health care, patient safety, cost-effectiveness and satisfaction of the clients and their families are some of the major concerns of healthcare leaders and the top priorities in the strategic plans of their organizations. ***Purpose:*** The purpose of this study is to gain insights on the competency preparedness and practice expectations of new graduates among the preceptors and nurse leaders and professional development nurses of hospitals accredited by The Joint Commission (TJC) in UAE. The theoretical framework of the study is formulated by consulting the theories and models such as Patricia Benner's Novice to Expert theory, The QSEN (Quality and Safety Education for Nurses) competency model, COPA (Competency outcomes and performance assessment) model, Behaviorist learning theory, Constructivist learning theory and the Conscious competence learning theory. A review of the literature, both regionally and globally, presents the competency preparedness, by various stakeholders but there has been no study, published until date, from the UAE regarding the current and expected level of competency. ***Design/ Methodology/ Approach:*** The researcher employed a mixed methodology approach, and within that, concurrent exploratory approach was adopted to collect data using the Nursing Practice Readiness Tool among 104 nursing personnel of the hospitals. Fifty-six semi-structured interviews were conducted among them, especially the nursing leaders of the hospitals in Abu Dhabi. ***Results:*** The quantitative analysis and qualitative analysis indicated the general competency preparedness that is acceptable with gaps in domains such as critical thinking and clinical knowledge and high level of preparedness in communication and technical skills. ***Implications:*** The study has several implications for nursing education, nursing practice setting and policy in the United Arab Emirates and the region.

ملخص البحث

الخلفية العامة:تعد جاهزية كفاءة خريج التمريض الحاصل على البكالوريوس حديثا موضوعًا يثير اهتمام المتخصصين في التمريض في كل من الأوساط الأكاديمية والسريرية. في العصر الحالي ، تعد الرعاية الصحية الجيدة وسلامة المرضى وعائلاتهم من الاهتمامات الرئيسية لقادة الرعاية الصحية والأولويات القصوى في والفعالية من حيث التكلفة ورضا العملاء الخطط الإستراتيجية لمنظماتهم.

الهدف: الغرض من هذه الدراسة هو اكتساب رؤى حول الاستعداد للكفاءات وممارسة توقعات الخريجين الجدد من بين المدرسين وقادة التمريض وممرضات التطوير المهني في المستشفيات المعتمدة من قبل اللجنة المشتركة (TJC) في دولة **منهجية التصميم:** تمت صياغة إطار العمل النظري للدراسة من خلال استشارة النظريات الامارات العربية المتحدة. ، ونتائج الكفاءة ونموذج تقييم الأداء ، QSEN والنماذج مثل نظرية باتريشيا بينر المبتدئ إلى الخبير، ونموذج كفاءة ونظرية التعلم السلوكي ، ونظرية التعلم البنائية ، ونظرية تعلم الكفاءة الواعية. تعرض مراجعة الأدبيات ، على الصعيدين الإقليمي والعالمي ، مدى جاهزية الكفاءة من قبل مختلف أصحاب المصلحة ولكن لم تكن هناك دراسة منشورة حتى الآن من دولة الإمارات العربية المتحدة فيما يتعلق بمستوى الكفاءة الحالي والمتوقع. ضمن نهج منهجية مختلطة ، تم اعتماد نهج استكشافي متزامن لجمع 104 بيانات باستخدام أداة جاهزية ممارسة التمريض بين طاقم التمريض في المستشفيات. تم إجراء ستة وخمسين مقابلة شبه منظمة بينهم ولا سيما قادة التمريض في مستشفيات أبو ظبي.

النتائج: أشار التحليل الكمي والتحليل النوعي إلى أن جاهزية الكفاءة العامة مقبولة مع وجود فجوات في مجالات مثل التفكير **التداعيات:** الدراسة لها العديد النقدي والمعرفة السريرية ومستوى عالٍ من الاستعداد في مهارات الاتصال والمهارات الفنية. من الآثار المترتبة على تعليم التمريض ، ووضع ممارسات التمريض والسياسة في دولة الإمارات العربية المتحدة والمنطقة باكملها.

DEDICATION

To my father Arul Raj and mother Reeta Nirmala Kumari;

To my husband Charles Rajkumar and daughters Karen Jane and Kathryn Joan;

To all my family members.

I dedicate this work!

I thank my father and mother for their continuous support and encouragement. My mother's prayers, love and strength have guided and guarded me thus far. I would like to thank my husband who shares this accomplishment with me. His care and understanding throughout this process has supported me a lot. It is also my pleasure to dedicate this work to my lovely daughters who always cherish my success moments. I love you both beyond comprehension and want you to take this as an inspiration and soar to greater heights in life.

I also dedicate this work to my other family members, and friends who have supported me throughout this interesting and challenging journey. I would like to express my gratitude and appreciation to my parents and family members, especially, my in-laws Mrs. Johny Dawson, Mr. Moses Gnanaraj, Mrs. Vimala Moses, who always supported me with their prayers, brothers Allwyn Rufus & Justin Nirmal Raj, sisters-in -law Mrs. Nithya Allwyn and Mrs. Joice Justin with their words of encouragement and the little ones of the family Andrew, Melvin and Samuel for spreading their love and lifting my spirits.

Also, many thanks to my friends, who have always been there for me and support during my study years and encouraged me to continue with my dreams related to obtaining this degree, despite all of the challenges and obstacles I have encountered.

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LIST OF ABBREVIATIONS

ADON : Assistant Director of Nursing

AVE : Average Variance Extraction

CCTST : California Critical Thinking Skills Test

CNO : Chief Nursing Officers

COPA : Competency Outcomes and Performance Assessment

CRN : Clinical Resource Nurse

DHA : Dubai Health Authority

DOH : Department of Health

DV : Discriminant Validity

FDON : Federal Department of Nursing

GCC : Gulf Cooperation council –consisting of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates)

GNI : Graduate Nurse Intern

HAAD : Health Authority of Abu Dhabi

ICN : International Council of Nurses

IOM : Institute of medicine

JCAHO : Joint Commission Accreditation of Health Care Organizations

JCIA	:	Joint Commission International Accreditation
MEWS	:	Modified Early warning scoring system
MoHAP	:	Ministry of Health and Prevention
NGRNs	:	New graduate registered nurses
NPRT	:	Nursing Practice Readiness Tool
QSEN	:	Quality and Safety Education for Nurses
QSEN	:	Quality and Safety Education for Nurses
RN	:	Registered nurse
SEHA	:	Arabic word meaning Health -Abu Dhabi Health Services Company
SINMAC	:	SEHA International Nurses, Midwifery and Allied Health Conference,
TJC	:	The Joint Commission
UAE	:	United Arab Emirates
UAE-NMC	:	United Arab Emirates-Nursing and Midwifery Council

CHAPTER 1

INTRODUCTION

Chapter 1

Introduction

Nursing is a practice-based discipline, and there is increasing emphasis on competency preparedness of new graduates entering the health care setup. New graduate nurses' competence is an essential international concern for all health care organizations, and the previous studies show heterogeneous levels of competency preparedness being reported (Charette et al., 2020). Competence is defined in nursing as a complex and evolutive combination of knowledge, skills, attitudes, and values, bound to their context of practice (Gonczi., 1994). Many studies report a direct correlation between the competency of the nurses and the quality of nursing care. For example, in 2007, the Quality and Safety Education for Nurses collaborative (QSEN) proposed that all nurses in the hospital should be competent in 1, patient care; 2, teamwork and collaboration; 3. evidence-based practice; 4, quality improvement; 5. Safety; and 6, informatics (Cronenwett et al., 2007).

Competency is heavily viewed as technical skills, but it is also crucial that other domains such as critical thinking, communication, etc., should be assessed to reflect competency preparedness. Even though new graduates' competency assessment reports the competency preparedness as reasonable or adequate, many reports highlight the inadequate competency preparedness. Competency preparedness of new graduates is a global aspiration (Charette et al., 2020). This study explores the competency preparedness of new baccalaureate nursing graduates and the expected level of competency preparedness by the nursing personnel and nursing leadership of the hospitals in the United Arab Emirates.

1.1 Overview of the Chapter

This first chapter introduces the study problem, the background of the study, the significance of the study purpose, research questions, and the need for the study. This chapter concludes by introducing the overview of the chapters to follow.

1.2 Background and Motivation to the Study

Clinical performance and competence of new graduate nurses as they enter the health care setting have been the leading professional and corporate problem for providers and clients of health care (Manoochehri et al., 2015). Nursing competence is defined as the expected knowledge and skills, including personal attributes and clinical judgment skills, which nurses need to possess to perform their duties to the desired level (Benner, 1984). Today, the nursing career is considered one of the most sensitive professions that require a diversity of interrelated competencies essential to manage nursing practices in general. It also guides day-to-day nursing skills based on ethical considerations and strong moral reasoning skills (Brennan & Olson, 2018). Having the needed competencies is essential for nurses to care for the patients, and it affects the safety, health, and positive patient outcome without medical errors. Furthermore, nurses with expected competencies are essential to provide quality nursing care. Nursing competence is not only a professional standard but also an international accreditation standard of the Joint Commission requirement. Therefore, the nursing personnel and leadership expect a demonstration of basic competency by the entry-level graduates regardless of the educational qualification in the hospital, and it not only allows to arrive at a consensus but also stimulates the nurse educators for competency development (White et al., 2010).

Nursing graduates enter the hospital setting to start their careers with the considerable amount of information but lacking in clinical judgement. They have gaps in nursing practice due to

ineffective communication, complexity of the clinical setting and lack of knowledge of patient care (Dabrow-Woods & Stegman, 2020). It is vital that the understanding of the competency preparedness of the graduates supports the development of standardized transition program by the nurse educators in practice. The understanding of this by the nursing faculty enhances the understanding of the challenges experienced by the nurses and integrate the needed competencies into the curriculum so that the graduates' preparedness to enter the practice setting can be improved (Schnur., 2020)

Nursing educators strive to produce graduates well-prepared for their future role as competent professional nurses. However, graduates' capabilities may not fully meet the demand of the employers (Watkins, 2020). As a result, preparing graduates to enter the health care setting becomes the responsibility of both the nursing academic institution and the hospitals where the clinical training happens (Walton et al., 2018a). Thus, the concept of work readiness and competency preparedness has become a dire issue that requires successful strategies suggested and implemented in nursing education and practice (Keshk & Mersal, 2017).

UAE is no exception to this state. The health care system is undergoing a dramatic change in the UAE (United Arab Emirates). The Ministry of Health and Prevention (MoHAP) has launched the UAE National Strategy for Nursing and Midwifery – Roadmap for 2025 that was launched in April 2021 focuses on best regional and international practices in the sustainability of the health care system, enhancing the performance of all health care sectors. The strategy provides special attention to encourage more citizens to join the profession and promote the academic programme and raise the quality of nursing care around the country.

The strategy is constructed around five key pillars, namely governance, leadership and effective legislation, a comprehensive labor administration system for nursing and midwifery profession, high-quality health and nursing services, improving the quality and innovation in education and professional development, and scientific research and evidence-based practice (Murray, Sundin & Cope, 2019).

The fresh graduate nurses are the critical workforce of the future. Their transition from the new graduate to competent registered nurse (RN) is challenging due to the complex health care environment. (Little, Ditmer & Bashaw, 2013). They are expected to master clinical and critical thinking skills rapidly (Anonymous 2019). Competence is defined as “the ability to perform according to defined expectations." But educators are starting to realize that nursing competencies extend beyond skills and policies. Other elements of nursing competence include values, attitudes, general nursing knowledge, and clinical skills. (White, Duncan & Baumle, 2010)**.** The U.S National Health care retention and RN staffing Report of 2020 highlights that the average cost of turnover for a nurse ranges from $33,300 to $56,000. This gives rise to the loss of $3.6m -$6.1m. Each percentage of RN turnover will cost $306,400 on average to the hospital every year.

This study was undertaken to explore the demand of the workplace from the fresh graduate nurses by understanding the perceptions of the hospital nursing personnel at all levels, especially the registered nurse serving as a preceptor. The preceptor is the trainer with whom the fresh nursing graduate is expected to shadow and learn nursing care skills during the internship (Painter, 2017). Other participants include the top and middle management nursing leadership personnel. This study further explores the current and expected level of competency preparedness among the fresh nursing graduates and the strategies suggested by the hospital personnel to bridge the gap between theory and practice.

Practice readiness of new nursing graduate is a topic that interests nursing professionals in both academic and clinical settings. This generates lively conversations, discussions, and divergent viewpoints. (Reinert, Bigelow & Kautz, 2012). In the present era, quality health care, patient safety, cost-effectiveness, and satisfaction of the clients and their families are some of the major concerns of healthcare leaders and the top priorities in their organizations' strategic plans (Purling & King, 2012).

In the United Arab Emirates (UAE), the nursing graduates enter the clinical practice as soon as they graduate in nursing. The unintended consequence of rapid deployment has given rise to more stressful situations for fresh graduates (Ulupinar & Aydogan, 2021). When deployed in the hospital, they are expected to assume professional responsibilities that are potentially beyond their capabilities. In the current era, with drastic changes in the healthcare system, rising acuity in the condition of patients in the hospital, rising demand for reducing the length of stay of patients, staffing shortage, use of cutting-edge technologies and with a more informed public, the nursing leadership is forced to shorten the undergraduate nursing training period and move the new staff to the patient care setting more quickly. Currently, owing to this reason, the Graduate Nurse Internship program has been reduced to six months from twelve months' duration.

The DOH (Department of Health) and SEHA (Abu Dhabi Health Services Company) have taken many efforts to strengthen the Graduate Nurse Internship program. The present study is intended to throw light on and communicate feedback about the progress and performance of the fresh nursing graduates to the academic educators so that they could focus on those areas of competencies that are mentioned as deficient in the graduate in the current cohort and

strengthen the potential graduates and the students on the core nursing competency and their employability skills. Employability refers to the generic skills, competencies, knowledge and the personal qualities that enhance a person to achieve career success at all levels and types of employment. These are the skills that are essential for all jobs which are not job-specific or technical (Römgens, Scoupe & Beausaert, 2019).

To better prepare nursing graduates to meet the workplace demand, it is necessary to understand what kind of skills are expected by the nursing leadership in the hospital, which are also considered as the employability skills as per the employer from the graduate nurses, who are the job applicants. In the present era of economic globalization and the reformation of healthcare, the requirement related to the entry-level nurses' competency continues to evolve rapidly. For today's fresh nursing graduates, what are the skills and competencies that employers consider critical for clinical practice and successful transition? What skills do they consider important? Are there any discrepancies between the current level of competency preparedness and the expected level of competency preparedness? These are some of the crucial questions that are certain to understand.

A majority of fresh nursing graduates do not possess the required skill. The skills that is mentioned as very important and highly ranked by 95% of the nurses in the hospital of Australia as necessary for the new graduates are related to clinical monitoring and management, use of assessment tools, identification of criticality of the situation and communicating the situation with the urgency (Brown & Crookes, 2016). These are considered as the expected employability skills by the hospital personnel. This poses the leading question, Does the skill instruction provided by the nursing colleges match the demand of the hospital?. When fresh nursing graduates become the employees of the hospital, they are considered as an important member of the healthcare industry. They perform their roles in the delivery of safe patient care

which is very critical. An effort to close the practice competency gap is imperative from academia and the healthcare industry, which should be taken collaboratively. This is a critical step to be taken because of technical ability requirements, cognitive abilities and communication abilities that the nurses especially the fresh graduates are evolving in the nursing profession (Burns & Poster, 2008a; Batch-Wilson, 2016.).

Even though the faculties in academia are making every effort to prepare their graduates, train and test the competency among the nursing students related to competency preparedness, there is a practice competency gap regarding the expected and the actual level of competency preparedness of new nursing graduates (Burns & Poster, 2008a). Identification of areas of competency that are deficient in the nursing graduates guides the nurse educator of the academic institutions to structure their curriculum to adapt to the needs of the stakeholders, who are the future employers and enhancing in molding the new nurses and assisting them in providing competent nursing care when they join the workforce.

1.3 Statement of the Problem

The nursing graduates hired are expected to have nursing competence in a variety of areas, but the new nurses while entering the hospital are not able to perform and meet the expectations of the hospital and specific units. According to Keshk and Mersal (2017) nearly 90% of the nursing educators believe their graduates are fully prepared contrastingly 10% of the hospital personnel agree with that. Burns and Poster (2008) reported that nursing personnel, including the nurse managers, report that the new graduates often are very stressed as they enter the health care setting and transition. This is directly linked with the competency preparedness of the new graduates. The divisions exist between students' expectations of the graduate year and the actual work experience (Heslop, 2001) . The nursing academic institutions strive very hard

with the limited time and clinical training while providing a comprehensive curriculum that encompasses the knowledge and skill along with personal attributes that the new nurses require as they begin their career (Reinert, Bigelow & Kautz, 2012).

The establishment of the first nursing institute in Abu Dhabi was a significant milestone during the late 1970s/early 1980s, followed by nursing institutes in Sharjah, Ras Al Khaimah, and Fujairah. Increasing the number of UAE nationals (Emiratis) in all medical professions forms an integral part of the UAE's Vision 2021 (Koornneef & Robben, 2019), (Al-Yateem et al., 2020). The UAE has committed itself to an ambitious reform program, Vision 2021, aiming to be ranked globally among the top 20 countries. (Koornneef & Robben, 2019). Global nursing education has identified areas of significant importance that contribute to the profession's progression. These include nursing specialization, the need to strengthen education to match the practice expectation, competency-based education, and producing new graduate nurses who are competent and can practice globally (Ryskina, Lam, & Jung, 2019). In UAE, steps toward the above said are still in infancy, and it can be initiated only by strengthening the nursing education. Currently, the academic institutions that provide Bachelor of Nursing programs are: 1. University of Sharjah (Sharjah), 2. Ras Al Khaimah Medical and Health Science University (Ras Al Khaimah), 3. Higher Colleges of Technology (Sharjah and Fujairah), 4. Fatima College of Health Sciences (Abu Dhabi in 3 campuses and one campus in Ajman), and 5. Gulf Medical University (Ajman).

Clinical competence is described as the problem that is addressed in this study is the lack of a clear understanding of the entry-level competencies that are expected from the fresh baccalaureate nursing graduates in the United Arab Emirates. Furthermore, it is not known about the perceptions of the current level of competency preparedness of fresh nursing

graduates (Brownie, 2015) . An additional 16,158 nurses are projected to be required by 2025 in the Emirate of Abu Dhabi alone (Department of Health 2018). This study is aimed to determine perceptions of nursing personnel and nursing leadership in selected hospitals in Abu Dhabi UAE focusing on the competency preparedness of new graduate nurses entering the health care setting. Internationally, there has been debate around the clinical preparedness of nursing graduates and clinical performance of recent graduates highlighted over the last two decades Haddad, Moxham & Broadbent (2017). Farokhzadian, Nayeri and Borhani (2018) insists that nursing education must change to meet the demands of the rapidly changing health care systems and the complexity of the newly emerging diseases. It is also mentioned that these changes demand nursing professionals be adequately prepared to combat the challenges concerning the quality and patient safety competencies Though recently there are works of literature that report the need for integrating the quality and safety education into the curriculum and addressing the concern, there is a significantly lesser number of studies regarding the quality and safety education for nursing students. This study is being undertaken to focus on those mentioned areas. The nursing institutions' goal is to ensure that new graduates are both confident and competent. By identifying the expected level of competency preparedness for the entry-level competencies, nurse educators can structure the nursing curriculum to adapt to meet the needs of the hospital nursing personnel and the leadership in providing competent and quality nursing care.

This current study is in complete configuration with the requirement as the objectives of the study and the findings of the study will form the basis to move forward in the directives of the UAE Nursing and Midwifery Strategy 2021. The study's objectives align with the strategic objectives of UAE and aims to enhance the scope of the profession through professional organizational policies and practices ensuring the profession sustainability and contribution to

development goals. The strategy also aims to ensure proper planning of nursing workforce in terms of recruitment and retention in response to the needs and priorities. (MoHAP., 2021). The UAE Nursing and Midwifery Strategy for Nursing and Midwifery- Roadmap for 2025 is developed by local and international experts from the World Health Organization (WHO) and International Council of Nurses (ICN) and approved by the Education and Human Resources Council. It also has a progressive outlook to enhance the status of the nursing profession as one of the most strategic nursing professions in the health care system and plans to include the profession in first to twelfth grade in the schools to create a new image about the profession in the society *(UAE Health*., 2021). This informs that the nursing universities and the training hospitals to gear up with their strategies and be committed to produce competent graduates to be able to perform as per the expectations in the health care setting.

1.4 Purpose and Objectives

The main purpose of this study is to gain insights on the perceptions of hospital nursing personnel such as preceptors, professional development nurses and the nurse leaders regarding competency preparedness of new graduates and the hospital nursing personnel's practice expectations in hospitals accredited by The Joint Commission (TJC) in UAE. The conceptual framework of the study presents the association between the study and the concepts.

Focusing on the main purpose of the study, the other purposes of the study are to explore the expected level of competency preparedness , the current level of competency preparedness for new nursing graduates, to identify the skill levels of practice expectations, to find the competencies perceived as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital as perceived by the nurse preceptors, unit

managers, professional development nurses, and hospital nurse leaders. The study also has the purpose to explore the gaps in new graduate nurses' competency preparedness and which of the competencies are reported to have wider gaps by the hospital nursing personnel. Furthermore, the study focuses to identify the strategies that are suggested by the hospital nurse leaders, unit managers, and professional development nurses to enhance the competency preparedness and concomitant practice expectations of new graduate nurses.

The ultimate aim of nursing practice is to improve the patient outcome, for this to happen the nursing education system has a responsibility to adopt appropriate strategies for them to develop competencies and be successful in their careers. Numerous studies have been undertaken in the western world and present extensive data related to the subject. However, the academics, and also the leaders of the hospital, recognize that there is lacking a comprehensive plan on what to teach and how to teach concerning the expectations of the hospital and patient populations. (Cronenwett, 2007; Kim, 2015 & Virgolesi, 2014). Edwards et al. (2019) affirm that the stakeholders of nursing education need to be involved in the curriculum building process, so that the health professionals, including the nursing graduates, will be trained to meet the demands of the health care delivery system and the stakeholders. The stakeholders or the players involved in the education to practice gap are the health care organizations, the clients of the health care organizations, who are the patients, the nurses, the profession of nursing and the nursing education program.

1.5 Research Questions

In today’s world the transformation of the nursing program is vital and individual nursing education programs need to identify the strategy to enhance their graduates’ competency

preparedness (Edwards et al., 2019). On the other hand, due to the varying conditions and acuity and complexity of hospitalized patients, even the very best baccalaureate college of nursing cannot prepare new graduates to work in today's acute care setting immediately as soon as they hit the floor in the health care environment. Anecdotally, it is said by many nurse executives that the Baccalaureate College of nursing is doing a very good job of preparing new graduates and providing the foundation needed to start their clinical practice (Goode et al., 2009). To this end, the main research question and the sub-questions emerged as follows.

Main Question:

What is the perception of the hospital nursing personnel about the competency preparedness of new baccalaureate nursing graduates of UAE as they begin the practice in UAE?

Sub Questions:

Research Question 1. What is the expected level of competency preparedness as perceived by the nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders?

Research Question 2. What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the current level of competency preparedness of new graduate nurses?

Research Question 3. What skill levels and practice expectations of the new graduate nurses, do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as most important?

Research Question 4. Which are the competencies that nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital?

Research Question 5. What are the gaps in new graduate nurses' competency preparedness and which of the competencies are reported to have wider gaps by the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders?

Research Question 6. What strategies do the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggest to enhance the competency preparedness and concomitant practice expectations of new graduate nurses?

1.6 Rationale for the Study

The main reason for undertaking this study is to explore and understand the perceptions of the hospital nurse managers about the competency preparedness of the graduate nurse interns and practice expectations related to the QSEN competencies and JCIA standards. The researcher considers the study as the first step to move towards achieving the national goal and the vision of UAE 2021 (*UAE Vision*, 2021). UAE leads the world with the largest number of hospitals accredited by the Joint Commission International (DHA, 2016). Joint Commission International (JCI) is an organization that is the oldest, largest gold standard for hospitals and the accrediting body. It has been updated (JCIA., 2017). It inspires and guides the health care setting to excel in providing safe and effective care.

The UAE has 145 JCI accredited health organizations, the highest among 67 countries. The UAE ministry of Health and prevention has adopted internally accredited protocols and standards in clinical care and is committed to the national agenda to achieve the UAE vision 2021, to take steps in developing the health care system with international standards. JCIA's achievement is within the ministry's strategic plan and to accelerate UAE's propulsion to be among the world's best countries with the health care of international standards by 2021. Having highlighted the preordained destination of the health care system of UAE, the reason for taking up the study is very clear that the nursing education system needs to be geared up to meet the demands of the health care system.

The International Council of Nurses (ICN) outlines the specifics concerning the scope of nurses in the promotion of health and prevention of illness, as well as the care of ill, disabled, and dying people. Contemporary nursing includes the roles of being the advocate for the patients and family, proving them a safe environment and continuing to demonstrate competence (Girvin 2016). The United Arab Emirates-Nursing and Midwifery Council (UAENMC) was established in 2009 by the Supreme Council by Cabinet Decree (UAE Nursing & Midwifery Council 2010). Its main aim is to strengthen the nursing and midwifery workforce to keep abreast with nursing global trends in current nursing practice. It also focuses on the developing effective clinical learning environments related standards, which will guide the nursing educators and health service clinical placement providers (UAE Nursing & Midwifery Council 2010).

The UAE is a young country that came into being in 1971. However, the country has seen manifold growth and development in key areas such as health, education, business, and tourism. The UAE's nursing education system, like its health care, has grown exponentially

over the past 8-10 years (Koornneef, Robben & Blair, 2017). It is found that there is a lack of consistency of the program design and delivery and there is no one single curriculum followed across UAE. The nursing program was first established using an Australian curriculum, which was later amended and established in 2012. In short, the nursing program is an Australian program delivered in an American system in the UAE by a largely diverse, disparate non-indigenous workforce. The curriculum though is moving towards contextualization; it is not completely tailor-made to fit the context (Brownie et al., 2015). The present study will contribute to providing the foundation on which the nursing program can be strengthened to produce the nursing workforce adequately competently prepared. Besides, the study will enhance the institution to achieve its objective as per the key performance indicator as to ensure all programs meet the skills requirements for student placement in the relevant jobs and career pathways (ACTVET 2015).

It is anticipated that the present study will further throw light on the current level of competency preparedness and expected competency preparedness so that it serves as the foundation to strengthen the nursing education by informing and enhancing the nursing curriculum. Improving the health outcomes through artificial intelligence, Innovative work environment and staff well-being, was the theme of the SEHA International Nurses, Midwifery and Allied Health Conference, SINMAC (2019) Abu Dhabi. The conference also aimed to bring together national and international nursing experts to discuss the current issues in nursing education, path forward in the next five years related to nursing practice and nursing education focusing on the recent global educational innovations to bridge the local gaps in the UAE health care educational systems (SINMAC 2019). The researcher found that there were no studies undertaken to study the competency preparedness of new graduate nurses. To fill this gap in the literature and to meet the needs of the nursing education and practice field, the study will

investigate this arena and provide a basis for the said field by finding the answers to the research questions of the study.

The researcher's dual experience in both the academic and the practice setting, and exposure being working in the profile of the lecturer, chief nursing educator, nursing administrator, nurse recruiter, Joint Commission International accreditation coordinator for the hospital and presently as lecturer, clinical instructor and clinical coordinator have inspired and enthused the researcher to explore the topic of focus for the present study, which is the competency preparedness of new nursing graduates.

1.7 Structure of the Dissertation

The overall structure of the thesis is built in five chapters. This chapter introduces the study, orienting the problem and highlighting the need for the present study to be undertaken with the overview of the context related to the nursing education and nursing clinical training and health care in UAE, the research purpose and objectives and the rationale to undertake this study.

The second chapter, titled as Literature review, presents the conceptual analysis which unpacks and defines the concepts and also maps out the concepts involved in the study specifically the competency, competence, performance, skills and competencies. Additionally, the theoretical framework includes the key theories that is related to the study namely Patricia Benner's Novice to Expert theory, QSEN competency model, COPA model, Behaviorist learning theory, Constructivist learning theory and Conscious competence learning theory. Followed by that, it presents reviewing several similar previous studies and presents key theoretical findings and

gap that explores the present study where it highlights how the current study situated is presented.

Chapter three presents the methodology adopted in the study. It also discusses the research approach and the research paradigms. In addition to that, the site, sampling, population, data collection plan, data collection instruments including their validity and reliability including the pre and post piloted tool, data analysis plan informing the analysis results, discuss and interpret the results. It is followed by scope of the current study and also ethical considerations mentioning the role of the researcher and also presents the measures taken to deal with the bias focusing on the risk involved in the study. Finally, trustworthiness or reliability of the data, site and samples are also presented in this chapter.

The fourth chapter presents the analysis of the data collected. First, the analysis of the quantitative data with the critical analysis, discussion and interpretation of the study results are presented along with the quantitative results that is summarized. Followed by that, analysis of the qualitative data with critical analysis, discussion and interpretation of the study results are presented along with the qualitative results that is summarized.

The fifth and the final chapter presents the summary of the study, followed by key findings which helped to answer the research questions, recommendations that was derived from the current study and from the literature consulted, the implications of the study, limitations and finally the scope for the further study, where the future studies recommend based on the contribution and limitations of the study is presented.

CHAPTER 2

LITERATURE REVIEW

Chapter 2.

Literature Review

2.1 Chapter Overview

The review of the literature was carried out focusing on the relevance of literature to the area of inquiry and included in this chapter. Government publications were also reviewed for further sources. The literature revealed that the practice readiness of new graduate nurses is a concern for higher education, the healthcare industry, and the nursing profession. The review of literature is categorized with themes and subthemes (Table:1) which frame the background discussion in this chapter. This chapter includes studies that addressed the aim and focus of the study, which is the competency preparedness of the new graduate nurses. The articles in the review were identified by conducting searches in the following databases: PubMed, CINAHL, Medline, Ebscohost and ProQuest Nursing, and Allied Health. The articles within the time frame of the 10-15-year period, that is from the year 2005-2020 were considered for review of the literature. The keywords that were used to search were Graduate nurses. Fresh nurses, Novice nurses, new nurse graduates, employability of new nurses, preparedness, entry-level competencies, skills expected on entry, perception of hospital personnel, the expectation of nursing leadership, faculty perceptions.

The Boolean term “and” was used during the literature search so that the search would yield more comprehensive results. Besides, references were identified from the research article reference lists. The search revealed that many qualitative studies were examining the faculty’s’ perceptions about the preparedness of the new graduates, hospital personnel’s’ perceptions of the effectiveness of the graduate nurse internship program, and their competency preparedness

when they enter the health care setting. But there were very few studies focusing on the expectations or demands of the hospital industry or the so-called stakeholder's perception of the expectation of the new graduate nurses' competency preparedness.

The Review of literature provides the roadmap of information regarding the competency outcomes performance assessment model (COPA) and also the extraction of articles involving the perception of hospital nurses and the nursing leadership about the level of competency preparedness of new graduate nurses, areas of competency or skills the new nurses need to improve on, the areas the new nursing graduates excel and also studies that focused on the theories and models that were relevant to study the competency preparedness of the new nursing graduates.

The sole aim of this study was to explore the perception of the hospital personnel, especially the nurses of different levels including the leadership about the practice preparedness of the new nursing graduates of United Arab Emirates (UAE). The literature was reviewed to understand the needs and demands of the nursing personnel of the health care industry in different sectors and different regions of GCC (Gulf Cooperation council –consisting of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates) and also across the world. Additionally, the literature review included the theoretical framework that was used in this study and its translation to the practice of nursing.

This chapter also addresses the scholarly pieces of evidence regarding the level of prevailing theory-practice gap among the nursing graduates, transition to practice, demands of the health care industry, expected nursing competencies based on major reports and international standards, and patient outcomes.

> *"A New Graduate Nurse, while entering the health care setting as a part of the entry into professional practice, is at the commencement of the journey to develop the expertise which will lead to confident, intuitive, and fully appropriate and comprehensive nursing care management. New Nurses enter the health care system with so much enthusiasm, wanting to make a difference in enhancing positive patient care and outcome, and the nursing leadership personnel and the educators are in critical role in providing encouragement and coaching in ways that will enable new nurses to maintain their enthusiasm and vision while they are acquiring the skills and perspectives they need to become effective in the system."* (Benner, 1982).

New graduate registered nurses (NGRNs) are facing a workplace environment that is complex, demanding, and resource constrained. The workplace culture may be difficult and different where gaining acceptance is very difficult. The only thing that can ease-out the acceptability to the workplace is the preparedness of undergraduate nursing students for this reality (Mellor, Gregoric & Gillham, 2017). The review of the literature indicates that health care is undergoing tremendous change and it is essential that the new workforce is expected to be prepared so that they will be able to meet the expectations of the health care industry.

The changes in the health care industry are aimed to bring about certain changes, which are framed as the key performance indicators of the nursing care and the quality of the hospital such as decreasing the length of stay of patients in the hospital, nil medication errors, nil medical errors, avoiding readmission, prevent complications in any diagnostic or therapeutic procedures. At this juncture, there is a question that arises, which is the focus of this study, namely, are new graduate nurses geared up to meet the expectations when they join the

workforce. The literature is focused on the different themes that are directly and indirectly connected to the competency preparedness.

2.2 Conceptual Framework

The concept is an abstraction contingent from observation of performances, conditions, or characteristics (Kim, 2017). Key concepts here are competency and preparedness. This doctoral study focuses on competency preparedness. Sturgess (2012) described three different ways of conceptualizing competence. They are (1) A behaviorist approach that can be referred to as a task-specific approach, which can be assessed by observation of the performance for evidence, (2) An attribute approach or generic skills approach and general attributes that are critical to effective performance based on the general competencies that are already learned, and (3) An integrated approach or task attribute approach.

Furthermore, Juceviciene and Lepaite (2005) Collaborative learning is considered to be one of the most promising meta-paradigms of the postmodern age. The article seeks to answer the following problem question: how can student collaborative learning be empowered considering the aspects of legitimacy, competence, and inclusion in the learning process? Based on the analysis of research literature, explanations are provided on how to educationally empower collaborative learning in the studies Juceviciene and Vizgirdaite (2012) have proposed a multidisciplinary approach to the conceptualization of competence. They proposed the conceptualization of competence in the view of different competence in various hierarchical levels. Level 1: Behavioral competencies related to the actual operations at the ground level to meet the demands of the workplace. this level constitutes the competencies. Level 2: This level includes the competencies that are based on the behavior and additional knowledge that is

needed to bring about improvement in the workplace. Level 3: This level includes the competencies that are termed are integrated competencies that support the internal and external working conditions. Knowledge, skills, and understanding are an integral part of the internal and external work conditions. Level 4: This level of competencies includes the holistic competencies that are important to develop new work skills and transfer knowledge and skills to the situations they encounter in the workplace (Sturgess, 2012). A huge ambiguity revolves around the meaning and difference among the word "competence" "competency" and "performance".

2.2.1 Definition of Terms Key Concepts

The oldest definition on records dates back to the 15th century wherein 1590, the term competence meant essential, or desirable qualification for office holding (Gagliardo, 2014). The term is currently defined as the ability to do something well and the quality or state of being competent (Merriam-Webster's Online Dictionary, n.d.; Oxford Advanced Learner's Dictionary, n.d).

Competencies: A cluster of related abilities, commitments, knowledge, and skills that enable a person to act effectively in a job or situation." (Downes 2015). A measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual need to perform work roles or occupational functions successfully (Ravet 2015). Competence is a holistic term that refers to a nurse's overall capacity for pertinent knowledge, skills, and abilities that are developmental, evolving, and contextualized (Pijl-Zieber et al. 2014).

Competency: Competency denotes knowledge, skills, abilities, and values, which are expected to be integrated into practice (Pijl-Zieber et al., 2014). Takase and Teraoka (2011) defined nursing competency as a nurse's ability to effectively demonstrate a set of attributes, such as personal characteristics, professional attitude, values, knowledge and skills and to fulfill his/her professional responsibility through practice.

Competent: The demonstration of integrated knowledge, skills, abilities, and judgment required to practice nursing safely and ethically (Pijl-Zieber et al., 2014). Takase and Teraoka (2011) defines a competent person must possess these attributes, have the motivation and ability to utilize them and must effectively use them to provide safe, effective and professional nursing care to his/her patient.

Practice Expectations: The expectations of the new nurses on the role of a qualified nurse on a day-to-day basis.

Practice Preparedness: Preparedness to practice is defined as "The nurse is prepared to practice with patients including individuals, families, groups, communities, and population across the lifespan and the continuum of health care environments" (AACN, 2008).

Perception of Preparedness to Practice: It is conceptually defined as one's belief that the graduate nurse possesses the necessary knowledge, skills and attributes to perform in a complex work environment demonstrating critical thinking including problem-solving and clinical decision making, complex skills, prioritization, organization, and managing a caseload of patients (Wright 2014; Haddad, Moxham & Broadbent 2017).

Graduate Nurse Intern: An individual who completes a basic nursing education program and is authorized to work under the supervision of the preceptor and gets trained on the job (NCSBN 2017).

Nurse Manager/ Unit manager: A middle manager who is responsible for the patient care unit, has the staff nurses report to them and is accountable for the operation of the unit. It is a formal leadership role, where the staff have day-to-day responsibility for the operations of a specific patient care unit. The said personnel also coordinates between the front-line employees and the senior leadership staff (Rundio & Wilson, 2016).

Nurse preceptor: The Registered Nurse who holds the license, working in the patient care unit and has the Graduate nurse intern working under her supervision and are responsible to train her on the job.(Painter, 2017)

Clinical Resource Nurse (CRN): A Clinical Resource Nurse is a member of a healthcare organization who provides post-licensure education to nurses who work in healthcare facilities for the skills and knowledge needed to provide the best possible care to their patients. The training and education provided by them include areas related to staff development concerns, in-services, and transition to professional practice within their facility are devoted to teaching nurses (Burns & Poster 2008; Brennan & Olson, 2018).

Nursing Hospital Leadership: A nursing leader within the healthcare setting, nursing leaders are chief nursing officers, nurse managers, clinical resource nurses, and clinical practice educators (Nursing Executive Center, 2008). Clinical leader refers to any staff nurse who

influences the healthcare team and facilitates individual and team efforts to accomplish mutual clinical objectives (Chávez & Yoder, 2015).

Skills: The nurses throughout their careers beginning in nursing school develop the skills that nurses possess to perform quality care of their patient population safely and effectively. These skills include, but are not limited to, the psychomotor, technical skills used to perform procedures and nursing duties; decision-making and critical thinking ability; delegation; prioritization; interpretation of assessment data; communication; and recognition of patient status changes (Nursing Executive Center 2008b; Worth-Butler, Murphy & Fraser 1994).

JCIA Standards: The Joint Commission International Accreditation (JCIA) standards are the foundation of an accreditation process that guides the health care organizations to measure, assess, and improve performance. These standards promote quality and ensure patient safety. JCI standards set clear expectations for organizations that are reasonable, achievable, and measurable. The standards are developed and organized around important functions common to all health care organizations (JCIA, 2020).

QSEN: Quality and Safety Education for Nurses (QSEN) identifies graduate-level quality and safety competencies and proposed targets for the knowledge, skill, and attitudes for each competency. It also addresses the challenge of preparing nurses with the competencies that are necessary to continuously improve the quality and safety of the health care systems in which they work (‘Graduate-QSEN-Competencies. n. d; Cronenwett, 2007a). QSEN helps nurses to identify and bridge the gaps between what is and what should be. (Cronenwett et al., 2007b).

2.2.2 Competency, Competence, and Performance

Competency focuses on the individual's ability to perform the activities that the workplace demands, skills for life, or learning. Competence indicates the activity that the individual is expected to be able to demonstrate. Performance is specific, measurable behaviors and reflects the individual does (Moore, 2002; Anema & McCoy, 2009). Three core approaches to intellectualizing competence can be found in the literature: 1) behaviorist; a task and skill-based approach, 2) generic; focus on transferable attributes and 3) holistic; brings together knowledge, skills, attitudes, and values (Kee & Eraut, 2011; Fukada, 2018; Kajander-Unkuri, 2015).

There can never be an agreement about the list of competencies that are necessary for any job. This list because of many reasons and many questions that can endlessly be subdivided. Some of the questions makes it difficult to arrive at a standard list of competencies. The questions are: How can the skills be derived and from where can these skills be derived?, On what basis can the skills be chosen?, How explicitly should the competencies be described in detail?, How many competencies are expected?, What is the evidence that the said competency has been acquired?, What is the priority of the competency and how much importance is given?, How will the years of experience affect the level of expectation incompetence? (Cossart & Fish, 2005). In the review of articles for definitions of competence, competent, and competency, the terms namely, level of performance (Downes 2015), behaviors, safety, integration, application of knowledge (Pijl-Zieber et al., 2014), skills in a context, measurable actions (Kajander-Unkuri 2015), desirable outcomes, and quality patient care (Ravet 2015) were noted.

Some authors used "competence," "competent," or "competency" synonymously, whereas other authors argued that the words were subtly but essentially different (Koncaba, 2007). It

was studied about both competency and performance and concluded that competence is job-related, and it is referring to the individual's ability to meet the requirements and competency is person-related which refers to the individual's knowledge, skills, and abilities, and influences the effective function in a job (Zhang et al., 2001). On the other hand, Watson et al. (2002), Worth-Butler, Murphy and Fraser (1994) and Norman et al. (2002) have settled with the argument that both competency and performance are the same and are inseparable.

2.2.3 Skills and Competencies

The term skills and competencies are also used interchangeably. Having discussed that competencies are those that deal with the behavioral aspect of the person's ability to perform in the workplace, it becomes necessary to understand the relationship with the term "skill" (Robichaux, 2017). The literature also mentions that the transferability of meaning for the terms 'skill' and 'competence' are interchanged due to lack of clarity of the term 'skill', how it is related to the broader umbrella called competence, and not merely the synonym of competence (Cossart & Fish 2005).

Skills are the abilities that are learned already and are needed to be performing the job well based on the role. However, a clear line needs to be drawn between hard skills and soft skills (Norman et al., 2002). The hard skills are the skills that can be measured and be quantified, whereas the soft skills are those that are non-technical, but vital to be able to carry out the job such as communication skills, time management, etc. (NCSBN, 2017). The skills that the new nurse possesses, and is expected to have when entering the health care institutions, are those that are developed and inculcated during their training period in the college or university of nursing which includes, but are not limited to the psychomotor, technical skills used to perform

procedures and nursing duties; decision-making and critical thinking ability; delegation; prioritization; interpretation of assessment data; communication; and recognition of patient status changes (Nursing Executive Center 2017).

The conceptual framework of the study presents the association between the concepts involved in the study as in Figure 2.1. The overall aim of the study is to gain insights on current competency preparedness and practice expectations of new graduates among the preceptors, nurse leaders, professional development nurses and nursing leaders of Hospitals accredited by The Joint Commission (TJC) in UAE. This investigation is undertaken with the background between the JCI standards and QSEN standard's crosswalk. The light is thrown on the standards in the study, as it is well understood that the competencies are strengthened and updated as per the evidence based practice enforced by the standards followed.

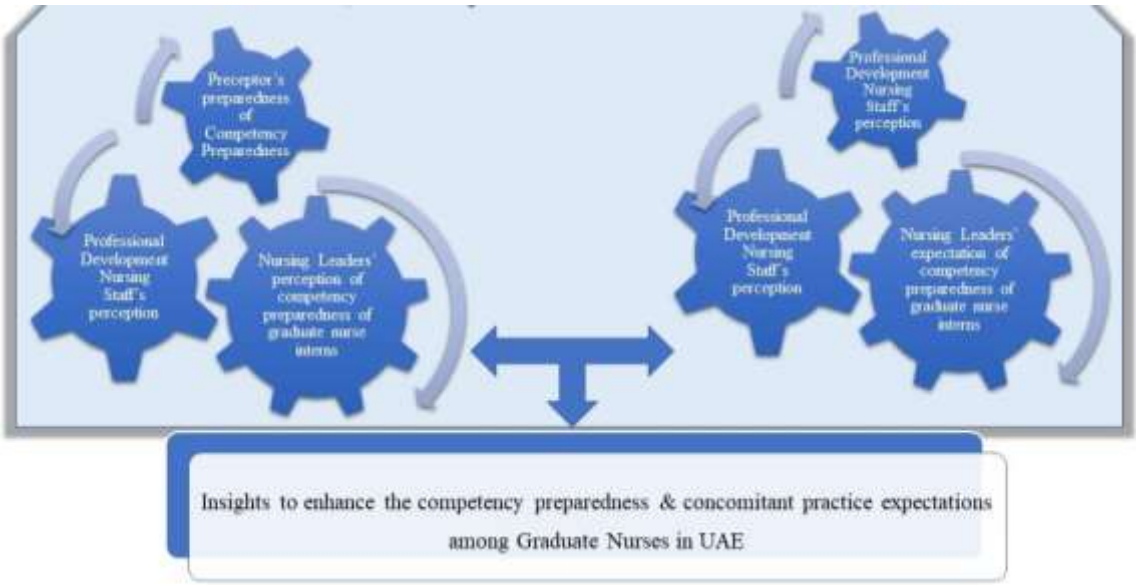


Figure 2.1: Conceptual framework: Competency preparedness & practice expectations

The study that explores the current competency preparedness level and the expected competency level as reported by the different nursing personnel and leadership of the hospital. The participants namely registered RNs with the preceptor role, charge nurses, unit managers, clinical resource nurses, assistant director of nursing and the chief nursing officers in the selected SEHA hospitals that are accredited by the Joint Commission. The results of the study are anticipated to provide insights to enhance the nursing curriculum and clinical training, which thereby enhances the competency preparedness as per the expected level of competency preparedness.

2.3 Theoretical Framework

The theoretical framework guiding this study is derived from different models and theories. The theoretical framework that has been chosen is represented in Figure 2.2. Among the literature that was consulted, it was observed that the researchers used more than two theories and models that guided the study.

In the present study, where the focus was to explore the level of competency preparedness of nursing graduates, more than one theory and models were consulted and the predominant ones being, Patricia Benner's novice to expert model (Benner 2001), Quality and Safety Education for Nurses model (2012) and the Competency assessment and performance model (2009), along with consulting the above-mentioned models, under the preview of behaviorist learning theory and constructivist learning theory. The theoretical framework of the study was formulated by consulting the theories and models such as Patricia Benner's Novice to expert theory, The QSEN competency model, Competency outcomes and performance assessment model, Behaviorist learning theory, Constructivist learning theory and the Conscious

competence learning theory. Different theories, models and frameworks exist in the literature which was consulted provided the basis to formulate the theoretical framework

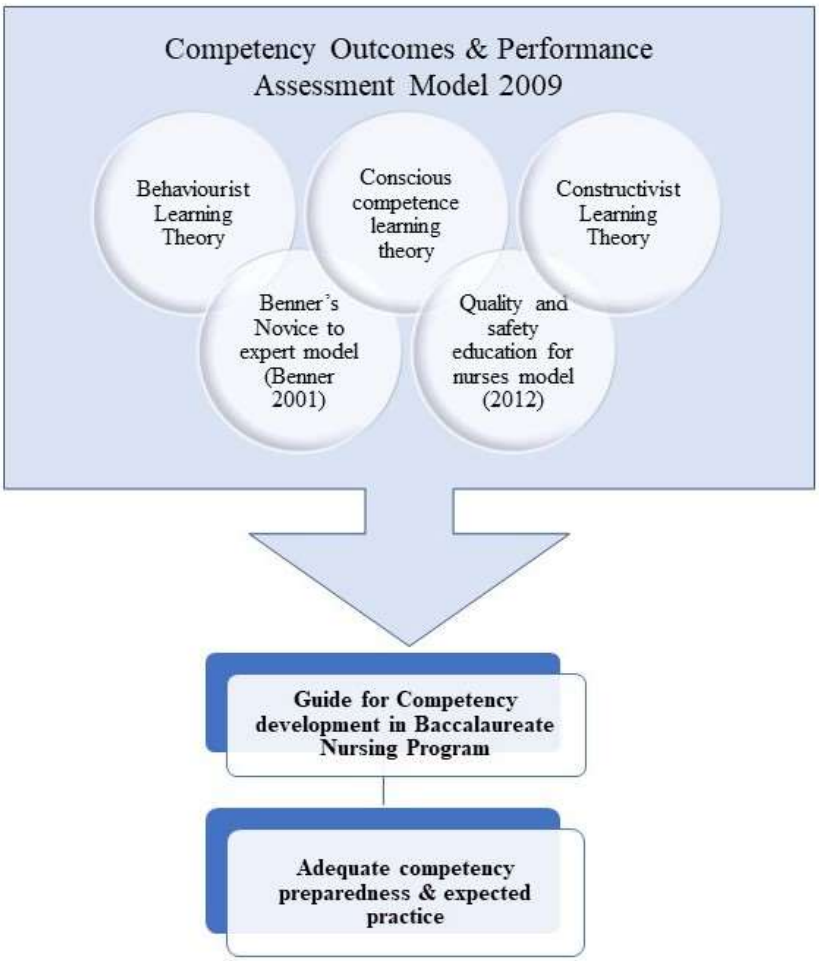


Figure 2.2: Theoretical framework

The theories consulted for the study also enhance the measurement and insight towards competency preparedness, and thereby inform insights to produce the nursing graduates who can provide holistic nursing care focusing on the quality and safety of patient care. The discussion on the theories, and the way in which the current study utilized its framework to situate the study, is presented as follows.

2.3.1 Patricia Benner's Novice to Expert Theory

Benner's theory and framework have been used widely as a rationale for career development and continuing education of nurses (Brykcznski, 2010b, p 141; Ozdemir, 2019). The theory has provided guidance in developing the foundations for building and improving skills of the primary care nurse through examining the acquisition of nurse's experience (Fennig et al., 2005; Sunkes, 2017). This study employed Novice to expert explained by Benner (2001) and Murray et al. (2019) as a major framework that is used extensively to examine how the new graduate nurses are practice prepared in contrast to what is the level of competency preparedness as expected by the hospital personnel, including the hospital leadership.

Patricia Benner's novice to expert theory is a theory of skill acquisition. Benner's model of skill acquisition can be used to help define and measure expert practice (Haag-Heitman, 2008). It identifies five levels of competence: Novice, Advanced Beginner, Competent, Proficient, and Expert (Benner 1984). The theory also throws light on the progress of the individual during the movement from one level to the other as they acquire skills. The three levels of skill performance that the theory mentions are, the first level where the individual moves from depending on abstract principles to the use of previous experience in dealing with the situation using a particular skill. Secondly, the individual, who was viewing the situation as fragmented pieces of tasks now begins to view the situation, where only certain pieces of the fragment are the priority to be dealt with at that particular situation. Lastly the individual changes the role of being just as an observer to an involved performer (Benner 1984). The elements of the theory are as follows.

Novice: According to Benner (2001), the novice level applies to those who do not have any experience in the field of job. Furthermore, they are task-oriented, governed by rules and their

focus is just learning and acquiring skills. It is also added that the period lasts for the first-year post-training. The individual who is in this stage, for them to progress to the next level, they must be exposed to many clinical situations. The nursing practice is limited, and they just go by the rules and are not flexible.

In this study, the new nursing graduate is identified in the Novice level of competency preparedness if they have the characteristics such as being able to recognize various objective facts and features of a skill. They should be able to perceive relevant elements of the situation as clearly and objectively defined and recognize relevant elements without reference to the overall situation in which they occur (Gagliardo 2014). They should apply relevant rules to those context-free elements not knowing the complete story or the situation, act unambiguously defined context-free elements by specific rules and as follows:

- Ignore context when applying rules,
- Not have/ know the context of performing any activity,
- Unable to understand that in certain situations, the rule should be violated,
- Not have a holistic understanding of the situation.
- Recognize context-free features and apply objective procedures,
- Look at everything at the same time,
- Get overwhelmed by too much information,
- Are not intuitive in skill,
- Just follow the steps in procedure without contextualizing and are very analytical at decision making (Manoochehri et al., 2015).
- Are completely detached from the process. They do not have an emotional or intuitive aspect being considered when they set the goal, decide what to do and also, they do not consider thinking about the action of their actions (Thomas and Kellgren, 2017a).

- Able to recall and apply the concepts and theory and subsequently, does not exhibit the feeling of responsibility for the outcome of his/her performances,
- Point fingers at the process for any faults that happen and do not have personal involvement.
- Considers their role to be very challenging.
- Does not know which part of the variable to focus on and which part of the variable in the skill can be ignored (Gagliardo 2014).

In general, the new nursing graduate who is identified to belong to this stage of skill acquisition act in the manner of "tell me what to do and I will do it" (Benner 2001; Wayne 2019; Upouthe 2015). A student graduating from college who only ever focused on their grades and extracurricular activities might be a novice or might not even be at that stage (Eliason 2017).

Advanced Beginner: The next skill acquisition level is the advanced beginner level, who can identify and recognize the critical situations and episodes from their previous experience. According to Dreyfus (2004), this level is defined as the individual who can exhibit a relatively acceptable level of skill performance and have managed enough real situations. In this study, the characteristics of new graduate nurses in the advanced beginner level of skill acquisition are identified with the following characteristics.

- Has obtained familiarity in handling their problems in patient care.
- Deliberates more context-free facts, although they still rely on the rules.
- Learns to use more refined rules and has contextual awareness.
- Able to identify vital areas of the clinical situation and can understand and comprehend abstract ideas.
- Before perceiving something, they do not rely on the objective, which is not context based.
- Perceives similarities to prior examples or situations.

- Perceives new elements as “situational” rather than context-free.
- Follows formal procedures or sequential directions without observing and weighing what is most important
- Exhibits difficulty identifying and prioritizing what is most important.
- Recognizes learned components and applies learned rules, and consequently, feels little responsibility for the outcome of his/her acts.
- They do not possess the full picture of the skill but are trying to develop the context.
- They are not completely lost when something goes wrong, they can consider the context and manage the situation based on the previous experience.
- They can identify the situational cues.
- They get easily overwhelmed by their feeling while they are trying to manage the situation.
- Needs pieces of advice and guidance from their experienced colleagues (McHugh & Lake, 2010).

In summary, the new graduate nurse can grasp the understanding of the patient’s situation in a holistic manner Manoochehri et al. (2015), but unable to consider the patient's previous status, current illness, and plan according to the future expectations (Upouthe, 2015). They find it difficult to prioritize the nursing diagnosis (Themes 2017; Benner 2001). Generally, they are task-oriented and perform patient care as completing the list of tasks (Wayne, 2019). They can only focus on one aspect of the individual during care such as their requirements (Thomas & Kellgren, 2017a), values, beliefs, behaviors, emotions, perceptions, etc., (Gagliardo, 2014).

Competent Level: The nurses at this level can draw the plan based on previous experiences. They gain knowledge and skills about the patient’s condition, the background, and the priority and urgency. They can develop individualized care plans (Benner et al., 2009). The other

characteristics of the new graduates identified in the competent level of skill acquisition are as follows:

- Recognizing situation related variables along with present in real situation becomes overwhelming.
- Recognizes the need to identify and prioritize what is most important.
- Able to develop a plan to organize the situation, then examine only a smaller set of factors that are most important based upon the chosen plan.
- Able to identify the elements that can be considered as irrelevant to decision-making and responding.
- Follows the protocol in decision making and adheres to the hierarchical procedure of decision-making.
- Sees a situation as a set of facts where the importance of some facts may depend on the presence of other facts.
- Learns that when a situation has a particular pattern of elements, a certain conclusion should be drawn, the decision made, or expectation investigated.
- Exhibits more skill and less analytical reasoning.
- Assesses the urgency of competing needs and plans work accordingly.
- Monitors the plan to identify new situational elements, assesses the presence or absence of certain factors, and modifies the plan when indicated.
- Determines whether new situational elements become important or should be ignored.
- Pays attention to only a few of the immense number of factors impinging on the overall situation to decide the hierarchy of action.
- Choosing an organizing plan that is individualized based on the patients' needs.

- Combines and assigns nonobjective and necessary elements when wrestling with the question of the choice of a plan, and consequently, feels responsible for and emotionally involved in the product of his/her choice.
- Recognizes and decides in a detached manner but finds himself/herself intensely involved in what occurs thereafter.
- Feels genuinely fulfilled with effective outcomes.
- Remembers poor outcomes and linked feelings.
- Remembers successfully chosen plans and remembers the situation from the perspective of the plan (Anonymous 2011; Greiner 2003).

In particular, although they can manage the patient care with confidence and can expect the future conditions and recovery of patients, and they do not have the flexibility for reflection of their actions in the situation or feedback for practice and the speed. They are not overwhelmed by what they learn in the patient care situation. They are not anxious when they perform what they learned. They have a sense of responsibility in the clinical area. The focus of blame shifts from the process and the system to themselves. (Themes 2017; Benner 2001; Wayne 2019 ; Thomas and Kellgren, 2017a ; Gagliardo, 2014 ; Manoochehri et al., 2015; Upouthe., 2015). It is the planning, that is characteristic of this skill level; it is what helps the competent nurse to be more efficient and organized (Thomas & Kellgren, 2017b).

According to the theory, the individual can view the clinical situation comprehensively instead of separate fragments of the situation. In this level, the nurse can take better clinical decisions looking at the situation holistically based on the previous experience, which improves the decision-making process as well as the decisions (Anonymous 2011; Ozdemir, 2019). The other specific characteristics are as follows:

- Deeply involved in the task and experiences it from some specific perspective based on previous experiences.
- Perceives certain aspects of the clinical situation as important or obvious while others are ignored.
- Perceives changes gradually as events modify the salient features, plans, and expectations, and reorders the relative importance or saliency of features.
- Displays rapid, fluid, involved behavior.
- Adopting a particular intervention is engaged rather than detached.
- Recalls experiences to similar situations in the past and memories trigger plans similar to those that worked in the past.
- Recalls experiences to similar situations in the past and anticipates events similar to those that occurred in the past.
- Possesses an intuitive ability to use patterns.
- Intuitively organizes and understands tasks where intuition is the product of deep situational involvement and recognition of similarity.
- Intuitively organizes his/her actions by assessing elements defined as important through prior experience along with combining rules to produce decisions about how best to manipulate the environment to achieve the desired outcome (Wright, 2014).

The summary is that, at the proficient level, that the individual has an intuitive sense of the goal and the expected outcomes (Themes 2017). They have the skills that are well absorbed so they focus on aspects that are important and ignore the data that are not very important for the decision of the clinical interventions (Benner 2001; Wayne 2019; Thomas &and Kellgren, 2017a).

Expert level: In this level, the nurse has the speed, flexibility, and knowledge, which can be applied appropriately based on previous experiences. (Benner 2001). The other characteristics that are defined for this level of skill acquisition are as follows:

- Knows what to do based upon mature and practiced understanding.
- Totally engages in his/her environment and does not see problems in some detached way or work at solving them.
- Present at the moment and do not worry about the future and devising plans.
- Rapid automatic response.
- So, engrossed in the present experience as an "involved participant" that he/she uses tools or media to connect to the environment.
- Loses awareness of his/her separateness from the tools, media, or activity manipulated in the environment and connects to a world of opportunities, threats, strengths, weaknesses, hopes, and fears.
- Displays rapid, fluid, involved behavior that bears no similarity to the slow, detached reasoning of the problem-solving process.
- Associates particular features of a pattern in a given situation with a condition stored in memory and triggers a decision.
- Performs mostly in an ongoing and non-reflective manner doing what normally works.
- When time permits, and outcomes are crucial, experts will deliberate before acting. This deliberation is qualitatively different from detached, calculative problem-solving, the expert's deliberation involves critical reflection on one's intuitions.
- Responds to "holistic recognition of similarities" produced through the deep situational understanding of past experiences, relates current situations to prior similar situations, and associates the related decision, action, or tactic simultaneously.
- Performs so fluidly that the situation defies complete verbal description.

Studies that were carried out to explore the theory-practice gap and nursing student's transition to RN have cited this model, (Benner 2001; Wayne 2019; Thomas & Kellgren 2017; Gagliardo 2014; Manoochehri et al. 2015; Upouthe 2015). In the present study, the aim was to explore the perceptions of the hospital personnel, the preceptor, nurse manager, and the professional development staff concerning the graduate nurse intern's competency preparedness and the practice expectations. Readiness for practice is a measure that is focused on advanced beginners, which is why the mentioned model is utilized to frame this study as illustrated in Figure 2.3.

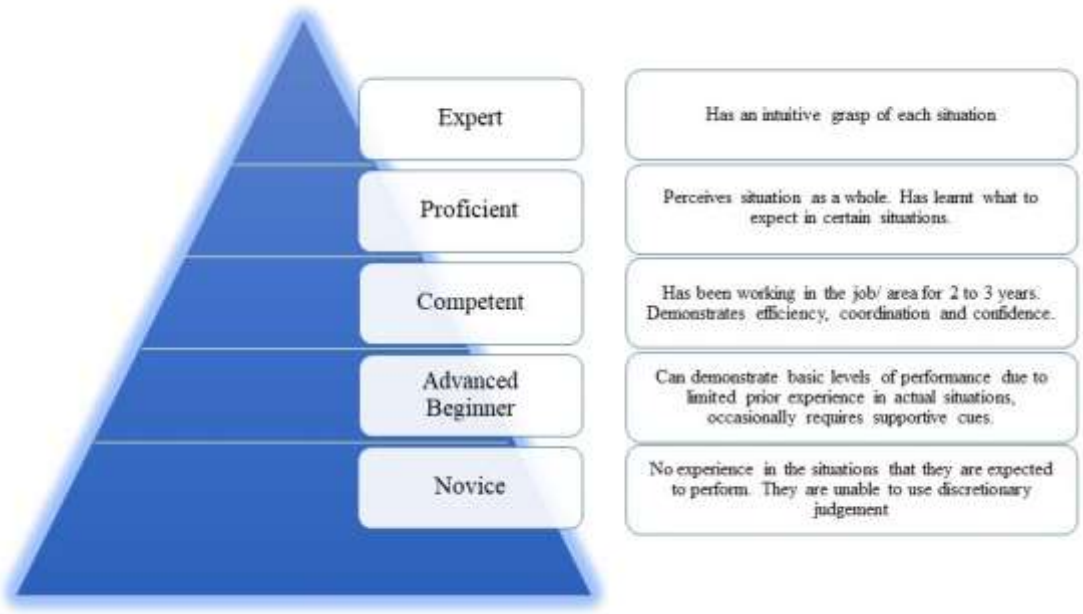


Figure 2.3: Benner's Novice to expert model of skill acquisition (Murray, Sundin & Cope 2019).

The stage at which the new graduate enters practice is at the novice level. The pre-licensure preparation that occurs in the university is intended to bring the nursing student to the novice level through the curriculum design used as appropriate in the education programs. Novice-to-

expert theory clearly indicates that the novice is seen to be the need to move along the skill acquisition path to become fully immersed in professional practice to meet patient outcomes. The use of this framework to address the education-practice gap for this study guided the revelation of skills preparedness of the new graduates in the view of hospital personnel including the hospital nursing leadership.

2.3.2 The QSEN Competency Model

The foundation stones of health care are quality and safety. In the year 1999, the Institute of Medicine insisted on quality and safety to be the inevitabilities in health care. Since that report, many initiatives have been put in place to measure the quality and safety of medical facilities. Quality and safety data are reported as part of accreditation through The Joint Commission and Magnet designation, which is one of the highest status or credentials that is awarded for nursing facilities in United states of America and around the world. To be certified as a Magnet hospital, a medical facility must satisfy a set of criteria created by the ANCC to measure nursing excellence. The QSEN project works with colleges and universities to focus on six core competencies that are similar to the competencies mentioned by Institute of Medicine.

The health care stakeholders expect the new graduate nurses to provide safe and quality patient care at all times Hospitals, where the new nurses were competent and confident, have very few untoward incidents and influence the stakeholders including the patient, nurse hospital, and the community (Dobbins, 2018). The QSEN competencies are based on the Institute of Medicine competencies for enhancing and integrating quality and improving safety (Spector, 2015). The QSEN applied the same competencies, including patient- and family-centered care, teamwork, evidence-based practice, quality improvement, safety, and informatics (Sullivan et al., 2019).

QSEN is relevant to nursing practice, as it was an answer to the call by IOM (Institute of Medicine) to improve patient care with quality and safety (Altmiller & Hopkins-Pepe 2019). Crononwett et al. (2007) affirms that the QSEN model sets the standards of practice for the RN and it also guides the curricular development, provides the framework for the accrediting bodies both in the academic and the health care practice avenues.

Additionally, Edrosolo (2016), in research of crosswalk between The Joint Commission standards, QSEN competencies, and the Magnet standards, identified the overlapping and close integration between the three. In this study, the competency preparedness of the graduate nurse interns was explored as perceived by the selected nursing profile personnel specifically in the hospitals that have received The Joint Commission International accreditations. The results of the study are expected to inform the development and implementation of an institutional endorsed intervention or strategy that could enhance the competency preparedness of the graduate intern nurse. The QSEN's six core competencies are Patient-Centered Care, Teamwork and Collaboration, Evidence-Based Practice, Quality Improvement, Safety, and Informatics. The QSEN core competencies were utilized initially focusing on the educational process on the nursing program, however, the core competencies are applicable as the expected competencies of the registered nurses in all the settings of the health care system. (Wright, 2014).

Patient safety and quality patient care is vital to prevent consequences of medical errors that can be tragic. While universities are striving to prepare new graduates adequately to match the needs of the practice setting, it is imperative that they also follow and integrate QSEN competencies and the assessments related to QSEN competency which will help them to transition to practice better. If the universities do not follow the QSEN related assessments,

then they may transition to practice with competencies that were not similar and make the transition more stressful (Dolansky & Moore, 2013). As the IOM stated, all health professionals should be geared up to deliver patient-centered care through teamwork in collaboration, with teamwork and collaboration, with evidence-based care from continuous quality improvement, with a mindset for safety and employing informatics (Sherwood & Zomorodi 2014).

Interestingly, Tregunno (2014) stresses the importance of involvement of the faculties by mentioning that patient safety and quality curricular innovation and practice with good sustainment and significant impact depends on the faculty's perception of the importance and knowledge of the standards that guide the practice of nursing care and health care system. It was also mentioned that the champions among the faculties can be identified and the responsibility of integrating into the curriculum can be achieved. The faculty members, who have been trained during a different era, with not so much demand on quality and patient safety education and competency preparation, may not give the necessary importance and emphasize the said competencies. They may not be familiar with the error tracing process error prevention practices, near misses, and the other safety competencies that may contribute to poor preparation (Vaismoradi, 2012).

Furthermore, light is thrown upon by Tella (2015) by his study indicating how students perceive the importance of incorporating patient safety education. Preheim (2009) states that the curricular redesign requires a committed shift of focus from the task and psychomotor training to the incorporation of systems context reflecting the development of quality and safety competencies. The academic universities, which probably might channel their new graduates into the hospitals, have embraced the QSEN model to enhance better and smooth transition to

practice, as it is important to mirror the demands and expectation of the hospital into the assessment and evaluation of future graduates in the academic institutions (Wright, 2014).

2.3.3 The COPA Model

The theoretical framework for this study employs the COPA (Competency outcome and performance assessment) model. It is a model that was developed as a theoretical framework to promote competence for practice (Lenburg et al., 2011). This framework is pertinent to this study as this study applies to the hospital side and more precisely to the new nursing graduates 'competency measurement, the definition of competency, and the description of competency level on entry. The COPA model also is briefly compared to an upcoming competency preparedness initiative (Lenburg et al., 2011).

The nursing profession has been facing issues of quality and patient safety for very many years and decades and for many reasons lacked adequate resources to bring about improvements in quality care and preparedness of new graduate nurses. Lenburg et al. developed the COPA model and structured it as a theoretical curriculum framework to promote competence for nursing practice. (Lenburg et al., 2011). The COPA model is more comprehensive, and it goes beyond just focusing and listing and validation of competence through the structured and objective performance examinations. The framework also highlights the evidence of competence and is applicable in academic and practice settings It is based on the philosophy of competency-based, practice-oriented methods, that is formulated around four main conceptual pillars namely (a) the specification of essential core practice competencies, (b) end-result competency outcomes, and (c) practice-driven interactive learning strategies and (d) objective competency performance examination and assessments (Lenburg et al., 2009).

The COPA model requires that the faculty resolve four fundamental questions posed to the academic faculties: 1) What are the essential competencies needed for nursing practice? 2) What are the most effective outcome statements that integrate and address these identified competencies?, 3) What effective learning strategies achieve the outcomes based on the identified essential competencies? and 4) What are the most effective methods to assess the performance to validate the achievement of the essential competencies and sub-skills? (Spencer & Boyer, 2009). This COPA model has been used to bring about curriculum innovation and curriculum development in nursing education, nursing specialized education, continuing nursing education, and also in patient and family education programs (Anema & McCoy, 2010). In this study, the main purpose is to focus on the practice readiness and the competencies that are expected to be displayed by the graduate nurse intern.

The major focus in curriculum enhancement is to prepare the nursing graduate interns when utilizing the COPA model to identify the expectations regarding the competencies necessary for actual practice preparedness that is related to each of eight "universal" competency areas (Lenburg et al., 2009). The eight universal core competency areas are: (1) assessment and intervention skills, (2) communication skills, (3) critical thinking skills, (4) human caring and relationship skills, (5) teaching skills, (6) management skills, (7) leadership skills and (8) knowledge integration.

The model guides to move away from the traditional educational model which focused only on "new" and "knew how" to novel competency and experiential learning modalities. (Watkins, 2020). Lenburg et al. (2009) assert that any competency area that is given little importance makes the nursing graduate poorly prepared for practice and also eliminates the chance for

developing and acquiring the essential competencies. The expectations of the stakeholder concerning the competency preparedness for practice related to the quality and patient safety can be analyzed by the current practice environment as stated by Lenburg (1999) or by simply ensuring that the standards and competencies identified and laid down by the regulatory organizations, agencies, professional groups, employers and also other stakeholders and the employers are strictly developed and integrated into the health professional's curriculum (Anema & McCoy, 2010). In this study, the emphasis is on the competency that the graduate nurse is expected to display during their internship, to identify the gap between academia and the health care industry. Consequently, it is found that this model appropriate to be consulted to draw the theoretical framework for the study.

2.3.4 Behaviorist Learning Theory

Behaviorists mainly focus on what is directly observable (Aliakbari et al. 2015). The behaviorist learning theory is predominantly consulted for the development of competencies and for evaluating the demonstration of technical and psychomotor skills. This theory has an advantage and provides scope when a change in behavior is the desired outcome of educational program intervention (Aliakbari et al. 2015). In this case, the achievement and demonstration of the competencies are expected to be exhibited by the graduate to show the preparedness for practice. In this study, the researcher intended to study the perceptions of the preceptor, and the other hospital leaders about the competency preparedness of the new graduates. Takase (2011) in a concept analysis study, nursing competency is referred with theories that includes behaviorism as an important theory defining the nursing competency. Behaviorism refers to competency as an ability to perform individual core skills, and is evaluated by demonstration of those skills (McKenna, 1995). Since competency is considered as an individual trait needed

for effectively performing the nursing duties that includes knowledge, critical thinking skills and holism considers competency as a cluster of elements, including knowledge, skills, attitudes, thinking ability and values that are required.

In certain contexts, observing the demonstration of the competencies while performing those skills are considered as behaviorism (Fukada 2018). According to Braungart (2007, p.54) behaviorists focus on skills that are directly observable and are considered useful in nursing and health care and getting the behavior to transfer from the initial learning situation to the other setting is largely related to strengthening of practices as illustrated in figure 2.4. In this study where the focus is on observing the behavior that refers to the skills in nursing care is observed by the hospital nursing personnel and express their perception regarding the competency preparedness of graduate nurse interns and the expected level of competency preparedness.

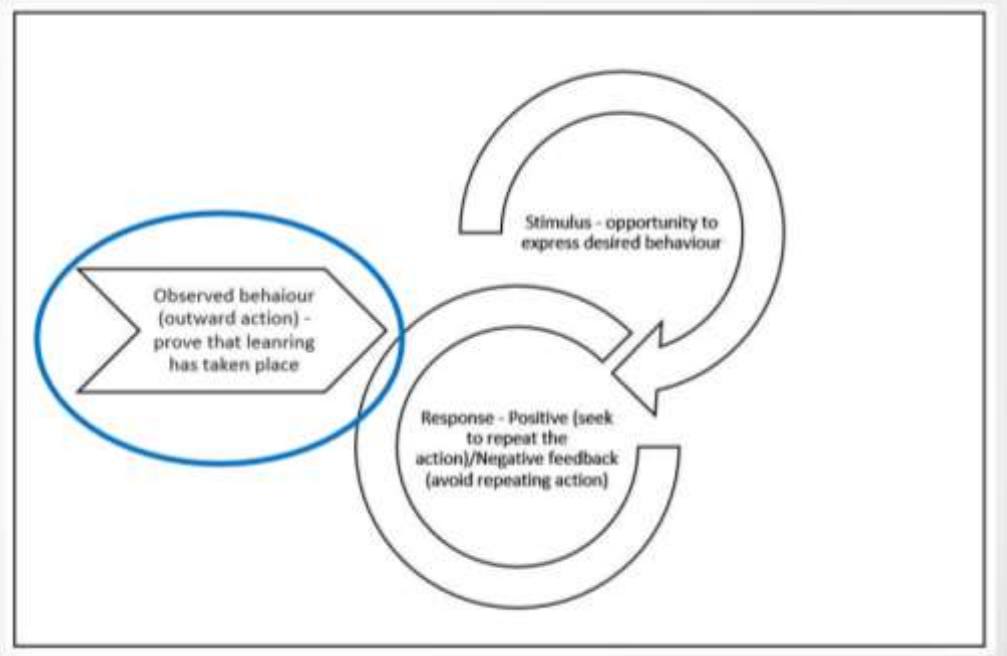


Figure 2.4 : Illustration of Application of Behaviorist learning theory (Keramida, 2015).

Behaviourism is an approach to learning that centres on guiding learners through a pre-established outcomes as illustrated in figure (Keramida, 2015). Behaviorism has been a dominant approach at the beginning of the 20th century, it was believed that learning is a change in the behavior that is obvious and can be observed (McKenna, 1995). Behaviorism stands on the pillar of three basic assumptions: the behavior that can be observed forms the focus of learning, the environment contributes majorly to the learning process and reinforcement is the core of the learning process. Behaviorism has the orientation to focus on the mastery of prerequisite steps before the learner progresses to the subsequent steps or stages in the learning process. The theory focuses on aiming at reinforcing what the faculty wants the learner to perform (Fukada 2018). The behaviorist theory encourages clear, objective analysis of observable environmental patient care related stimulus conditions and the learner responses which is identified as graduate response on patient care. Much of the respondent conditioning which is also called as classical conditioning emphasizes the importance of stimulus conditions and the associations formed during the clinical learning process during the student period (Braungart, 2007). In this study, the behaviorist approach is consulted so that the researcher will be able to know from the preceptors and other hospital personnel, the exact level of performance of competency preparedness of the graduates and the concomitant level of practice expectations related to the competency preparedness, which is the expected behavior of the learning.

2.3.5 Constructivist Learning Theory

The constructivist learning theory is one of the unique learning frameworks, where the constructivists believe that the learner can acquire knowledge and perform by integrating the learning activities and experiences (Tasheva & Bogdanov, 2018). The cognitive approach

focuses on making knowledge meaningful and helping learners organize and relate new information to prior knowledge in memory (Yilmaz, 2011). The underlying philosophy of constructive theory is different from other theories, in the area, that this constructivist theory, the objective reality of the world of learning is acquired through experience or exploration, where the training heavily relies on exploratory learning as illustrated in figure 2.5. It is also believed that the learners learn by creating and assigning significance to the learning experiences. The locus of achieving the intended learning objective in a constructivist orientation is internal and involves creating a deeper understanding and foster critical reflection (Dario et al., 2005). In constructivist learning theory, some of the predominant assumptions are: the emphasis is laid on the context in which the skills are learned and applied subsequently, and honing the skill of problem-solving allows the learner to go beyond the obvious information and assessment on the focus on the transfer of knowledge and skills as illustrated in the figure (Tasheva & Bogdanov, 2018).

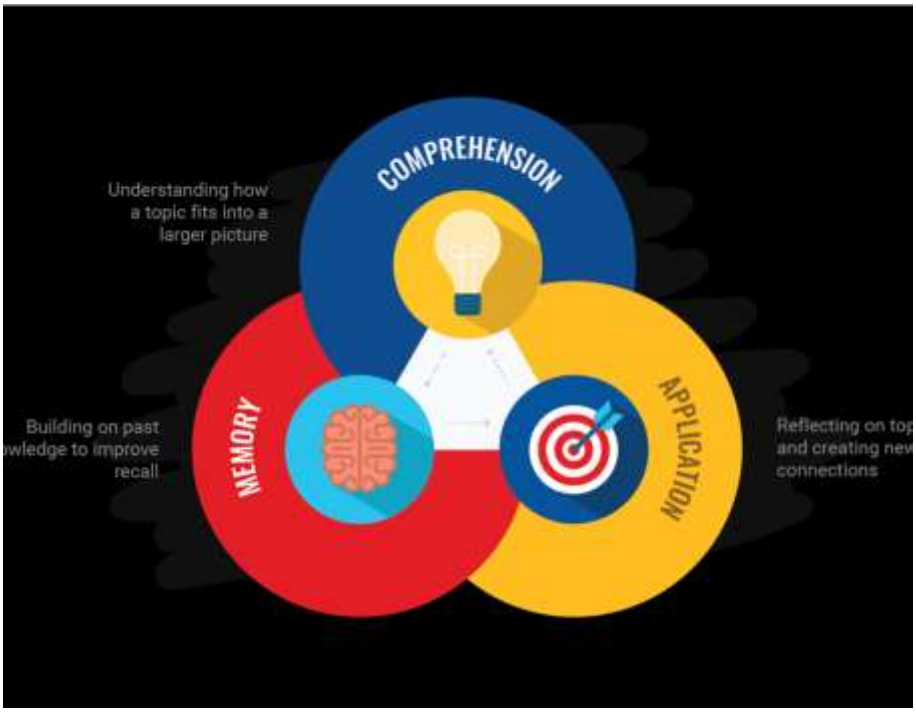


Figure 2.5 : Illustration of Constructivist Learning Theory (Tasheva and Bogdanov 2018).

In this study, the researcher will explore the perception of the nursing leaders about the level of preparedness. As the main objective of nursing education is to develop students to be graduates with competencies to perform effectively in the practice setting, this will be assessed by studying the perception of the same among the nursing leaders in the hospitals. As per the theory's assumptions, the researcher will explore the extent of skill demonstration and transfer of skills among the graduate nurses, which will also involve the problem-solving skills at specific occasions.

2.3.6 The Conscious Competence Learning Theory

The conscious competence theory focuses mainly on the different stages of learning or acquiring a new skill. The concept is commonly referred to as 'conscious competence learning model', or 'conscious competence learning theory', 'conscious competence ladder' or 'conscious competence matrix' (Lane & Roberts, 2020). The conscious competence learning theory or model or matrix explains the stages by which the learner acquires the new skill. Being consciously competent often takes a while for the learner as they learn about the new idea either through experience or more formal learning (Cannon, Feinstein and Feinstein, 2010). As per the theory, the first stage for the learner is the stage of unconscious incompetence, then the stage of conscious incompetence, then through stage three which is conscious competence, and the final stage is the unconscious competence. There are recent discussions on including another stage as the fifth stage although there is no definitive conclusion arrived on this. However, this theory is considered as simple and a very helpful explanation of how one learns and also serves as a reminder to consider the need to train the people as they move along the continuum of learning and skill attainment .

In the unconscious incompetent stage, the learner is identified to seek to solve problem intuitively with little or no insight into the principles guiding their actions referred as 'the learners don't know what they don't know' . Followed by conscious incompetence stage where the learner seek out to solve the problems, here in this study it is the patient assessment or interpretation or patient care as a whole, able to recognize the problems with their intuitive analysis, but not yet knowing how to handle the situation and referred as 'the learners know what they don't know. The stage three is the one where the learner learns to solve the problems logically and mechanically, adopting the analysis creatively and spontaneously to new situations, referred as 'the learners apply what they know. The last and the fourth stage is the stage where the learner is able to solve the problems logically but they understand the analysis on an intuitive level and can adopt them creatively and spontaneously to fit new situations commonly referred as 'the learners apply what they now without thinking (Cannon, Feinstein & Feinstein, 2010).

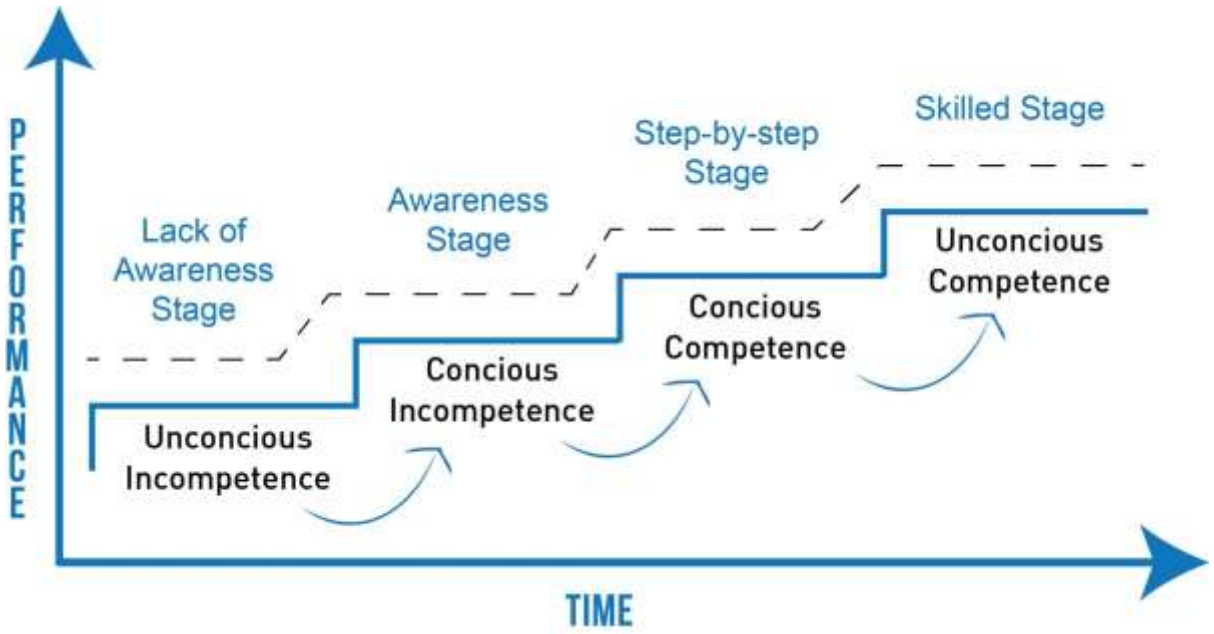


Figure 2.6 : Illustration of Conscious competence model (Cannon, Feinstein and Feinstein 2010).

Conscious-competence model appeal as a way of looking at the experiential learning process. it views learning along two dimensions, consciousness and competence, moving through a four-stage progression from unconscious incompetence to conscious incompetence to conscious competence to unconscious competence (Cannon, Feinstein & Feinstein, 2010). It views learning along two dimensions, consciousness and competence, moving through a four-stage progression from unconscious incompetence to conscious incompetence to conscious competence to unconscious competence. From the perspective of the conscious-competence model, we see why accurate feedback is so important. It provides the disconfirming signal to students that their aspirations and/or process is wrong and needs fixing, thus moving them from unconscious incompetence to conscious incompetence as illustrated in figure 2.6. In this context, Teach's (1987, 1990) forecasting approach for evaluating student performance represents a very important issue. At a more general level, the importance of valid feedback attaches more significance to studies suggesting that traditional measures of company financial performance are poor indicators of student learning.

The theorist explains that the trainers may perceive that the learners are in stage two already and try to focus on the next stage, whereas the trainees had not achieved the previous stage as well. This is the prime reason for training or skill development programs to have a failure. In this study, the researcher intends to explore the perception of the hospital personnel especially the nursing leaders about the level of preparedness of the competency among the nursing graduates. Since the theory explains the different stages in which the learner becomes competent, this theory is being consulted to design the study (Chapman, 2015).

The current study has investigated and explored the level of competency preparedness with which the new graduates enter the health care setting and also the expected level of competency preparedness that is looked forward to, by the nursing personnel in the hospital. In addition, the study also highlights the top 15 competencies that the new graduates are performing as per expectations and the 15 competencies, the new graduates had very low performance that needed attention in the nursing curriculum. In this research study, four theories and two models were consulted. First, Patricia Benner's Novice to expert theory was used for assessing the level of competencies, both current level of competency and also the expected level of competencies where the measurement of level of competencies were done utilizing the skill acquisition level namely, Novice, Advanced Beginner, Competent, proficient, and Expert (Dreyfus, 1980; as cited by Benner 1984). Followed by conscious competence theory, where the trainers tend to group the trainees into the four quadrants of competency which coincides with the study where the hospital nursing personnel are asked to situate the new nursing graduates in one of the areas of competency. An illustration is presented in figure 2.7, integrating both Benner's model which is based on Dreyfus & Dreyfus's (1986) five stages of skill acquisition and the conscious-competence theory which are superimposed. Then the QSEN competency model as it sets the standard of nursing practice for RN, where the QSEN's six core competencies are Patient-Centered Care, Teamwork & Collaboration, Evidence-Based Practice, Quality Improvement, Safety, and Informatics are considered as a part of the competency measurement.

Then the competency outcomes and performance assessment model, which is compared to the competency preparedness initiative, and it echoes the study's main purpose and objectives, which is identifying the essential competencies needed for nursing practice and also to effective learning strategies to achieve the outcomes based on the identified essential competencies (Lenburg 1999). Then it is the behaviorist learning theory which is consulted as it focuses on

development of competencies and also for evaluating the demonstration of technical and psychomotor skills. The constructivist learning theory is one of the unique theory which focuses on the context in which the competencies and skills are learned and applied subsequently, in this study the study aims at evaluating the competency level taught in the student period to match the expectancy in the health care setting as they enter from academic to hospital.

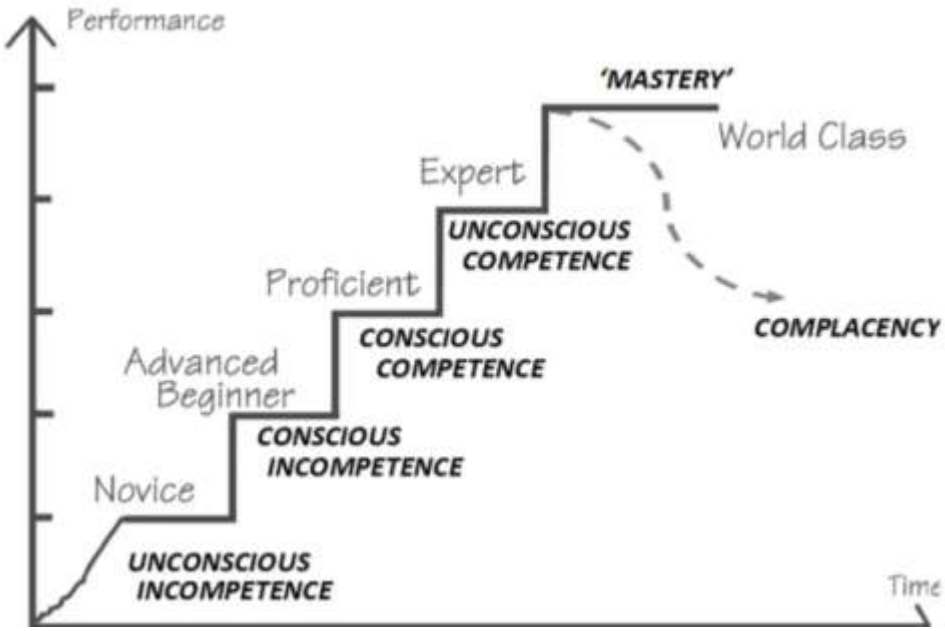


Figure 2.7 : Superimposition of Dreyfus & Dreyfus's (1986) five stages of skill acquisition explained through unconscious competence theory (Attri, 2019)

2.4 Review of Related Literature

This review of the literature is undertaken with the efforts to understand the areas that are already explored concerning the study undertaken, which can serve as the foundation to build on. This doctoral scholarly work will review the literature on graduate preparedness from different stakeholders' views which include, the new nursing graduate intern, the academic

faculties, preceptor and the hospital nursing leadership. It is imperative to be knowledgeable and base the study on these shreds of evidence to have an authentic direction for the study undertaken. The studies on competency preparedness of Baccalaureate nursing graduate intern, transitioning from Novice to Expert, QSEN (Quality and safety education for Nurses) competencies and TJC (The Joint Commission) standards & Studies on Education and Practice Gap were consulted predominantly.

2.4.1 The Context of Nursing Practice in UAE Health Care System

In the UAE, there is a huge need and demand for nurses to enter the health care sector. The nursing profession is considered as one of the critical elements in the health service. The Ministry of Health and Prevention had launched many initiatives to promote attractiveness of nursing profession. The Ministry also promotes and has set up strategies to enhance employment of the nationals. An additional 16,158 nurses are projected to be required by 2025 in the Emirate of Abu Dhabi alone (Department of Health (DOH), 2018).

Quote: "National nursing human resources are the real support for the country in its crises and needs." - His Highness Sheikh Mohammed bin Rashid Al Maktoum, Vice President and Prime Minister of the UAE and Ruler of Dubai. The UAE government provides utmost support to the nursing profession in all means and the quote above is evidence for the enormous support for the nursing profession.

2.4.1.1 The UAE Health Care System and Nursing:

The UAE, United Arab Emirates is a Middle East country comprising seven emirates, which has three health authorities: The Ministry of Health and Prevention (MOHaP), the Dubai Health

Authority (DHA), and the Department of Health - Abu Dhabi (DOH). The MOHaP, DHA, and DOH recently published strategic plans for 2017–2021 (MOHAP Strategy - Ministry of Health and Prevention - UAE, n.d). Those strategies are as follows:

First Objective*: Provide a comprehensive and integrated healthcare in innovative and sustainable ways to prevent the spread of diseases in. the community*.
Second Objective*: Develop effective health information systems and apply global standards in the management of health facilities and infrastructure.*

Third Objective*: Build quality and safety for therapeutic, healthcare and pharmaceutical systems according to international standards.*

Fourth Objective*: Provide a vital legislative framework and, governance, and distinctive regulatory and supervisory services for the healthcare sector.*

Fifth Objective*: Ensure and guarantee the provision of all administrative services according to the standards of quality, efficiency and transparency*

Sixth Objective*: Entrench a culture of innovation in the institutional work environment*

(MOHAP Strategy - Ministry of Health and Prevention - UAE, n.d).

These strategies are to focus on delivering high quality health services and nursing professionals are an important stakeholder to help the nation achieve these goals. The results of the study aim to enhance the achievability of these strategic goals. The new graduates also

play an important role in achievement of these goals. The UAE government (Ministry of Health and Prevention Launches Internship Program for Nursing Graduates - Ministry of Health and Prevention - UAE, 2019) is supporting this profession by all means, and the below quote from His Highness Sheikh Mohammed bin Rashid Al Maktoum, Vice President and Prime Minister of the UAE and Ruler of Dubai shows the importance of this profession:

"National nursing human resources are the real support for the country in its crises and needs.".

-His Highness Sheikh Mohammed bin Rashid Al Maktoum,

Vice President and Prime Minister of the UAE and Ruler of Dubai (MOHAP, 2019)

For many governments across the globe, health care is the most challenging, complex public service area requiring enormous resources to manage, control and oversee. The vision for the year 2021 was decided in 2013 where the UAE ruler His Highness Sheikh Mohammad Bin Rashid Al Maktoum, Vice President and Prime Minister of the UAE and Ruler of Dubai, stated that health care is a human right and formulated the vision which drives the health services in a high priority .The UAE aims to develop a world-class healthcare system (Al-Yateem et al., 2020). When the federal UAE was still not established, and the seven emirates were not formed until 1971, traditional healing was practiced and there were small health facilities sponsored by Kuwait government. The establishment of UAE and the establishment of Ministry of Health (now called the Ministry of Health and Prevention [MOHAP]) was in 1971. Following that, other regulatory health bodies were established in different emirates like Dubai Health Authority (DHA) (Dubai Health Authority (DHA), n.d.) and the Health Authority of Abu Dhabi (recently renamed the Department of Health – Abu Dhabi) were established in 2007 (UAE Government, n.d.). These regulatory authorities established standards and regulations for healthcare, including the standards and regulations for the nursing profession.

This multi-regulatory system for healthcare, which included nursing, was the corner stone for the inception of the UAE Nursing and Midwifery Council (UAE-NMC) in 2009. UAE-NMC had the overarching aims of unifying and coordinating efforts to regulate the nursing/midwifery professions, promote and advance nursing/midwifery services, protect and promote public health and safety. The UAE-NMC also aims to achieve agreement on health care and nursing priorities and activities; set standards for practice, registration, licensure, and education and also prioritize the national nursing and midwifery research agenda (UAE Nursing and Midwifery Council, n.d.). Despite the presence of a clear professionalizing agenda, the nursing profession in the UAE faces ongoing challenges (Dubai Health Authority, n.d).

The health services in Abu Dhabi are undergoing commendable expansion and transformation for the past few years. There is remarkable increase in the number of hospitals and available beds in 2020; 1,898 beds in Abu Dhabi region, 732 beds in Al Ain Region and 220 beds in Al Dhafra Region which is 2.7 beds per 100,000 population in Abu Dhabi. The number of nurses to serve the patients admitted the beds are 1,127 955 and 300 nurses in Abu Dhabi, Al Ain, and Al Dhafra region respectively, which is 10.79 nurses per 100.000 population (The Statistical Yearbook of Abu Dhabi, 2019). There are currently 33,429 nurses and midwives employed in various roles across the public and private sectors in UAE. (UAE Nursing and Midwifery Council, n.d.).

The nursing and midwifery population comprises a range of cultures, predominately Filipino, Indian, Pakistani, and people from Western and other Arab countries. These nurses and midwives come to the UAE with varying education and skill levels (Al-Yateem et al., 2019; WHO, n. d). The UAE-NMC (2018) states to implement steps to implement the initiative

‘Enhance the attractiveness of the nursing profession’, increasing the number of candidates joining the Bachelor of Nursing program in the UAE is needed. It was also presented that the number of students in nursing programs in these colleges reached 177 in 2018 and special focus was placed on professional qualification requirements and also for licensing the new nurses. The researcher considers the study as the first step to move towards achieving the national goal and the vision of UAE 2021.

As UAE leads the world with the largest number of hospitals accredited by the Joint Commission International (DHA, 2016). Joint commission international is an organization that is the oldest, largest gold standards for hospitals and the accrediting body. The Accreditation standards is being updated and released on 1st April 2017 and effective from 1st July 2017 (JCIA., 2017). The commission inspires and guides the health care setting to excel in providing safe and effective care. The UAE has 145 JCI accredited health organizations, the highest among 67 countries. The UAE ministry has adopted internally accredited protocols and standards in clinical care and is committed to the national agenda to achieve the UAE vision 2021, to take steps in developing the health care system with international standards. JCIA achievement is within the ministry’s strategic plan and also to accelerate UAE’s propulsion to be among the world’s best countries with health care of international standards by 2021.

Having highlighted the preordained destination of the health care system of UAE, the reason for taking up the study is very clear that the nursing education system need to be geared up to meet the demands of the health care system. The International Council of Nurses (ICN) outlines the details regarding the role of nurses in promotion of health and prevention of illness, as well as care of ill, disabled, and dying people. Contemporary nursing includes the roles of being the advocate for the patients and family, proving them safe environment and also continue to

demonstrate competence (Girvin, 2016). The UAE-NMC was established in 2009 by Supreme Council by Cabinet Decree (UAE Nursing & Midwifery Council, 2010). Its main aim is to strengthen the nursing and midwifery workforce to keep abreast with nursing global trends in contemporary nursing practice. It also focuses on development of standards for effective clinical learning environments, which will guide providers of nursing education and health service clinical placement providers.

Furthermore, Brownie (2014) presents a study that contributes in providing the foundation on which the nursing program can be strengthened to produce the nursing workforce adequately and competency prepared. In addition, the present study will enhance the institution to achieve its objective as per the key performance indicator as "Ensure all programs meet the skills requirements for student placement in the relevant jobs and career pathways" ACTVET, (2015). The UAE aims to develop the best healthcare system in the world. The Government is working with health authorities across the country to ensure that public and private hospitals are accredited according to clear national and international quality standards. Furthermore, the National Agenda emphasizes the importance of preventive medicine and seeks to reduce cancer and lifestyle-related diseases such as diabetes and cardiovascular diseases to ensure longer, healthier lives for citizens and residents (UAE SDG Report, 2016).

Health care in UAE is provided by both government and private providers that includes facilities ranging from pharmacies, clinics, rehabilitation centers to primary, secondary and tertiary hospitals. The UAE has committed itself on an ambitious reform program, Vision 2021, with an overall aim to be ranked globally among the top 20 countries (in 2017 the UAE was ranked 39th on the Legatum Prosperity Index 25). The MOHAP, Ministry of Health and prevention aims to implement Emiratization in the profession of nursing so that distinguished

health care is provided appropriate to the environment and culture of the UAE community. This aim will be achieved by constantly improving the nursing practices and career paths that meets the best of the international standards (MOHAP, 2019).

2.4.1.2. The UAE Nursing Work Force

Nursing was unstructured and unregulated, comprising some locally trained nurses and many expatriate nurses from the Indian continent and other Arab countries before the formation of federal UAE, which is before the unification of the seven emirates (Emirates Nursing Association, n.d.). Another historic progress was the Federal Department of Nursing (FDON), which was established in 1992 to manage, regulate, and develop UAE nursing services (El-Haddad 2006; Federal Department of Nursing - MOH – UAE 2019). The role of the FDON included: administration of the MOH nursing registration exams, maintaining a nursing registry, refining the nursing care and services, improving the public image of nursing, supporting nurses' professional development, improving/retaining Emirati nurses, planning and allocating the nursing workforce, and supporting nursing quality programs to comply with international quality standards. Following the establishment of federal UAE, other regulatory health bodies were established in different emirates like. (Al-Yateem et al., 2020)

The global need for the nursing work force is more magnified in the UAE since the native Emirati nurses are less in the total nursing workforce and there is high burden of non-communicable diseases, where the death rate (per 100,000 population) with the cause of death is 41.4 for Diseases of the Circulatory System, 18.1 due to Neoplasms and 16.3 with the cause of death as External Causes of Morbidity and Mortality as per Statistical year book of Abu Dhabi (2020).The Emirate has significantly high rates of chronic diseases related to life style

including obesity, diabetes and cardiovascular diseases. Over the last three decades, the prevalence of diabetes has increased fivefold from around 5% to almost 25% , 21% of Emirati nationals have diabetes and 35% of the Emirati population are obese (Koornneef & Robben, 2019). An effort to attract UAE nationals to nursing, and also to retain them along with the expatriates who have graduated from the nursing universities, is a strategy that needs to be implemented and reinforced. These graduates also need to be supported in the system after graduation as they are an asset for the UAE healthcare system, who are likely to make long-term contributions to the healthcare team (Al-Yateem et al., 2020).

In an effort to support the graduates of UAE, who are nationals, certain privileges are provided following graduation: 1) immediate appointment following graduation at one of Ministry of Health and Prevention institutions, 2) Opportunity to pursue higher education by applying for Masters and PhD scholarships for specialization in nursing within and outside the country, and 3) Provided training and continuing education programs. The other initiatives are Nursing Department at Ministry of Health and Prevention (MOHAP) initiated and established the nursing internship program targeting nursing graduates to enhance the preparedness of nursing graduates towards practice licensing exam for nursing profession in the UAE. The enrolled graduates are from various universities in the UAE (MOHAP-Ministry of Health and Prevention - UAE, 2019).

2.4.2 Perception of Various Stakeholders on Competency Preparedness

The challenges that is in front of the nurses in today's world is that in this rapidly changing health care environment, there is critical need that is highlighted for graduating students is to be competent and be prepared for practice. In addition, it is expected by nursing professionals

that the new graduates are expected to demonstrate all the attributes of caring as relevant by the nursing authority of the country. It is also termed as 'fitness to practice', a term that is not clearly formulated. Indeed, what is meant by competency preparedness and fitness to practice, which of the stakeholders are appropriate enough to delineate or define it. Such, deliberation is due to the reported difference in opinion between nurses in education and those in clinical practice sectors, as to if the new GNI's (Graduate Nurse Interns) are in fact practice ready.

2.4.2.1 Global trend of New Graduates' practice readiness- hospital personnel's' views

With respect to new nursing graduates' readiness to practice, many countries such as Australia, New Zealand and the US, have reported that the expectation from the hospital setting is not met by the new graduates and to support them transitioning to the practice setting there are transition support programs planned and implemented. In Korea and in India, such transition programs are not offered, the Korean and the Indian new graduate nurses are expected to hit the floor running but with support from the preceptors and orientation program for 1-3 months (Ko & Yu, 2019). Moghaddam et al. (2020) affirm that new graduate nurses lack adequate preparation while entering the hospital setting, while exploring the challenges of clinical learning experience as nursing is a practice-based profession.

The UAE-Nursing and Midwifery Council (UAE-NMC, 2018) in their report insists a need to attract a greater number of graduates in the nursing profession and support the health care of UAE with local workforce to respond to the growing demands in the health care. Haddad, Moxham and Broadbent (2017) point out that each nursing graduate is expected to be able to hit the floor running, in spite of knowing that is it not a reasonable expectation. Having nursing graduates who can seamlessly merge with the workforce is a concern that is an age-old

expectation, as well as in a health care system that is ever changing and with newer emerging situations like COVID 19, health care demands of old age population and also the shortage in the profession (Haddad et al., 2017). Monaghan (2015) describes by analyzing the literature and theoretical perspectives regarding the practice preparedness among newly qualified nurses in United Kingdom, it was affirmed that newly graduated nurses feel unprepared for practice. They do not have confidence in practice and have expressed feeling that adequate time was not dedicated for the clinical training and clinical practice during their student training period in order to produce clinical skills.

In Taiwan, a cross-sectional, quantitative exploratory study that investigated the perceptions of the hospital employers about the extent to which the nursing skills are expected was carried out with 89 nursing employers (nursing directors, associate directors, supervisor, or head nurse). The study had 21 competencies which were grouped into three categories: basic-level patient care, intermediate-level patient care and basic management, and advanced-level patient care and supervision. The study revealed that there were disparities in the expectation of competency preparedness among the employers. The levels of competency preparedness differed by the type of the accreditation of the hospital, type of services provided, profile of the employer, professional title and the years of experience of the currently employed nurses, who serve as the manager of the unit or the preceptor (Tzeng & Ketefian, 2003)

Stimulatingly, El Haddad, Moxham and Broadbent (2017) undertook a study in Australia using a grounded theory methodology to explore the perspectives of Nursing unit managers regarding the graduate nurses' readiness to practice. In-depth, semi-structured interviews were conducted with the nurse managers, who expressed that maybe the graduate nurses met their curricular

requirements and standards but what is actually needed in the ability of the graduate nurses to be able to hit the floor running (Murray, Sundin & Cope 2019 ; Manoochehri et al., 2015).

Another study was carried out in Australia to explore the self-reported preparedness for practice. The result of the study revealed that the majority of students reported feeling prepared for practice. It was found that expanded placements, increased use of simulation for clinical skills practice, smaller clinical skills class sizes and modern equipment were identified as areas for improvement to improve practice preparedness (Woods, West & Mills, 2015). Health care service personnel expect graduate nurses to be practice ready, however there is lack of clarity in this regard in the literature and also regarding the concept of practice readiness and how the readiness is determined (Harrison et al. 2020; Brownie et al., 2018). About 42% of new hires in the hospital setting comprise of new graduate nurses. The new graduate nurses are expected to exhibit nursing competence in many areas of clinical practice, which can create stress and stretch the available resources of the organization (Altmiller & Hopkins-Pepe, 2019).

2.4.2.2 Perception of Graduate Nurses' Practice Preparedness

The literature evidence summarizes that new graduate nurses in the transition phase have reported to be underprepared, overwhelmed by the responsibilities to be taken in patient care. New graduates also have reported increased stress levels and feelings of incompetence, which influences the patient care delivery and patient outcome as well (El Haddad, Moxham and Broadbent, 2017). In a study carried out in Australia to explore the self-reported preparedness for practice, 235 newly graduating nurses were approached for data collection for the study. The results of the study revealed that the majority of students reported feeling prepared for practice and felt that simulation experiences helped attain this state. Confidence in caring for

multiple patients was inversely associated with age indicating higher levels of confidence in younger nursing students. It was also found that expanded placements, increased use of simulation for clinical skills practice, smaller clinical skills class sizes and modern equipment were identified as areas for improvement to improve practice preparedness (Woods, West and Mills, 2015).

Interestingly, Messum et al. (2016) carried out a survey among recent graduates with the intention of exploring the employability skills' importance and rate their own skills level on the same items. The gap between the two ratings were found for 44 employability skills. This study was taken up with the background that, the employer skill requirements perceived by the graduates were important to know, but were not reported. This feedback is considered important for the academics as they intend to modify and restructure their teaching strategies to meet the competency requirements of the employers. The results of the study throw light on employability skills that recent graduates ranked the skills in the order as: verbal communication skills, integrity and ethical conduct, time management, teamwork, priority setting, ability to work independently, organizational skills, written communication, being flexible and open minded and networking.

Highest self-ratings were found for integrity and ethical conduct, ability to work independently, being flexible and open minded, tertiary qualifications, interpersonal skills, written communication skills, time management, life-long learning, priority setting and administration skills. Generally, graduates rated their skills lower than their ratings of importance. It is interesting to note that the employers' rating was consistently lower than the importance of the employability skills mentioned by the graduates. This could be because the recent graduates

are well placed in the real word to perceive what is most important based on the employment expectations in the field.

Echoing those findings, Kumaran (2014) studied 10 nurses during their transition period from student nurses to staff nurses, with the intention to explore the experiences of role transition among the Irish nurses. It was reported that the newly qualified nurses felt very excited upon qualification but eventually it was an overwhelming experience and was expecting adequate support during this phase so that they are guided and assisted to translate their knowledge into clinical practice. It was concluded that the required education level and scope of practice demand needs to be considered while developing an education program.

In Singapore, Liaw et al. (2014) surveyed 94 final year student nurses and concluded that the simulated professional learning education program which was offered to prepare the final year nursing students had been very beneficial during their transition period. Similar findings were reported by Brown and Crookes (2016) affirming that the eligibility to practice program helps to better prepare nurses competency. Deasy et al. (2011) conclude that the graduate nurse in their study conducted, interns expressed the need for support in areas of managing the workload, prioritizing the care for patients, interpersonal skills, time management and working in a multi-disciplinary team. The recommendations given were in areas of stress management, supportive environment, and preceptorship program to enhance professional development. In Australia, McKenna and Newton (2008) explored phenomenologically, the experiences of 25 graduates and found that only after the completion of the graduate year, did the graduate interns feel the sense of belonging and were accepted by their peers as equal colleagues.

A review of 199 articles was done to determine the transition experience of new graduate nurses. The evidence points that the intervention for effective transition has led to improvement in practice confidence, competency preparedness and job satisfaction, critical thinking and stress and anxiety also reduced considerably (Edwards et al., 2015). Dobbins (2018) undertook a study with the purpose to examine the confidence level of new graduate nurses in delivering safe, competent patient care which is termed as clinical competency. It was brought out that the novice nursing graduates considered it very challenging as they transitioned from the academic environment to the work environment in the health care setting. It was unrealistic to expect that the new nurse to have received all the training that is required as soon as they depart from their university doors and enter the hospital to be in the work force. In the hospital, clinical competency is used as the index for evaluation and often times it was found that the novice graduates lacked confidence in performing professional practice. The transitioning novice nurses have reported that the experience while transitioning from the academia to the health care setting is quite stressful and overwhelming.

2.4.3 Current Scenario of Competency Preparedness in New Nursing Graduates

The new nurses' competency is a global concern, and adequate competency preparation is an international aspiration. The role of nurses from the mindset of the general public and health professionals has changed significantly over time, from being an attendant of the sick person to a professional (Chernenko, 2013). In many works of literature that were consulted, the new graduate nurses rated themselves to be adequately prepared; the academic educators also reflected the idea of being adequately prepared. In contrast, the nursing personnel in the hospital felt that competency preparedness is inadequate. The following discussions throw light

on the competency preparedness that is perceived as current performance and the expected competency levels presented in the literature.

2.4.3.1. Level of Competency Preparedness on Entry

Evidence in the literature shows that novice nurses lack clinical skills that are needed for them to have a smooth transition from the role of a student nurse to become one among the nursing workforce in the health care set up. The new nurses need support in various clinical procedure areas, but along with their need in improving the clinical competency, steps to be taken in lifting their confidence level and socialization skills (Kim et al., 2015). In spite of being graduated from universities that are accredited and also following professional standards, the new graduates who are expected to be deemed practice prepared with attributes required to be considered as practice prepared for the RN role are regarded as inadequately prepared by the hospital personnel (Harrison et al., 2020; Missen et al., 2016)

The new graduates enter the health care setting with little or no experience, but there are a lot of expectations that are placed on them. The area of gap that was identified during the entry of new graduate nurses are critical thinking, healthcare decision-making and competencies that were identified as major gap were safe medication administration; failure to rescue; patient falls; risk management; and multitasking, prioritizing, and delegating responsibilities. However, these new graduates have extensive knowledge of these mentioned areas, but it is found that they do not have competence to perform the procedures which is critical for a successful transition to practice (Dobbins 2018 ; Nour & Williams 2019).

The number of new graduates in the hospital influences the patient outcome and the direct patient care. The new nursing graduate is expected to be competent in different aspects and areas of nursing. Many hospitals in various countries have the nurse residency programs to equip the new nurses with the skills that is expected of them to work in the patient care area where they are posted, which is to be competent and confident. The main purpose of these residency program is to transition the new graduate nurse into competent practice nurses. The nursing competencies are not only described by the professional standard, external regulatory agencies and accrediting organizations, accrediting bodies, but also a requirement mentioned by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). The health care entity which aims to achieve magnet status drives to have its workforce to be competent and uses competency-based approaches to demonstrate the outcomes.

Interestingly, Sherwood (2014) mentions that health professionals, though they have been taught about the aspects of quality and patient safety, the health care system is been affected with the patient safety issues and the quality issues, which clarifies that there is a necessity to bring about changes to insist more on those aspects and focus on preparing the nursing students and other health care professionals regarding the quality and safety competencies. Quality and safety are core values for the health care professions which are based on the ethical principle of "No harm", so it is vital to inculcate the quality in today's generation of health professionals (Egan, 2016). It is popularly said that there are no patients whom you cannot harm. The problem of poor patient safety and the errors caused by medical professionals have been an area of focus for many decades and it is been well documented in very many reports and researches.it is vital for us to understand the magnitude of the problem and the approaches taken toward combating the issue. Understanding and recognizing the importance of nurses' education to make them well prepared to meet the demands of the practice area in terms of

quality and safety gave rise to the origin of (QSEN) quality and safety education to nurses. This project was funded by the Robert Wood foundation, which proposed the core competencies of quality and patient safety education for nurses as patient-centered care, teamwork and collaboration, evidence-based practice, quality, safety, and informatics (Cronwett et al., 2007).

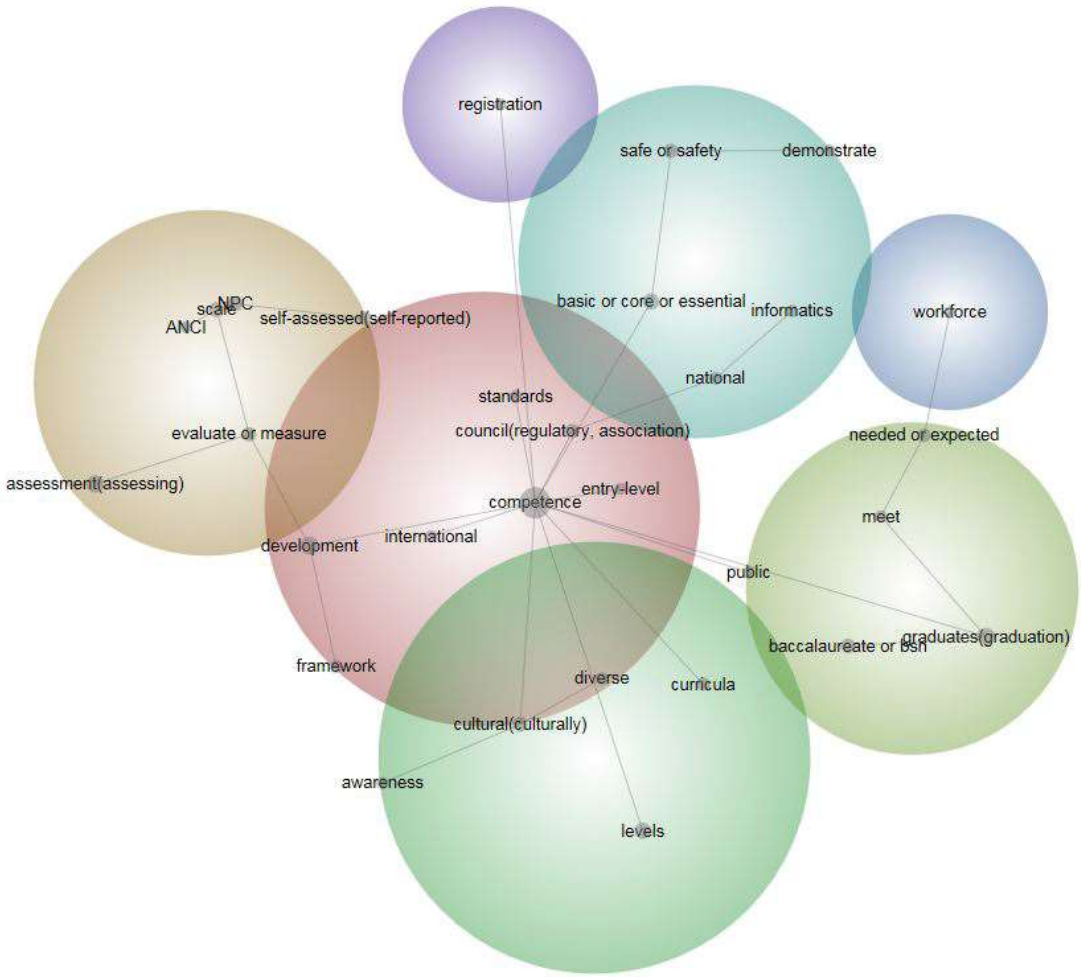


Figure 2.8 : Concept map of 'Competence' in the international literature (Hyun, 2019)

In 2003, the Institute of Medicine called for the development of a framework that would guide academicians to develop the curriculum or bring about innovation in the curriculum. Sherwood (2014) insists that the strategies for developing the mindset to achieve competency of quality and patient safety is more important than the mere development of the competencies for the

nurses to be (Sherwood & Horton-Deutch, 2012). Tanner's (2006) clinical judgment model helps nurses and nursing students to make informed clinical judgments. They notice the occurrence, interpret the significance and rationale of the incident occurred, respond, and reflect. Analyzing case studies proves to be an effective strategy.

Woods (2015) in her study explored the perception of the third –year nursing students enrolled in their final semester about their preparedness for practice. One hundred and thirteen nursing students were surveyed, and the key findings were the majority of the students reported that they were adequately prepared for practice and felt that the simulation exercises had helped them prepare adequately for practice. The study also indicated that the confidence in caring for patients with complex conditions and also taking care of multiple patients increased as the age of the nursing graduate is higher. Walker et al. (2013) reported that graduate nurses and Nurse Unit Managers had a varying perspective of their preparedness, especially regarding unprofessional workplace behavior, and coping with death and dying. They also had different perceptions regarding the stressors during the transition period.

Fink (2008) surveyed 270 graduate nurse interns and reported that only 4% of the graduate nurse respondents were confident and comfortable in performing the skills, 37% were uncomfortable to care for the patient who is dying, and 41% expressed their satisfaction to work in straight shifts. The areas of difficulty identified were in the areas of critical thinking, clinical knowledge, relationship with the peers and preceptors and priority setting skills. Hickey (2009) studied and reported that the graduate interns are weak in administering IV medication administration, dressing changes, Foley catheter care, management of tubes and drains, pumps, assessment skills, critical thinking, and delegation.

2.4.3.2 Expected Competency Preparedness on Entry

Strikingly, Utley-Smith (2004) points out the five leading competencies expected from the new graduate nurses as they enter the health care setup. As the nurse educators strive towards preparing the graduates adequately, a part of the challenge is to enhance the capabilities of those new graduates to function in a broad health continuum of care with increased responsibilities. To identify the needed competencies on entry to practice, the researcher adopted a cross-sectional survey design, and data was collected from 363 nurse administrators from three health care settings.

The nurse administrators rated the importance of 45 nursing competencies, among which six critical competencies were mentioned as necessary by most nursing administrators. They were Health Promotion Competency, Supervision Competency, Interpersonal Communication Competency, Direct Care Competency, Computer Competency, and Caseload Management Competency. Figure 2.4 presents a concept map of 'Competence' in the international literature (Hyun, 2019). The health care stakeholders always expect new graduate nurses to provide safe and quality patient care at all times (Data on Employment of New Nurse Graduates and Employer Preferences for Baccalaureate-Prepared Nurses, 2019).

There is little or no literature expressing the preparedness of new nursing graduates of UAE, so this is the first study undertaken to study novice nurses' preparedness. Some of the initiatives of the Nursing Department at the Ministry of Health and Prevention (MOHAP) initiated and established the nursing internship program targeting nursing graduates to enhance the preparedness of nursing graduates towards practice licensing exams for the nursing profession in the UAE. The enrolled graduates are from various universities in the UAE. (MOHAP-Ministry of Health and Prevention - UAE, 2019).

2.4.4 Quality and Safety Education for Nurses (QSEN) Competencies and the Joint Commission (TJC) Standards.

Remarkably, Lyle (2016) mentions, while the hospitals and the college of nursing aim to prepare nurses to provide safe, effective quality care in the academic and practice settings, the leaders should increase their understanding regarding QSEN (Quality and safety education for Nurses) competencies, TJC (The Joint Commission) standards, and the Magnet standards so that the necessary competencies will be integrated into the curriculum and prepare the graduates adequately. Disch (2013) describes the implementation and evaluation of the performance and assessment of the impact of incorporating the QSEN content into nursing curricula in 22 schools of nursing in the San Francisco. The majority of schools have instituted many of the knowledge, skills, and attitudes for the six competencies; significant curricular change is occurring, and academic-clinical partnerships have been strengthened.

Interestingly, Sherwood (2014) insists that developing the mindset to achieve competency of quality and patient safety is more important than the mere development of the nurses' competencies. Therefore, to maintain the leading practices and help the health care institutions benchmark and bench lead, the JCI standards are developed with the inputs taken from: 1) Health care organizations, 2) Subject matter experts, 3) Scientific literature and industry guidelines, 4) JCI Standards Advisory Panel and 5) Other key stakeholders. The advisory panel members of the JCI are composed of proficient physicians, nurses, administrators, and public-policy experts, who guide the development and revision of all the JCI accreditation standards (Joint commission international Standards, n d).

Integrating QSEN competencies in the university for nursing education will allow the nursing professionals in the academic and healthcare service setting to practice and promote the exact

language of quality and safety. The QSEN competencies enable the educators in academic and professional development to emphasize the rationale behind every nursing intervention while also focusing on evidence-based care (Altmiller & Hopkins-Pepe, 2019). In addition, the Joint Commission Accreditation Standards guides and supports the hospitals in meeting the international standards, regulatory requirements, and excellence. Through it all, the aims have always been matching between nursing practice and academia, but the two have not always shared a common language or understanding.

Although curricular changes are happening in nursing education to integrate the quality and safety in nursing education, there is a constant concern that the rate or pace of changes is not proportionate to the demand of the practice area (Tregunno, 2014). Lee (2014) also mentions that, as educators of the largest segment of the health care workforce, each faculty member must be committed to implementing meticulously the curricular changes proposed. Nursing education and the curriculum adopted have a significant role in developing the nursing student's knowledge, attitude, and skills to meet the quality and safety demands in the health care system. Alongside, the policymakers and educators should bring about the innovation in teaching the competencies related to quality and safety and consider the cultural aspect in teaching the phenomenon of patient safety during the designing and innovation of curriculum (Vaismoradi 2012 ; Packer 1994).

Integrating the competency in quality and patient safety is at the entry to practice is vital, and efforts to be made to incorporate patient safety into the health professional education (Ginsburg 2012). It was also stated that the students' perceptions and the faculties need to be captured to support and enhance their understanding and adopt essential measures (Ginsburg 2012; Cronenwett 2007) states that unlike the medicine where the IOM competencies are followed

from medical school to residency until certification, there is no such consensus of the nursing competencies to define the nurse's qualification in terms of the competencies. Moore (2013) highlights the importance of quality and patient safety by mentioning that mere competency development is not enough for the nursing graduates; instead, the systems thinking needs to be inculcated into the nursing students, and other health professionals are beyond the application of those competencies. Nursing competence is not only a professional standard described by the American Nurses Association but also a Joint Commission requirement (American Nurses Association, 2008).

2.4.5 The Theory-Practice Gap in Nursing

The issue of the theory-practice gap is not new. Despite many academicians' efforts and hospital personnel to bridge the gap, the theory and practice gap is still an important issue requiring interventions to be taken in this regard. As it is sometimes called, the theory-practice gap or research-practice gap occurs when practitioners struggle to integrate knowledge learned in an academic environment with real-world clinical practice (Chapman, 2017). The term Theory-practice gap is common in phrases used to describe the status of the practice of nurses in the literature without a consistent, standard, or uniform description. The term Theory – practice gap is usually referred to as being bridged, avoided, minimized, or negotiated (Greenway, Butt & Walthall 2019; Safazadeh et al. 2018; Flood & Robinia 2014).

Captivatingly, Murray, Sundin & Cope (2018) analyzed the literature to summarize the evidence related to the patient safety knowledge and practices of new graduate nurses and found that all the articles mentioned the theory-practice gap that exists and suggests that the well-planned execution of transition to practice is vital to bridge the gap. Understanding these

gaps is critical to employ steps to counteract them. The researcher reviewed, and the study analysis acknowledges, that nurses have different stages of knowledge and practice capabilities. However, there was very little or no mention and acknowledgment of patient safety knowledge among the new graduate nurses among the 84 articles. Also, the issues that were present during the 1970s as a gap for the newly graduated nurses are still present in today's new graduate nurses. Rohde and Domm (2018) state that the gap exists in safe medication administration, awareness of risk for medication error, and clinical reasoning to maintain safe medication administration.

Furthermore, Nour and Williams (2019) present a study that was undertaken to explore the experiences of newly graduated nurses in acute healthcare settings that newly graduated nurses have reported having encountered a gap between theory and practice. Therefore, providing a supportive environment to assist new graduate nurses is vital to develop them into confident and independent nurses at the time of entry to health care services. Finally, Woo and Newman (2020) reaffirm the theory-practice gap phenomenon by presenting study results that were embarked on to investigate the experience of the novice nurses during the first six months to12 months after entry to the hospitals. The conclusion was arrived at after analyzing the data collected in two phases.

A persistent theory-practice gap is been pointed out in many studies (Monaghan 2015; Ter Maten-Speksnijder et al 2015; Haddad, Moxham & Broadbent 2017; Safazadeh et al. 2018). The theory-practice gap can be viewed in six ways, namely: (1) The difference between idealized practice and common practice, (2) The difference between the general principles taught in academia and the difficulty in comprehending and interpreting them for application to a specific situation in the actual workplace, (3) The gap between abstract nursing theory and

its use in practice, (4) The gap between scientific knowledge and theory used as common practice, (5) The gap between an individual's perceived representations of nursing and the published theories of nursing and (6) The gap between the theories practitioners' claims underlies their practice and the implicit theories embedded within their practice, which they may not be aware of (Chapman, 2017).

Nursing theory constitutes ethics, psychology, sociology, anatomy, physiology, pathophysiology, pharmacology, applied nutrition for nurses, and information technology, among others, because the nursing profession is not a purely academic discipline, but rather a complex set of activities using a wide range of skills and knowledge. Nurses are not expected or rather should not expect to know everything, but by making a conscious effort to apply the theory into practice, they will develop their skills and knowledge throughout their careers (Shoghi et al., 2019). According to many researchers, nursing students have experienced and stated about this gap as something that gives a feeling of incompatibility of the content learned in the didactic teaching with what is seen or expected from them in the practice setting (Flood & Robinia, 2014).

The nursing students, nursing administrators, and researchers have expressed their discontentment regarding the nursing graduate interns' preparedness to work in the complex health care setting and the present format of nursing education (Benner 2015). As per the report presented by the National Council of the State Board of Nursing of the United States of America (2012), 50% of the new nursing graduates during their internship mentioned that they were not confident to identify a deteriorating patient, and about 40% of the graduates admitted that they had committed medication error. About 43% of them reported that they had experienced a lack of confidence, high level of stress, inability to perform procedures,

communicate with the physicians about the patient's condition, receiving and giving a patient endorsement, and prioritizing the duties during their shift. 57% of the graduate interns have expressed that they might leave the profession within three, six or 12 months after graduation due to the high expectation of competencies, which they feel they are not prepared adequately (Kitner, 2017). It was recommended that there should be integrating theory into the learning experiences, which will help the students develop a sense of the importance of problem-solving (Benner 2015). Dobbins (2018), while examining the confidence level of new graduate nurses in delivering safe, competent patient care, reaffirms that multiple factors affect the competency preparedness of new graduate nurses. It includes the quality of experience they received during the clinical placements in the academic setting that contributes to the existing gap in the theory and practice arena (Kiernan & Olsen, 2020).

Though the theory-practice gap is connoted in many works of literature negatively, few positive avenues have been recorded. It is mentioned that the existence of theory and practice gaps indicates that the profession is continuously changing and evolving. The new theories and new techniques are continuously being tested and indicate that the profession is vibrant and dynamic, constantly challenging the accepted practice norms and moving forward. It also avoids the complacency of the nurses in the practice setup (Haigh, 2009). The phrase theory-practice is frequently explored, investigated, and analyzed in any literature pertaining to the competency or preparedness of new graduate nurses. The study analyses the theory-practice gap is referred to synonymously as being 'bridged,'' avoided' or 'transferred' and the attributes of the theory-practice gap are (i) the problem pertaining between university and practice in the health care setting, (ii) The failure of the theory to be able to be linked with the practice, (iii) theory that is seen and considered as something that is not relevant to practice (Greenway, Butt, & Walthall 2019).

2.4.6 Nursing Education in the UAE

The establishment of the first nursing institute in Abu Dhabi was a significant milestone during the late 1970s/early 1980s, followed by nursing institutes in Sharjah, Ras Al Khaimah, and Fujairah. Increasing the number of UAE nationals (Emiratis) in all medical professions forms an integral part of the UAE's Vision 2021 (Koornneef & Robben, 2019; Al-Yateem et al., 2020). The UAE has committed itself to an ambitious reform program, Vision 2021, aiming to be ranked globally among the top 20 countries. (Koornneef & Robben, 2019). Global nursing education has identified areas of significant importance that contribute to the profession's progression. These include nursing specialization, the need to strengthen education to match the practice expectation, competency-based education, and producing new graduate nurses who are competent and can practice globally (Ryskina, Lam, & Jung, 2019). In UAE, steps toward the above said are still in infancy, and it can be initiated only by strengthening the nursing education. Currently, the academic institutions that provide Bachelor of Nursing programs are: 1) University of Sharjah (Sharjah), 2) Ras Al Khaimah Medical and Health Science University (Ras Al Khaimah), 3) Higher Colleges of Technology (Sharjah and Fujairah), 4) Fatima College of Health Sciences (Abu Dhabi in 3 campuses and one campus in Ajman), and 5) Gulf Medical University (Ajman).

2.4.7 Major Health care workforce Reports on global Nursing Education

The following assumptions are made about the preparation and practice of entry-level registered nurses:

- Requisite skills and abilities are required to attain the entry-level registered nurse competencies.

- Entry-level registered nurses are prepared to enter into practice safely, competently, compassionately, and ethically in situations of health and illness; with people of all genders and across the lifespan; with the following possible recipients of care: individuals, families, groups, communities, and populations; across diverse practice settings.
- The practice setting of entry-level registered nurses can be any environment or circumstance where nursing is practiced. It includes the site where nursing care is provided and programs designed to meet health care needs.
- Entry-level registered nurses enter into practice with transferable competencies across diverse practice settings.
- Entry-level registered nurses' experience in practicing the competencies during their nursing education program can vary and may be limited in some practice environments and with some clients.
- Entry-level registered nurses have a strong foundation in nursing theory, concepts and knowledge, health and sciences, humanities, research, and ethics.
- Entry-level registered nurses are prepared to engage in interprofessional collaborative practice, essential for improving client health outcomes.
- Entry-level registered nurses are beginning practitioners whose level of practice, autonomy, and proficiency will grow best through collaboration, mentoring, and support from registered nurse colleagues, managers, healthcare teams, and employers.
- Entry-level registered nurses have the knowledge required to select and implement a wide range of nursing interventions in the provision of nursing care. Frenk et al. (2010) produced a report by the Global independent commission, with 16 first authors who were experts in education for health professionals from diverse countries like USA, Pakistan, UK, Bangladesh, Peru, China, India, Uganda, and Lebanon.

The commission was formed, and the report was produced as a mark of the centennial of the 1910 Flexner report, which had made a great impact hundred years ago about groundbreaking reforms in education for health professionals applicable for Nursing education and curriculum development enhance competence preparedness. These reforms and reports are presented with the aim of the acquisition of competencies responsive to local needs but connected globally. (WHO 2013). Clark et al. (2016) uphold and affirm that the reformation in competency preparedness is achieved by outlining the global and the public core competencies after carrying out a systematic analysis of studies from 2012 onwards and included 25 studies and projected that these competencies could particularly inform the nursing universities to integrate the global health concepts into the curriculum, that allows better preparedness of new graduates.

By the beginning of the 21st century, glaring gaps and inequalities in health are found both within the countries and between the countries due to the failure to share health advances equitably. This poses serious and complex demands on the health workers, as the professional education has not been able to keep pace with the changes and challenges in the health care system, which obviously could not aid in preparing the new graduate interns to meet the competency preparedness need of the hospitals. As a result, the health professional graduates are produced who are ill-equipped to meet the needs of the patient and population. This is the reason for forming the global independent commission.

Nursing professionals and academic leaders have joined together to develop a shared vision and develop a strategy and framework for education in health systems. The report focuses mainly on the Quality of the education provided for the health professionals with the Flexner report as the background. Flexner's report was intended to bring science into medical education

and has brought about reformation in the education of health professionals. However, after a hundred years of Flexner report or Flexner model, we can witness that medical education has been fragmented and episodic in the Healthcare system. In this report, the authors worldwide, express the urge to refocus on instructional and institutional reforms to bring about the expected level of outcome that is transformative. The commissioner's deliberated and promoted consultation for one year in within the focus of developing a fresh vision and propose recommendations that might accelerate the steps taken towards the transformation of education for health professionals globally. The study is undertaken and reported to nurture a new generation of health professionals who are well prepared to meet the expectations and demands of the healthcare system as they will be equipped to handle the present and future health challenges in the Healthcare system. International health is a field of health care called global health. In this arena, the emphasis is on public health, considering the various health needs across the region and national boundaries.

More recently, with the COVID-19 pandemic situation, increased attention is drawn towards global health education. It also further emphasizes the importance of educating health care professionals to function in a globalized world similar to the situation during the emergence of the Ebola epidemic outbreak (Clark et al., 2016). Globalization is a hot word debated and discussed over several decades. It encompasses the communication and exchange of culture worldwide and implies international health management to a greater extent. Nursing, which is considered a global profession, is expected to play a vital role during this globalized era. This article clarifies the direction in which nursing education is expected to accelerate (Clark et al. 2016; Nour & Williams 2019). Nursing is a significant component of the healthcare system and plays an important part in ongoing healthcare service development. It is noteworthy that three of the five critical priorities identified in the study had been focused on patient safety,

specifically on and awareness of international patient safety goals, medication, and pain management for patients in different clinical areas in the UAE (Al-Yateem et al., 2019).

The report also presents the century of reforms in education categorized into three generations. It starts in 1900 as science-based education. The curriculum during the mid-century focuses on problem-based curriculum and later towards the system-based curriculum in 2000 and onwards. Parallel to it, there are two other categories mentioned: instructional design and institutional design. The report also noted that no countries in the world where all of its health professionals' education systems follow only science-based traditional education or entirely problem-based or all institutions following system-based approach. Instead, there is a mix of institutions following a blend of these educational systems.

A breakthrough worth mentioning is the institution breakthrough that happened where education focused on the problem-based curriculum. This fared much better than the dialectic teaching strategy. In addition, there was the introduction of other curriculum innovations brought in the continent of education from classroom to clinical training. It can be summarized that there are four significant reports focused on the Global Health workforce nursing education, public health education, and medical education. The reports' recommendations emphasize patient and population centeredness competency-based curriculum in the professional and team-based education. It empowered learning policy and management leadership skills, as in Figures 2.5 and 2.6. Lechthaler et al. (2020) affirm that assessment that was carried out in two of the nursing colleges in Tajikistan revealed that the educational environment had significant problems that included insufficient exposure to clinical training, lack of nursing tutors as role models, and more emphasis on factual knowledge, which

ultimately led to the launching of competency-based training that is intended to improve the competency preparedness of new nursing graduates.

The three-generation education for health professionals is illustrated in Figure 2.9, where the educational transformation happened from the year 1900 till the year 2000. It also accounts that the education or curriculum was institution-based in the beginning as illustrated in figure 2.10.

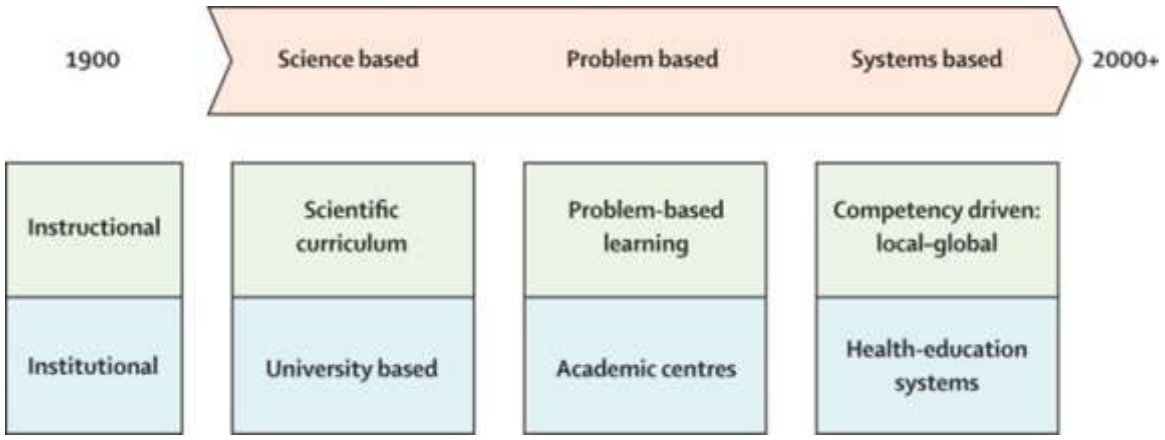


Figure 2.9 : Three generations of reform in education for health professionals (Frenk et al., 2010).

First, it was thoroughly carried out in the specific institutions. Then, there was the introduction of the curriculum that was science-based which was carried out in the universities and was called university-based; later, there was the concept of problem-based learning that the academic institutions followed, presently the medical and nursing education and the curriculum is competency-driven in both the global-international level and also in the local level and it is based on the needs or demands of the health care system. So, this explains the significance of the present study, where the focus is to get insights on the personnel in the health care setting

about the competency preparedness with which the new graduate nurses enter the health care setting.

The study further explores the nursing personnel's expected competency preparedness, including the nursing leadership of the hospital. The study is anticipated to provide results that can inform the academic educators in updating and modifying the curriculum so that nursing educational institutions will be geared toward preparing the workforce to meet the demands of the health care system. Notably, Frenk et al.'s (2010) report has ignited many groundbreaking reforms, such as integrating modern science into the curriculum of the universities of professional education for health professionals.

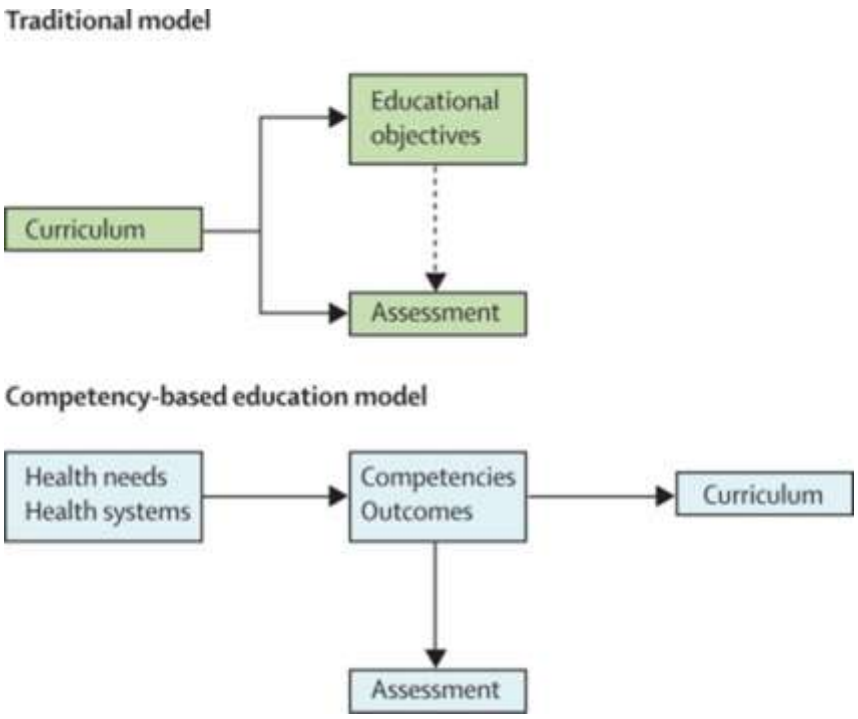


Figure 2.10 : Traditional and Competency-based education (Frenk et al.,2010).

One of the impacts of the integration that is worth mentioning is the doubling of the lifespan during the 20th century; however, by the beginning of the 21st century, the same positive impact did not continue as there were glaring gaps to failure of countries to share their new advances both within the countries and between the countries and the health systems as they became more complex. An effort to develop a middle-range model to guide actions of nursing education in Malawi included the key strategies like curriculum reforms, regulation, transformative learning, provision of infrastructure and resources, and capacity building to improve the quality of nursing education and improve the preparedness of nursing graduates for practice (Bvumbwe & Mtshali, 2018).The Framework throws light on the fact that people are the recipients of service provided by the healthcare system and the actual co-producers of their education and health. The Commission has recommended that the education system be able to cater to the needs of the demands of the health systems. This tenet does not imply the education system takes the subordinate position but rather the education system should be cleared up to produce professionals who can bring about positive change in their workplace.

This report also provides different approaches for designing education for health professionals. The other methods include a system approach where the linkage between the education system and the health system is described and the various determinants. The multiple determinants in those systems where the population is the labor markets tense to bridge both the systems. After describing the said linkage, the Framework in Figure Two highlights the three key dimensions of education: institutional design, instructional design, and educational outcomes. The institutional design focuses on the structure and function of the education system in three different levels, namely systemic level, organizational level, and global level. The Framework is comprehensive on which also reflects the instructional design. Both the institutional and instructional design lead to the proposed outcome, including the interdependence in education

and transformative learning. The Framework provides the answer to the question of what to health and how to teach and provides clarity towards were to teach while is not only the organization but also individual that implements the education system as per the demand of the healthcare system.

2.4.7.1 Transition to Practice

Remarkably, Graf et al. (2020) conducted a critical narrative literature review intending to determine applying theories in transition to practice for newly qualified graduate registered nurse programs. The review using the theories: Kramer's reality shock theory, Benner's novice to expert theory, Bridge's transition theory, and Duchscher's stages of transition theory points out that both the academic institution and hospital setting need to adapt their transition to practice program based on the needs of the new graduates and also the expectation in the hospital. The study conducted by Murray, Sundin, and Cope undertook a critical appraisal of the contemporary literature regarding the transition of new graduate nurses and their knowledge and practice concerning safety and quality patient care.

The study revealed that the transition program was imperative to enhance the preparedness of new graduates. It is also mentioned that the culture of the unit or the ward in which the new graduate nurses will be posted for practice influences the safety practices. At the same time, there are gaps between the practice, and the expectations remain. The new graduate nurses will be able to have a smooth transition and practice their skills and apply the clinical knowledge when the unit provides a supportive culture so that the new nursing graduates are without stress and anxiety (Murray, Sundin, & Cope, 2020).

While exploring the experiences of graduate nurses enrolled in the transition program to identify and gain insights on the enhancing factors and the factors that are the barriers for the phenomena of transition, principles of hermeneutic phenomenology were employed. The study recruited seven graduate nurses and conducted semi-structured interviews of those seven graduate nurses undertaking a Transition to Professional Practice Program in an Australian metropolitan hospital to investigate the lived experiences of transition within a transition program. The results revealed that the transition of new graduate nurses expressed that the transition period is highly stressful. It is a time of many demands that give rise to shock and negative emotions. However, the new graduate nurses also mention that though there are stressful situations, there are some positive aspects as well in the transition program that enhances their preparedness and practice (Ankers, Barton & Parry, 2018; Murray, Sundin, & Cope, 2020; Nour & Williams, 2019).

Woo and Newman (2020) undertook a study in Singapore to investigate the experiences of newly graduated registered nurses following their completion of student period and transitioning to the role of a registered nurse during the 6-12-month period. The study was a was mixed-methods study that revealed that their transition to professional practice was stressful and affirmed the theory-practice gap phenomenon. Clinical skills like intravenous cannulation and venipuncture were expected from them as a part of the role of registered nurses' preparedness, and role expectation; being unable to fulfill the requirement implies poor preparation for the practice of new graduate nurses. This made the new nurses to subsequently feel frustrated, leading them to question the quality of education received (Woo & Newman, 2020).

2.4.7.2 Inspirations Drawn for Nursing Education from the Report

The report mentions that the problem of inadequate competency preparedness exists in both rich and developing countries but are different in the character of the problem. It also mentions the pockets of good practices that have been happening around the world which can be adopted and from the areas of good practices it is a result of a collaborative effort from academic experts from all of the field of the medical education field came together and examined and explored to find out the recent find out the answer for what can be done better rather than continuing with an outdated, fragmented curriculum that is not touching upon the actual competency needed for practice?

The report mentions that professional education is preparing health professionals with a mismatch between the competencies to patient and population. The reason cited by the authors is that professional education is not keeping up with the pace with the challenges and change in the healthcare system. In addition, the report highlights that since the curriculum is fragmented, outdated, and static, other graduates passed out with this curriculum are ill-equipped. The author also highlights the need for the redesign of professional healthcare education that is more interactive between the educator and the health system who are the labor market which is considered co-producer of an educated workforce to meet the demand of the professionals. The article is a rich resource to understand the background of the education for health professionals and provides the direction for the future health professionals' education.

2.5 Situating the Current Study

To date, among the numerous studies that were consulted, there are no studies that have attempted to identify the expected level of competencies and present status of competency

preparedness as perceived by the hospital personnel in the UAE. This attempt to address the competency preparedness concern will help bridge the theory and practice gap. In this chapter, nursing competence in the present study can be defined as overall capacity as a professional registered nurse, including attaining multiple competencies integrating knowledge, skills, and attitudes.

There was no baseline for all nurses to meet as part of the nursing program because each university determines what the list of competencies will be. Thus, there is a lack of a standardized set of expected core competencies; and there is little known about what is perceived as competency preparedness in the view of the nursing personnel and nursing leadership of hospitals in the UAE. This study, therefore, aims to explore the competencies required for newly graduated nurses as professional registered nurses in the UAE. It is intended and hoped that this study can contribute valuable information, not only for educational institutions in UAE to improve and enhance their educational preparation, but also for nurse managers and educators to provide the support needed when graduates enter the nursing workforce.

In this chapter of the literature review, the literature related to the education-practice gap has identified the need to address this competency preparedness of new graduates' concern. Education programs and organizational structures contribute to this widening gap due to the differing levels of expectations present. This exploration will serve to balance the educational and organizational components to support the new graduate in the transition to professional practice. These findings will aid the researcher and the other academics and leaders of academic institutions in enhancing their efforts to improve prelicensure nursing education to promote a smooth transition improving the competence level of new graduates as expected by the hospital

personnel. Benner's novice-to-expert theory offers a framework to shape this evidence to support the educational underpinnings that can bridge the new graduate into practice. In turn, the clinical practice realm will also support the new graduate during the movement along the skill acquisition path.

The next chapter, Chapter 3, describes the methods of data gathering that occurred in the study's quest to address the education-practice gap. Again, a mixed-methods approach was used. The measures of data collection, evaluation, and analysis are discussed to structure the study's implementation. The Joint Commission Accreditation Standards supported hospitals in meeting the regulatory requirements, and Magnet standards drove excellence. Through it all, the aims have always been congruent between nursing practice and academia, but the two have not always shared a common language or understanding.

The work of Lyle-Edrosolo and Waxman (2016) has been significant in bridging academia and practice. Using crosswalk methodology, they aligned the six QSEN competencies, the Magnet® standards, and the Joint Commission Accreditation Standards. This work demonstrates the relationship among these three driving forces and how nursing education framed in quality and safety aligns with expectations for excellence in nursing practice. Although the QSEN competencies were originally designed for nursing education, this work validates the QSEN competencies as an effective framework to drive excellence and buttress the lifelong learning required by nursing professionals to ensure that the best care is provided to those who access the health care system.

CHAPTER 3

METHODOLOGY

Chapter 3.

Methodology

3.1 Overview of the Chapter

This chapter throws light on the research method that was carried out in this study as an attempt to answer the following main question: “What is the level of competency preparedness of baccalaureate nursing students at the entry-level as perceived by the nursing personnel in the hospital?” and sub-questions 1 What is the expected level of competency preparedness as perceived by the nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders?. 2. What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the current level of competency preparedness of new graduate nurses?. 3. What skill levels and practice expectations of the new graduate nurses, do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as most important? 4. Which are the competencies that nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital? 5. What are the gaps in new graduate nurses' competency preparedness and which of the competencies are reported to have wider gaps by the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders? 6. What strategies do the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggest enhancing the competency preparedness and concomitant practice expectations of new graduate nurses? Competency preparedness and practice readiness are not new concepts. However, it is still vague, affirms El Haddad et al. (2017). The chapter, while providing an overview of the methodology, the steps taken to ensure

quality data is collected appropriately, and the scientific reasons for the different methods for the inquiry are also presented.

This study is intended to explore the concerns related to the preparedness of the new graduates from the hospital personnel's view. The hospital personnel here in this study implies the preceptor nurses, unit in-charge nurse, unit nurse manager, and the nursing leadership team in the hospital that includes the director of Nursing, the Additional Director of Nursing, and the chief nursing officer. The chapter also presents details, including appropriate illustrations pointing to the selected research process for the study among the major research processes. It also highlights the objective for the adopted research process methodology and research design followed for the study, the research settings, research sampling, data collection instruments, data analysis plan, inclusion and exclusion criteria, ethical considerations, and reliability of the research. It briefs the rationale for the said aspects of methodology, which allows exploring the perception of the hospital personnel about the level of satisfaction of the hospital personnel on the competency preparedness of new graduate nurses indicated by the current competency preparedness of new nursing graduates, and the expected level of competency preparedness at the stage of entry to practice.

The main purpose of this study is to gain insights on the competency preparedness and practice expectations of new graduates among the preceptors and nurse leaders, and professional development nurses of Hospitals accredited by The Joint Commission (TJC) in UAE. Focusing on the main purpose, the other purposes are to analyze the level of satisfaction with the competency preparedness of graduates as perceived by the preceptor nurses, unit in-charge nurse, unit nurse manager, and the nursing leadership team in the hospital, to explore the degree of current and expected competency preparedness and also to identify the suggested strategies

to enhance the nursing clinical education to improve the competency preparedness of the new graduates of UAE. This chapter presents a brief description of the methodology. Research methodology can be identified as the path through which researchers need to conduct their research. It also shows the path through which the researchers formulate the problems, objectives and present their results from the data obtained during the study period (Sileyew, 2019). Choice of appropriate research approach is like choosing a corresponding key for opening a lock. If we select an appropriate research approach only, then corresponding methods could be applied, and results could be valid and reliable (Grover, 2015). Educational works of the literature suggest that there is no general agreement among the researchers on a unique system of categorizing the research methods, and it has been argued that several methods could be used in the same project (Johnson, 1977). In light of the above and also considering the context of the study, the researcher decided on the research methodology, which is briefed in the chapter.

This chapter aims to describe the main research method. To achieve this objective, the chapter is divided into eight sections. The second section describes the research approach, which includes the description of the research design, Research Design Framework, Research Philosophy, Research Approach, Research Method, Research Strategy, Research Design Framework designed for the study. The third section describes the data collection methods, including the rationale for using the selected data collection methods, the rationale for using questionnaires, methods of distributing the questionnaires, Setting, pilot study, Population, and Samples. The fourth section describes the instruments, includes the validation process, description of pre and post piloted instruments. The fifth section is about the Data Analysis Plan informing the plan to analyze results, discuss and interpret the results. The sixth section is the delimitation, which includes the scope of the study. The seventh section includes the

ethical consideration in which the role of the researcher in the study, steps taken to deal with the bias, the ethical risk of the study, and the steps to combat the same. The eighth section is about the trustworthiness and reliability of the data, site, and samples involved in the study.

3.2 Research Approach

Research approach is a critical part of the course of a research study. Research methodology becomes robust when it is built on an appropriate Research Design and approach. A structured approach was built having the Research Questions in mind with proper analysis performed to use the right methodological approach.

A mixed-method research design with both qualitative and quantitative data collection techniques was utilized in this study. Grover (2015) states that World views, research methods, and research designs are the important components of a research approach. The world views lead to forming three research approaches or methods: quantitative, qualitative, and mixed methods. The mixed-method approach adopted in this study is based on the pragmatic approach. Pragmatism is explained as "the knowledge claims arise out of the actions, situations, and consequences rather than antecedent conditions." From a pragmatic perspective, the research methodology and the direction of focus of the study draw on employing "what works," using multiple approaches, giving primary importance to the research problem and the related research question, and valuing both objective and subjective knowledge (Morgan, 2007). Furthermore, Grover (2015) states that the pragmatism paradigm deals with actions, situations, and consequences. Pragmatism debates about the actions and consequences rather than cause and effect, which is post-positivism. It is more contextual and also a time-bound approach. It also never aims at theory building or theory testing. The methods and techniques used may

seem to be traditional or self-invented, but the information and results have to be valid and reliable. More focus is given to the objectives and problems. It may have more than one approach, method, and technique and combined to reach an appropriate solution. Pragmatism is more flexible in choosing methods (Creswell, 2003, p.11). The Pragmatic approach is more practical and provides space for creativity and innovation. The phenomenon in which researchers are interested must be translated into concepts that can be measured, observed, or recorded" for this to happen meticulously the researcher needs to select an appropriate research approach, data collection methods and analyse them appropriately (Polit & Beck, 2006, p, 288). In response to the controversial debate about "paradigm wars," pragmatism has emerged as a sort of rejection of the forced choice between naturalistic and scientific approaches (Johnson & Onwuebuige, 2004). (Figure 3.5) illustrates the Major research approaches (Saunders et al., 2012) and the research approach adopted in the study.

The study intends to explore the perspectives of different people involved in the same area of research, the graduate preparedness as perceived by the hospital personnel, where the researcher is intending to explore the perceptions of competency preparedness of graduate interns, the competency areas that need improvement, and preparedness, the reason for it, and the strategies for concomitantly improving competency preparedness. The gap will be explored from what is mentioned by the hospital nursing personnel, including the expected competencies related to "The joint commission accreditation standards" and also the "Quality and Safety Education for nurses" competencies. In this study, the researcher uses both qualitative and quantitative research design in response to the research problem and the research objective. The overall map design of the mixed-method study presenting both the methods, qualitative and quantitative data collection techniques utilized in the study is represented in Figure 3.1.

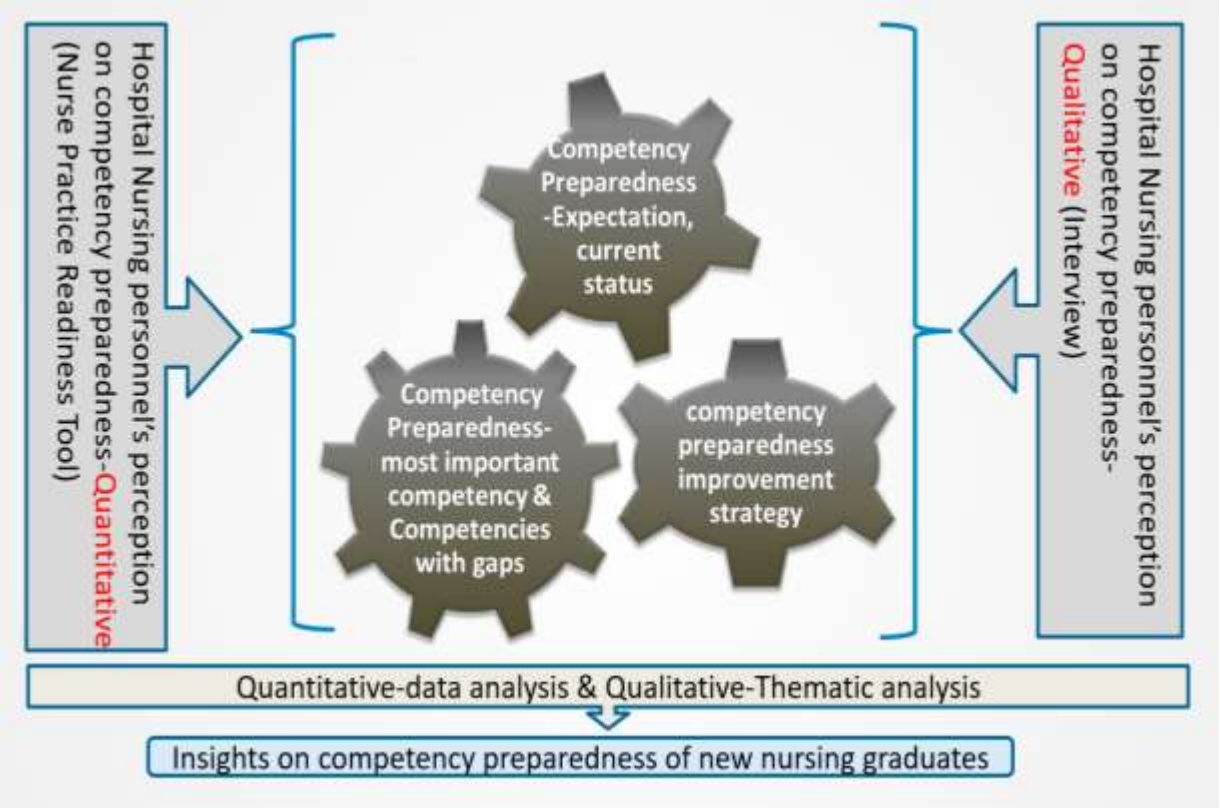


Figure 3.1 : Overall map design of the study

The increasing need for methodological diversity to reflect the complex nature of the issues is emerging in health science research as per the Office of the behavioral and social science research (OBSSR, Creswell, et al. 2010). Boswell & Cannon (2011, p, 250) describes mixed-method as the methodology which is a combination of quantitative and qualitative research methods and techniques for collecting and analyzing data, which is addressed with several names like multimethod, triangulated, and integrated designs. As the field of research has advanced, the mixed-method research design is also being referred to as "action research," as stated by Boswell & Cannon (2011, p, 251). Methodological assumptions consist of the assumptions made by the researcher regarding the methods used in the process of qualitative research (Creswell 2003). This allows answering the questions regarding the reasons adopted in choosing the methods used in both qualitative and quantitative research methods, where the quantitative research assumptions include that the researcher believes that the methods are

reliable, valid, and trustworthy and takes steps to ensure the same. The Qualitative assumptions include the assumptions of the topic discussed by the contents from the participants, and the analysis employed here is inductive.

The paradigm for human inquiry is characterized by how they respond to fundamental philosophical questions such as, what is the nature of reality? Ontological, what is the relationship between the inquirer and that being studied? Epistemological, "what is the role of values in the inquiry" Axiological, "how should the inquirer obtain knowledge? methodological. (Polit & Beck., 2014, p, 6). In the present study, the researcher has chosen methodological, as the effort is undertaken to obtain in-depth knowledge in the field of inquiry, which is to inquire about the competency preparedness of the new graduates on entry to health care setting.

Research methods or approaches adopted are the abductive approach among the broadly classified three types, namely: Inductive approach, deductive approach, and abductive approach. Abduction has the role of introducing new ideas into science: in a word, creativity (Grover, 2015). However, these three types of reasoning do not work independently or in parallel but in an integrated, cooperative manner over the successive stages of the scientific method (Moscoso & Moscoso, 2019). Abductive reasoning is also called an abductive approach which overcomes the weaknesses of inductive and deductive reasoning by adopting the pragmatic perspectives (Dudovskiy, 2017). Abduction belongs to the so-called context of justification. In modern usage, "abduction" is typically taken to be synonymous with "Inference to the Best Explanation." (Mitchell, 2018; Moscoso & Moscoso, 2019; Askeland, 2020). In the present study, there is a generalization from the interactions between the specific observations and the general understanding from the observations. The phenomenon, which is

the competency preparedness of new graduate nurses, is explained by using a qualitative and quantitative data collection method, and the data is analyzed using the integrated manner as per the Abductive method. Based on the purpose of the study, the need to use both qualitative and quantitative data is supported by pragmatic philosophy (Johnson & Christensen, 2014).

The selection of the type of research is very critical in the context of the study. The researcher explored the appropriateness among the alternatives and chose the descriptive type of research as the most suitable one. Figure. 3.2 shows the broadly classified designs based on which the Research methodology is built. Since this study is aimed at knowing more about the current status of the skill level of the graduate nurses in the eyes of the hospital personnel, where the new graduate nurses are posted during their internship period at the entry-level and the gaps associated with them, descriptive research is found to be more appropriate to carry out the inquiry. Atmowardoyo (2018) states that descriptive research includes subtypes of research methods like survey, correlation study, qualitative study, or content analysis. These subtypes differ in their types of procedures for data collection and/or analysis. Thus, the descriptive study might involve quantitative analysis or/and qualitative analysis. The survey may be designed to investigate the sample's perspective on a particular problem. Surveys are commonly conducted through the questionnaire, and its data analysis involves quantification. Content analysis may involve either quantitative or qualitative data analysis. In contrast, qualitative research and ethnography may tend to involve qualitative data analysis. In this study that is undertaken, the survey is conducted using the NPRT (Nursing Practice Readiness Tool (NPRT) (Appendix A) to operationalize the graduate nurse's preparedness to practice adopting the quantitative approach and semi structured interview as qualitative component.

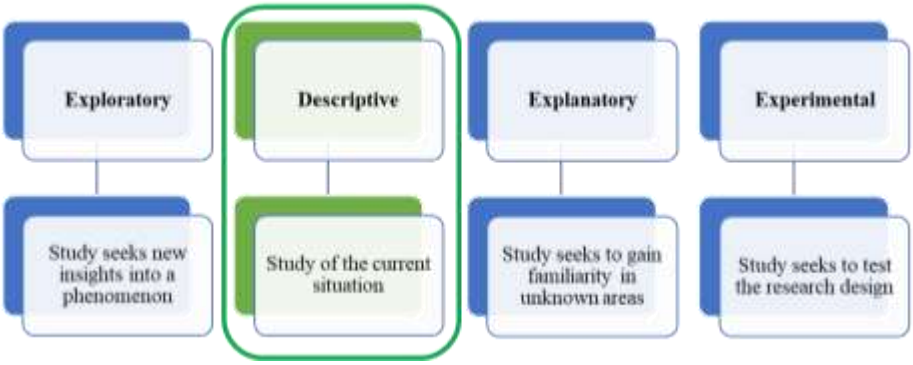


Figure 3.2: Researcher's Illustration of Types of Research Design (Akhtar, 2016).

Different types of research designs include types like exploratory, descriptive, explanatory, and experimental. (Sousa, Driessnack & Mendes, 2007) state that an experimental design is used for finding the causal effects and internal validity. The non-experimental designs are used to describe, differentiate, or examine associations, as opposed to direct relationships, between or among variables, groups, or situations. The selection of a research design is mostly based on the research questions or hypothesis and the phenomena being investigated. In this study, the main phenomenon that is being investigated is the competency preparedness of the new graduates at entry-level.

There are various steps involved in a Descriptive type of research design. The steps show clearly that there is no building of theory or theory validation. The process starts with defining the research objectives and the problem statement. The second step defines the method of data collection. (Akhtar, 2016) Then an appropriate sampling method is chosen, and the data collection is performed. The collected data is validated and analyzed concluding. Descriptive or exploratory studies are used if more details are not available about the phenomenon. The researcher observes, describes, and documents various aspects related to the phenomenon. Search for cause and effect is not involved in this type of research. Also, there is no

manipulation of variables related to the phenomenon. Descriptive designs describe what is happening and categorize the information. (Sousa, Driessnack & Mendes, 2007).

3.2.1 Research Methods

Research Methodology is a critical part of the course of a research study. Research methodology becomes robust when it is built on an appropriate research design and approach. A structured methodology was built having the research questions in mind with proper analysis performed to use the right methodological approach. This study is a concurrent mixed study carried out based on the aims of the study seeking to investigate broad aspects. The research design helps to convert the research questions into a researchable study by using an appropriate research process approach the phenomenon, which is the competency preparedness of new graduate nurses, is explained by using a qualitative and quantitative data collection method, and the data is analyzed using the integrated manner as per the Abductive method.

Akhtar (2016) states that a good research design minimizes bias in data collection and analysis, and it is the concept based on which the research is conducted that includes, the blueprint for the collection, measurement, and analysis of data. He also states that the research design should include an explanation of the type of data required, the purpose of study, the data sources, the place or area of the study, approximate time for the study, the sampling type, the data collection method, and the data analysis plan.

A descriptive non-experimental, concurrent triangulation mixed methods approach was utilized to measure the perceptions of hospital nursing personnel regarding graduate nurses' preparedness to practice. The purposive sample was adopted and the participants fulfilling the

inclusion criteria for both survey and interview were included, which includes the preceptor for whom the survey was done, charge nurse, unit manager, and clinical resource nurse had to participate in the survey and the hospital leadership comprising the Assistant Director of Nursing and Chief Nursing Officer participated in interviews. The participants of the survey as mentioned are included if they fulfill the inclusion criteria that they must have been in the medical -surgical units, should have been a preceptor or have been supervising the new graduate nurses in the past 2 years. The hospital leadership personnel who were the participants of interviews are from the hospital where the new nursing graduates are recruited and posted for the past 2 years.

The survey could be completed in 15-20 minutes and the interview took up to 45-60 minutes. The investigator contacted the prospective contact person at the nursing department at each hospital mailing the IRB approval of the hospital and the ethical approval from the Ministry of Health. A feasible time for the researcher and the contact person was fixed to meet in person and to discuss the objective of the study, methodology, the tool, sample size, method of data collection, plan of data collection, and other appropriate information to proceed with the data collection in the hospital. For interviewing the hospital leadership participants, the convenience sample of nursing leaders was recruited and sent email requesting consent to participate in the interview as a method of data collection describing the intent of the study and other studies related information.

The researcher decided to use the survey approach as it was the best approach in this mixed methods study because of the appropriateness and feasibility of the method to collect maximum data considering the practicality and feasibility for both the researcher and the participants. The participants were identified as per the inclusion and exclusion criteria which is their

participation concerning the competency related matters of the new graduate nurses. The survey tool was given to the preceptors by the investigator as identified by the unit managers or the clinical resource nurses. Since the preceptors were doing different shift duties, first they were contacted over the phone and met them at their convenient time and place to complete the survey.

For some preceptors, who were busy in the workplace the online version of the tool was mailed to them after briefing them about the study and the tool. This mixed-mode strategy using both the paper and online versions of the tool to collect the data was done considering the participant and group's request or characteristics, this was also intended to improve the response rate. The selection of samples was based on the inclusion criteria. Concerning the preceptors, the nursing staff who were assigned to the graduate nurse to be the preceptor and had been in the role for at least one year. For selecting the hospital nursing leaders, they were middle level and high-level nursing managers who were responsible for the operation of the particular patient care unit in the medical and surgical department. Frankel (2009) stated that purposeful sampling is all about selecting the participants who will be able to provide the information that is necessary to the researcher based upon the research questions. Creswell (2012) mentioned that the size of the sample should be based on the target population. He also added that the larger the sample size, the greater will be the credibility and the generalizability of the study.

The research methods and approaches are broadly classified into three types, namely the Quantitative (Positivism and Post-positivism) approach of measurements and numbers, Qualitative (Constructivism & Transformative): approach of words and images. Mixed Methods (Pragmatism): approach of measurements, numbers, words, and images. (Grover, 2015). Mixed research is research that uses multiple paradigms to profit from both qualitative

and quantitative strengths and to overcome the individual weaknesses of using either method (Johnson & Christensen, 2014). The incorporation of quantitative and qualitative methods can be used through diverse forms such as; merging data, connecting data, and embedding data (Creswell & Plano Clark, 2011). The pragmatism believes that it is valuable to find altered solutions to fit every member within any community or provide the same individuals more than one workable solution (Johnson & Christensen, 2014). Researchers have suggested that priority, implementation, integration, and theoretical perspective are the main principles to follow within mixed research studies (Creswell 2003). Several steps (appropriateness of the mixed-design, rationale, sampling design, constructing the research design, analyzing data, validating data, interpreting findings, and writing the final report) have been suggested by Johnson and Christensen (2014) to use in mixed research, and have been utilized in this study. Suitably, this study followed the concurrent mixed method study approach to answer the research question related to competency preparedness. Moreover, other researchers associate their paradigm definition with the way of seeing the others' point of view and accepting their perspectives on different issues to be open-minded to the world's beliefs (Creswell 2013). Consequently, Teddlie and Tashakkori (2010) argued that the study paradigm would give a new feature of accepting using different paradigms in the research field to match the researcher's interests, views, and nature of the context. Thus, the paradigm was discussed in some literature as the study related to differing paradigms, the worldview is that the differences in the basic set of beliefs or assumptions that will provide the guidance to the way they approach the investigations (Fraenkel, Wallen & Hyun, 2012).

The researcher of the study, the pragmatist, while following the mixed methods approach, harked back to Bryman (2006), accounting for around sixteen advantages while opting to follow a mixed methods approach over any other method. This is the reason for the researcher

to consider the mixed methods approach in comparison to other research approaches. The advantages are presented as follows: (1) Triangulation of mutual collaboration, (2) Offsetting of the strengths of one approach so that the weakness of the other can be compensated, (3) The area of inquiry can be explored well by collecting complete data in the field, (4) A sense of process was obtained qualitatively to explain the account of social structures obtained quantitatively, (5) Ability to be able to find the answers to various research questions, (6) For explaining especially while expecting or after having received unexpected or contrasting results, (7) To assist in purposive sample selection, (8) To improve the credibility of the findings, (9) To broaden understanding of relationships contextually, (10) For illustration, (11) The practitioners can be benefitted by improving the usefulness of findings with an applied focus, (12) For quantitative confirmation of a qualitatively generated theory within a single project, (13) To include a diversity of views from different perspectives and (14) For enhancement or building upon of previously generated qualitative and quantitative findings.

These are valid concerning the research question to explore the preparedness of new graduates as per the perceptions of the stakeholders regarding the quality and patient safety competencies. Concerning the research that is conducted in the social sciences, as in the case of the nursing profession, the deeply rooted social phenomena are very complex that more than one data collection method is needed to study these complexities. Creswell (2012) argues that, just like the triangle which has the three angles, the blend of information that can enhance the strength of one type of data that is being collected and also neutralize the weakness of the data collected by other method focusing on the types of the data and the phenomenon and blending the information collected.

The Research method helps to convert the research questions into a researchable study by using an appropriate research process approach. Akhtar (2016) states that a good research design minimizes bias in data collection and analysis, and it is the concept based on which the research is conducted that includes, The blueprint for the collection, Measurement, Analysis of data. He also states that the research design should include an explanation of the type of data required, the purpose of study, the data sources, the place or area of the study, approximate time for the study, the sampling type, the data collection method, and the data analysis plan. The selection of a research design is mostly based on the research questions or hypothesis and the phenomena being investigated. In this study, the main phenomena that are being investigated is the competency preparedness of the new graduates at entry-level and the main research question is What is the perception of the hospital nursing personnel about the competency preparedness of new baccalaureate nursing graduates of UAE as they begin the practice in UAE? and the overall design map of the study is presented in Figure 3.2

The study was undertaken to address the following research questions:

1. What is the expected level of competency preparedness as perceived by the nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders?
2. What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the current level of competency preparedness of new graduate nurses?
3. What skill levels and practice expectations of the new graduate nurses, do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as most important?

4. Which are the competencies that nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital?

5. What are the gaps in new graduate nurses' competency preparedness and which of the competencies are reported to have wider gaps by the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders?

6. What strategies do the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggest enhancing the competency preparedness and concomitant practice expectations of new graduate nurses?

Subsequently, the following paragraphs will be presenting the context and site, population and sample, instruments, data analysis, ethical consideration, and the limitations. A summary table 3.1 of the study presenting the approach, instruments, participants, and the data analysis followed for the research questions are given.

Table 3.1: Summary table of the study methodology

Research questions	Approach	Instrument	Participants	Data Analysis
1. What is the expected level of competency preparedness as perceived by the hospital nursing personnel	Quantitative and Qualitative	Survey & semi-structured interview on perception of competency preparedness.	Quantitative sample:104 Qualitative sample: 56	SPSS Descriptive statistics & Thematic analysis

2. What are the perceptions of hospital nursing personnel on the current level of competency preparedness of new graduate nurses?	Quantitative and Qualitative	Survey & semi-structured interview on perception of competency preparedness	Quantitative sample:104 Qualitative sample: 56	SPSS Descriptive statistics & Thematic analysis
3. What skill levels and practice expectations of the new graduate nurses, perceived as most important?	Quantitative and Qualitative	Survey & semi-structured interview on perception of competency preparedness.	Quantitative sample:104 Qualitative sample: 56	SPSS Descriptive statistics & Thematic analysis
4. Which are the competencies, perceived as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital?	Quantitative and Qualitative	Survey & semi-structured interview.	Quantitative sample:104 Qualitative sample: 56	SPSS Descriptive statistics & Thematic analysis
5. What are the gaps in new graduate nurses' competency preparedness and which of the	Quantitative and Qualitative	Survey & semi-structured interview.	Quantitative sample:104 Qualitative sample: 56	SPSS Descriptive statistics &

competencies are reported to have wider gaps?				Thematic analysis
6. What strategies do the hospital nursing personnel suggest to enhance the competency preparedness and concomitant practice expectations of new graduate nurses?	Qualitative	Semi-structured interview.	Qualitative sample: 56	Thematic analysis

The phenomenon in which researchers are interested must be translated into concepts that can be measured, observed, or recorded (Polit & Beck 2006). For this to happen meticulously, the researcher needs to select an appropriate research approach, data collection methods and analyze them appropriately**.** In this study, the concept or phenomenon identified to be studied is the perceptions regarding the competency preparedness of the graduate nurse interns, including their expectations related to TJC (The Joint Commission Standards and QSEN Quality and Safety Education to Nurses. Furthermore, the phenomenon is translated into smaller researchable concepts to understand the perceptions of the preceptors and the hospital leaders about the competency preparedness and also the practice expectations that are deficient. This will ultimately inform the researcher about the strategies or interventions that can enhance competency preparedness and job readiness among nursing graduates in the UAE. The result that is expected plays an important role in selecting the most appropriate and suitable research

approach (Onwuegbuzie, Gerber et al, 2016) , and not only that, but the focus of the study is also another vital factor that informs the researcher either qualitative, quantitative, or the mixed method is to be adopted (Peshkin, 1993).

The choice of research is with reference to the use of quantitative and qualitative research methods. The qualitative mono method is used when either quantitative or qualitative data collection is utilized. In mixed methods, both quantitative and qualitative methods are used to achieve different research objectives and offset the constraints of the use of single methods (Melnikovas, 2018). It is also found in many pieces of research where more than one method to study the problem enriches the data by widening the horizon of understanding. Cohen et al (2007) mention that the study design can either be a concurrent or simultaneous collection of quantitative or qualitative data. On the other hand, it can also be sequential where quantitative data are emphasized with relatively minimum emphasis on the qualitative data. In this study, the qualitative and quantitative approaches are used concurrently. During the review of many studies exploring similar concepts, it was very evident that the researchers have used mixed methods designs, where they would incorporate both qualitative and quantitative data. Creswell (2012) categorizes mixed methods into six different categories as convergent parallel design, the explanatory sequential method, the exploratory sequential design, the embedded design, the transformative design, and the multiphase design. Here in the study, a concurrent mixed-method approach is utilized as the researcher has converged and merged quantitative and qualitative data to provide a comprehensive analysis of the research problem.

The mixed methods research approach was first introduced in 1989 by Greene, Caracelli, and Graham, based on an analysis of published mixed methods studies (Schoonenboom & Johnson 2017). This classification is still in use. In this study, mixed methods were followed as it

allowed the researcher to understand the quantitative data with numerical data to apply values and measurement to the information but also, it was solidified and enhanced by the opinions, thoughts of the participants, and the perceptions about the competency gap and the extent of job readiness in their view, which was the focus of the study. Creswell (2012) defines mixed methods as a research design as a "procedure for collecting, analyzing and "mixing" both quantitative and qualitative methods in a single study or a series of studies to understand a problem." Greene et al. (1989, p. 259) distinguished the following five purposes for mixing in mixed methods research: namely (1) Triangulation seeks convergence, corroboration, correspondence of results from different methods; (2) Complementarity seeks elaboration, enhancement, illustration, clarification of the results from one method with the results from the other method; (3) Development seeks to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions. (4). Initiation seeks the discovery of paradox and contradiction, new perspectives of frameworks, the recasting of questions or results from one method with questions or results from the other method: and (5). The expansion seeks to extend the breadth and range of inquiry by using different methods for different inquiry components.

According to Noffke and Somekh (2009, p, 6), action research has been a huge part and has been used predominantly related to research in education, as well as in the fields of social science. As per the purpose of the research, some forms of action research throw light on new strategies for data collection and analysis which correspond to the different theoretical frameworks that underpin the research. Action research is considered as an approach to the research, rather than a specific method to collect data. It can also be mentioned that this approach is more related to doing research with and for the people (Gerrish & Lacey, 2007).

Action research is also described by Dodd (2008, p, 13) as a research approach that promotes change and describes, understands, and explains the focus of the research. Within action research, the process can take the direction of being cyclical (recurring steps in similar sequence", participative (all individuals working as partners within the process), qualitative (dealing with language, not numbers), or reflective (reflecting critically on the process and outcomes). The main idea behind the action research is to reduce the inappropriate uncertainty.

Mixed methods research is not only just collecting two types of data as two different strands, but it also involves the blend of the data and is essential to a mixed methods study (Creswell., 2012). The researcher planned to collect the quantitative data and the qualitative data from the participants to have an in-depth understanding of the topic of focus explored. The quantitative data and qualitative data were taken from the preceptors, charge nurses and the clinical resource nurse and further qualitative data was collected from the unit managers and the nursing leadership to have a better and in-depth understanding about their perceptions of current and expected competency preparedness, and also about the deficient areas of competency along with the strategies according to them that could be adopted to improve better competency preparedness.

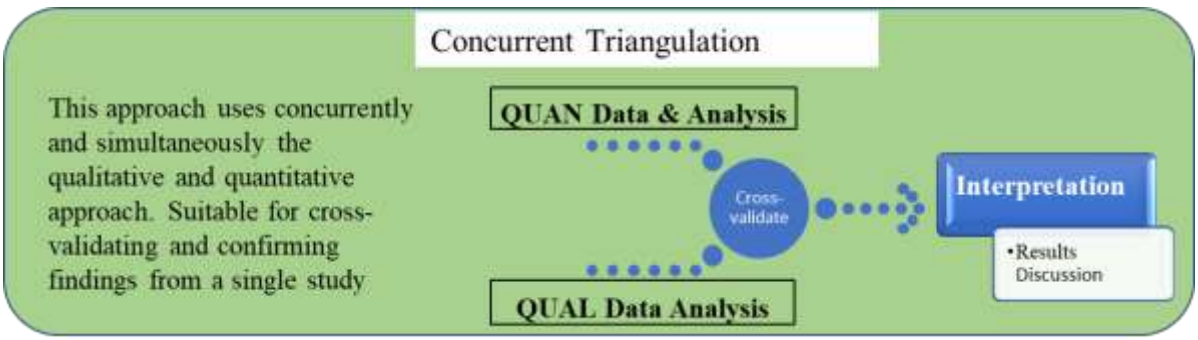


Figure 3.3: Illustration of Concurrent Mixed Research Designs highlighting the type of concurrent mixed methods adopted in the study.

The mixed methods approach is presented with the strength, which is the dynamic between the qualitative and quantitative portions of the study. The data that is collected following the mixed methods can mirror the findings from different types of research, provided, the design should be planned appropriately (Hughes, 2016).

The classification of mixed methods research design is done according to the time order and the emphasis that is given by the researcher on the paradigm, this means that the classification of the design is performed as per the desire of the researcher to carry out the research concurrently or consecutively. The research design is also classified according to the way the researcher would like to give the status of dominance either to the qualitative or the quantitative method or consider both as equal (Terry, 2012). Creswell and Plano Clark (2007) highlight that the most common approach of mixing the research methods is the triangulation method. The illustration for the Concurrent Mixed Research Designs is shown in Fig. 3.3. Concurrent Triangulation is the type of mixed methods chosen for this study.

The study's research framework is shown in Figure 3.4. The study that undertaken was guided by the pragmatic philosophy where the direction is demanded by the research questions and the objectives of the study. Traditionally, either quantitative or qualitative research designs are used. One cohesive framework, where the data collected, and the analysis can complement each other is the use of mixed methods. This can take the research to the next level as there is a combination of the methodologies (Sandelowski, 2000). There are various claims that are made that justify the use of mixed methods in the present study as presented above. The research design is a non-experimental, concurrent mixed methods, cross-sectional study using abductive and descriptive approaches.

Figure 3.4: Illustration of the study's research framework

The qualitative research method bridges the gap between research and practice (Silverstein & Auerbach, 2009). The qualitative method facilitates the discovery of common themes presented by the participants and incorporates the perceptions specific to the members in the research groups. Qualitative researchers focus on the premise that "Reality is a multilayered, interactive, shared social experience that is interpreted by individuals" (McMillan & Schumacher, 2006, p.315). In contrast, quantitative research focuses on the relationships between different variables and uses specific questions to obtain measurable and specific data (Creswell, 2005). Qualitative research designs focus on using general responses and establish general meanings based on the responses. Quantitative research uses numerical data to focus on the causes and changes in specific settings. Qualitative research focuses on unique details and interpretations based on the participants' specific perspectives (McMillan & Schumacher, 2006). A mixed-

method is applicable to research consisting of multiple complex levels requiring a combination of research methods to address the problem (Hesse-Biber & Leavy, 2010).

Site Selection

The context of the study was UAE SEHA governmental hospital in Abu Dhabi. Among the private and governmental hospitals, the government hospitals are chosen for the study as the nursing graduates were recruited and posted in governmental hospitals and the and the private hospital recruiting the new nursing graduates are still underway. Also, the study was specifically focused on SEHA hospitals only. There were 6 hospitals that were contacted to obtain permission for data collection for the study and out of which, 5 hospitals provided permission and ethical approval to proceed with the study and one hospital declined access. So, the data was collected from 5 hospitals in the emirate of Abu Dhabi.

Among the hospitals participated in the study, the highest participation was from Hospital A, where 49 (47.1%) of the participants were from Hospital A, followed by 19 (18.3 %) of the participants from hospital C, 18 (17.3%) of them participated from Hospital D, and from hospitals B and E there were 13(12.5%) and 5(4.8%) of the participants respectively.

3.2.2 Population, Sampling and Participants of the Study

The population is defined as the people or items with the same characteristics that are primarily the focus and desire to be explored and understood and to get insights (Creswell, 2003), but studying about all of the people or items with the common characteristics related to the study is not practically possible, careful sampling is necessary. The population of this study are the

hospital nursing personnel that includes the preceptors, charge nurses, unit managers, professional development nurses, Assistant Director of Nursing and Chief Nursing Officer. The aim was to find a sample that would be reflective of the larger population. Field (2005) asserts that sampling would enable to identify a small group that is used to define the realities that is concerning the population.

The data collection phase of the study is critical. The data collection protocols and procedures outlined are adopted. The choice of data collection mode - mail, telephone, personal interview, or group administration is related directly to the sample frame, research topic. characteristics of the sample, and available participants and facilities. It also influences the response rate, question forms, and survey costs (Fowler, 1984; Roberts, 2007). Here in this section, the data collection method adopted for both quantitative method and qualitative method is presented.

The selection of number of participants in a study is determined by the size of the sample needed and that a larger sample from the selected target population will be appropriate and advantageous to the study (Creswell 2009). However, because it is usually not feasible to approach the entire population, the researcher selected the sample of the participants who would represent the target population. The selection of participants is dependent on the type of research conducted, the objective research and also the availability of the participants. The study employed purposeful sampling and the participants were selected based on the inclusion and exclusion criteria. Participants were from five hospitals, that were SEHA's BE (Business Entity), that received and recruited the graduates of UAE and also the ones that had the Joint commission international accreditation. Table 3.2 indicates the distribution of the participants from each of the hospitals along with the method of data collection employed and the duration of the data collection. The sample size, as illustrated in Figure 3.5, was calculated statistically

using the confidence level of 95% and a confidence interval of 5%, which computes that the total sample size is 101 out of the total population of 136 hospital personnel that includes the preceptors, unit managers and charge nurses of the medical surgical units where the graduate nurse interns had their postings as they entered the hospital after graduation.

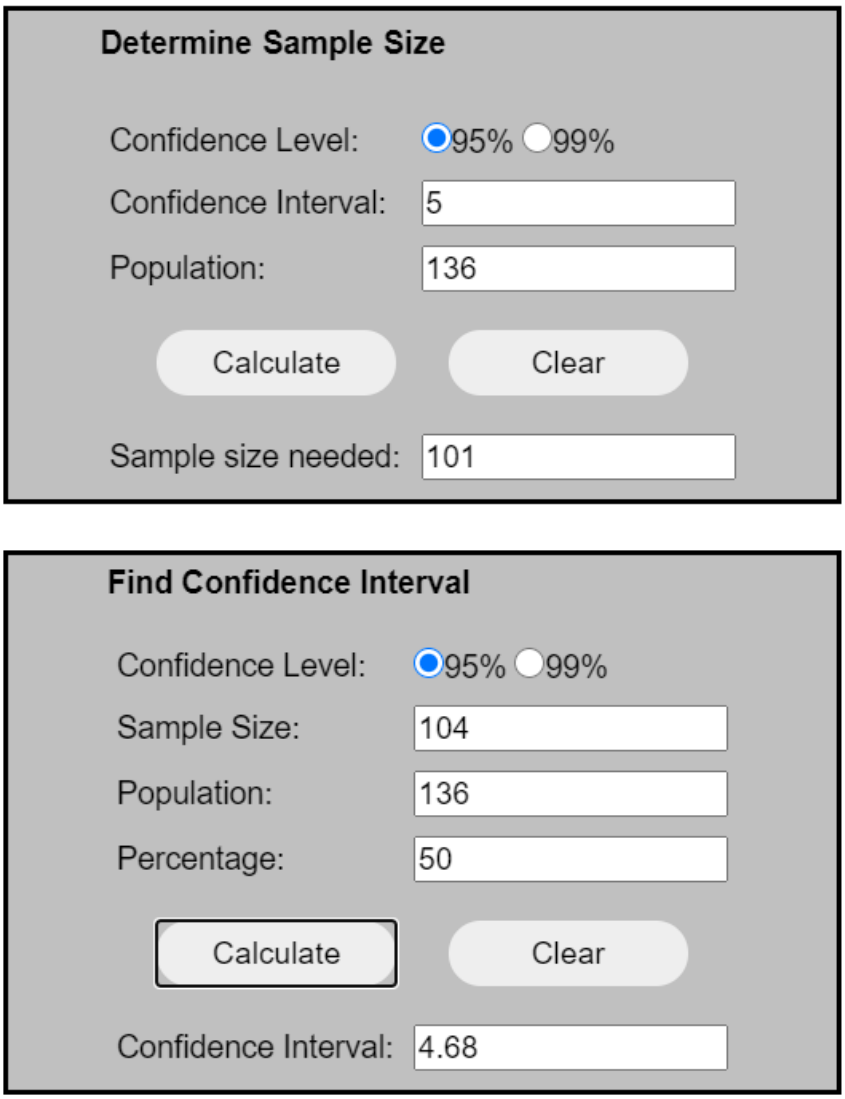


Figure 3.5 Sample size calculation, from https://www.surveysystem.com/sscalc.htm

The participants were from different job profiles that included the Registered Nurse (RN) who was the preceptor and had experience in precepting the new graduate nurse during the last two

years and working in the medical–surgical units, unit managers or charge nurses of the same units, Clinical resource nurses, who are responsible for training the new graduate nurses on entry and thereafter and the nursing department's leaders in the job profile of Assistant director of Nursing and chief nursing officers. The participants were identified as mentioned above due to the reason that the researcher recognized them to be the appropriate and immediate points of contact of personnel who would be able to provide accurate and appropriate information regarding the new nurses' competency preparedness which is the main focus of the study.

Table: 3.2 Illustration of participants' information and the mode of data collection

Participants	**Number Recruited**	**Setting**	**Mode of data collection**	**Duration**
Preceptors Nurse:	N = 80	Hospital A- 40 Hospital B- 17 Hospital C- 14 Hospital D- 5 Hospital E- 4	Survey 80 Interviews 24	10-15 minutes 30 -45 minutes
Nurse Unit Manager:	N = 10	Hospital A-3 Hospital B-2 Hospital C-2 Hospital D-2 Hospital E-1	Survey 10 Interviews 9	10-15 minutes 30 -45 minutes

Charge Nurses:	N = 9	Hospital A-4 Hospital B-2 Hospital C-2 Hospital D-1 Hospital E-0	Survey 9 Interviews 5	10-15 minutes 30 -45 minutes
Clinical Resource Nurse (CRN):	N = 5	Hospital A-2 Hospital B-1 Hospital C- 1 Hospital D-1 Hospital E-0	Survey Interviews	10-15 minutes 30 -45 minutes
Nursing Hospital leadership ADON +CNO	N = 7+2	Hospital A-3+1 Hospital B-2+1 Hospital C-Nil Hospital D-Nil Hospital E- 0+2	Survey 0 Interviews 9	10-15 minutes 30 -45 minutes

Preceptors: The Registered Nurse who was working in the medical-surgical unit and supervising and teaching the new Graduate nurse interns are addressed as preceptors. This category of nurses was chosen as the participants of the study because the preceptors are the closest contact with the new graduate, and they can reflect on the competency preparedness of the graduates accurately. They also play a major role in topping up the skills confidence and knowledge of the new graduate who enters the health care setting and developing them into an

independent, competent nurse. The inclusion criteria for the nurse preceptor was that they were serving as a preceptor for a minimum of two years, had a GNI under their supervision in the last two years, and working in the medical-surgical department. The exclusion criteria were being a nurse preceptor for less than two years, had not been supervising and teaching the GNI for the past more than two years, and those who were not in the medical–surgical department.

Nurse-Unit manager: A Nurse-Unit manager is a middle manager who is responsible for the patient care unit and has the staff nurses report to them and accountable for the operation of the unit. A nurse manager was defined as a first-line manager (a nursing unit manager) who was working between nursing administrators and nursing staff in the context of the UAE. The unit managers decide and recommend to retain the new graduate in the unit based on the actual level of competency exhibited by the new graduate nurse in comparison to the expected level of competency. They usually deal with the health care professionals in the unit, patients and their families, the staff of the unit. That is the major reason to include the unit managers as a participant for the study. The inclusion criteria for the Nurse-Unit manager is that they were working in the medical–surgical department and had new graduates in their unit within the past two years. The exclusion criteria was that they were not in the medical-surgical unit and had no experience dealing with the new graduates in the unit for the past two years.

Clinical Resource Nurse (CRN): A Clinical Resource Nurse is a member of a healthcare organization who provides post-licensure education to nurses who work in healthcare facilities and instill the skills and knowledge needed to provide the best possible care to their patients. The training and education provided by them include areas related to staff development concerns, in-services education, continuous professional development, and transition to professional practice within their facility are devoted to teaching nurses (Burns & Poster, 2008)

(Brennan & Olson, 2018). They are the group of nursing professionals who would closely monitor the progress of the new graduates by receiving periodic and regular feedback from the nurse preceptor and the unit managers and also conduct competency evaluations for the new graduates and also for the nursing staff in the units. This is the reason they were identified and included as the participants for the study. The inclusion criteria for this group of participants were, they should be the CRN for the medical and surgical units and have had new graduate nurses posted in the medical-surgical unit and had been closely monitoring their progress and receiving feedback about the new graduate within the last two years.

Nursing Hospital leadership: Nursing leadership is the nursing leaders in the health care setting with the title of Director of Nursing, Assistant Director of Nursing, and Chief Nursing Officer. The inclusion criteria were those nursing leaders who held one of the mentioned titles in the hospitals of SEHA, had received JCI accreditation, and also received GNI from the universities in UAE. The exclusion criteria were the nursing leaders who belong to the private hospitals, as those hospitals did not yet receive JCI accreditation, and those that did not receive GNI for the past two years.

3.3 Instrumentation

Gathering data about the practice preparedness can be achieved by utilizing the competency preparedness measurement tools like Casey Fink Casey-Fink Graduate Nurse Experience Survey (*Nursing Practice Readiness Tool*, no date; Casey et al., 2011). Nurse Resident's Readiness for Entry Into Practice Competence Questionnaire (Goode et al., 2009), Performance Based Development System Assessment from Finnbakk et al. (2015), California Critical

Thinking Skills Test "California Critical Thinking Skills Test (CCTST)," 2019), Basic Knowledge Assessment Tool (*The MED-SURG BKAT*, nd) by Toth (2008), Nurse Competence Scale from Meretoja, Isoaho and Leino-Kilpi (2004) and The Nursing Practice Readiness Tool (NPRT) (Virkstis et al., 2009).

While carefully examining the appropriateness of the instrument to be used to answer the research question of the study, The Nursing Practice Readiness Tool (NPRT) was found appropriate to gather data about the competency preparedness among the new graduate as perceived by the hospital nursing personnel. The qualitative aspect of the study was conducted by conducting interviews. The preceptors with whom the graduate nurse interns were posted and the unit managers of the units where the graduate interns were posted were chosen to collect data. The tool was developed by researchers given by Virkistis et.al. (2009) to explore and understand the concern about practice readiness. The tool was developed after the crosswalk of many models and frameworks including the QSEN competencies. It also has incorporated the data from interviews with nationwide academic leaders and nursing service leaders. The validity and reliability tests have yielded a positive result. The author of the tool has also performed psychometric tests (Wright, A.P., 2014).

3.3.1 The Nursing Practice Readiness Tool (NPRT)

The tool consists of two parts: Part I to collect demographic data and Part II to collect data regarding their perceptions about the graduate nurse interns' competency preparedness and job readiness including the TJC and QSEN competency domains. It has two parts, that includes the perception of the preceptor in regard to the current level of competency preparedness of the new graduate nurses and also the expected competency preparedness as perceived by the

participants. The tool includes forty-three (43) key nursing competency statements. Permission was obtained to use the tool and to modify it slightly after which the reliability and validity were checked during the pilot study. (Appendix-2a).

The Nursing Practice Readiness Tool (NPRT) (Appendix 1) was developed by the researchers Berkow and Virkstis (2009) in affiliation with the Nursing Executive center in the USA with the primary goal to enhance more focused and evidence-based discussion among the academic and the hospital-based nurse leaders regarding the new graduate preparation (Verkstis et al, 2009). More than 5,700 surveys were done involving hospital personnel such as preceptors and nurse leaders requiring respondents rating the new nurses' competency preparedness. Among the academicians from the nursing universities, more than 400 universities' deans, directors, and the department chairs and faculties also had participated in the survey using the tool, and thousands of the nursing leaders in both academic and the hospital setting has vetted the survey tool over some time. The tool is intended to obtain new graduate nurses' competency preparedness in 36 key competencies. According to Virkstis (2012), the NPRT was developed by the researchers after consulting multiple models, tools, and AACN's (The American Association of College of Nursing) essentials of Baccalaureate Education, and QSEN (Quality and Safety Education for Nurses) competencies. Furthermore, with the consent of the Nurse executive council, the researcher of the study, modified with a crosswalk between the JCIA (Joint Commission International Accreditation) standards, UAE RN scope of practice, Entry-level skills of GNI of UAE hospitals to capture the new graduate's competency preparedness which will be specific, actionable and reflective to the current needs of the Hospitals in UAE, including 45 key competencies.

The NPRT that was used for the study is categorized into six competency domains, namely Clinical Knowledge, Technical skills, Critical thinking, Communication, Professionalism, and management of responsibilities and with six competency statements included under the Clinical Knowledge domain, Technical skills domain comprises 11 competency statements, Critical thinking domain comprises eight competency statements. Six competency statements are included under the communication competency domain, Professionalism includes six competency statements, and management of Responsibilities comprises six competency statements. The tool uses a point and the participants are asked to mention their stand concerning the current competency preparedness of the new graduate nurse on entry to practice and the expected competency preparedness for the same competency statements. The participants were asked to respond by circling or marking for those who preferred to have a hard copy of the tool. For those participants who requested an online copy of the tool, it was sent to their email and the response was captured with the click of the aspects that they choose to respond to.

The tool has a Likert scale with levels of competency intended to capture from non-competent, less competent, moderately competent, very competent, and excellently competent which is corresponded to the levels of competency preparedness as in Benner's Novice to the expert model of skill acquisition which is consulted in this study. 'The Non-competent level' is equivalent to the 'Novice' where the graduate nurse intern has no practical experience and so no background understanding of them can only work under supervision. 'Less competent level' is equivalent to the 'Advanced beginner', where the new graduate nurse has enough experience to recognize patterns and begins to set priorities and can change her/ his approach according to the needs of individual patients. Still needs supervision. The 'moderately competent' is equivalent to the 'Competent level' in which the new graduate nurse is organized

and efficient and thus able to consider issues and plan dynamically. Not needing supervision for routine practice, the GNI seeks help from others as needed.

The ‘Very competent’ level is the ‘proficient’ level. Here, the GNI can view issues holistically rather than in parts and intuitively knows due to a deep understanding, clearly modifies plans as dynamics change, and can advise others. ‘Excellently competent’ is equivalent to Expert: GNI intuitively understands because of extensive experience as theoretical and practical knowledge was tested and developed in real-life clinical situations. She has a deep background of understanding in clinical situations and can also teach (Murray, Sundin & Cope, 2019). For better understanding and clarity, the same information was provided along with the directions to fill the tool and also as the footnote in the tool, and besides, explanation about the same was provided to all participants before the tool was administered.

The Psychometric testing of the NPRT was carried out by the author of the tool which was tested with 850 nurses at seven institutions yielded a Cronbach’s alpha coefficient of 0.972. this is called as composite reliability also called as construct reliability. The split-half reliability analysis yielded reported by the author of the tool is 0.916. the alternate forms reliability was checked using different tool and comparing the responses , inter-rater reliability was checked allowing three of the hospital personnel after explaining to them about the data collection process and the instrument and the results were compared. The validity was also established through researchers reviewing the competency statements with the nursing experts until the consensus was reached and did not have to make any revisions. (Virkstis, 2012). The NPRT was modified with the consent of the author and two versions were used as per the research question and the purpose of the study which was later combined as a single tool following the pilot study and feedback from the nursing experts from both academic and hospital nursing

leaders and from a different level of hospital personnel to suit the context of study, which will be the UAE. Regarding the construct validity, the confirmatory factor analysis with the main study data was done along with convergent and discriminant validity.

Table: 3.3 summary of validity and reliability of the instrument

Criteria	Status	Action Taken
Validity		
Content Validity	✓ Done	Expert Review
Construct Validity	✓ Done	Confirmatory Factor Analysis, Convergent & Discriminant Validity
Criterion-related validity	✓ Done	Using different instrument
Reliability		
Internal consistency reliability	✓ Done	Composite Reliability, Cronbach's alpha-: 0.9 The split-half reliability analysis -: 0.916.
Alternate forms reliability	✓ Done	Using different measurement scale
Inter-rater reliability	✓ Done	Using a personnel from the hospital

The convergent validity is known as the subtype of the construct validity. The construct validity is a means to test the construct, here in this tool it implies to test if two competency statements that are supposed to be measuring the same construct shown as they are related. Conversely, the discriminant validity shows two measures or competency statements that are not supposed to be related are in fact, unrelated. Both types of validity are required for excellent construct validity (Netemeyer, 2003).

3.3.2 The Semi-structured Interview

As a part of qualitative data collection, the semi-structured interview was opted to provide in-depth answers to the research questions of the study. Conducting interviews allows flexibility and facilitates a high response rate. (Ainsworth, 2020; Auver, 2012). This study is interesting, vital, and in need of the hour as it throws light on the critical aspect to provide safe nursing care. Interviewing has become a widely used data generation tool that provides in-depth information about the aspect explored. In-depth semi-structured interviews were conducted among the hospital nursing personnel comprising unit managers, Clinical resource nurses, Assistant director of the nursing department, and the Chief Nursing Officers of the hospital. This conversational approach in collecting data enabled the participants to provide in-depth responses and also it serves as an opportunity to clarify the question and also restate the question as per the understanding of the participant (Whitehead, n d). The interviews began by asking the participants a general open-ended question regarding their perception about the competency preparedness followed by other questions of the semi–structured interview guide and also the questions based on the participant's statements and responses. In addition, some supplementary questions like, 'would you elaborate more on this?' and 'what do you mean by this?' were also utilized based on the participant's responses.

The interviews lasted for 45 minutes to 60 minutes, in which the participant was pleased and more than willing to discuss the topic and the questions asked in the interview, as they mentioned that it was their area of interest and need and would willingly discuss the same. The interviews were digitally recorded and transcribed verbatim to proceed to analyze them. The transcription of the data was done at the end of the interviews and on the same day. It also facilitated immediate and concurrent data analysis (Baldwin et al., 2017).The interview initiated with the umbrella statement. "I would like to discuss with you about the competency

preparedness of new graduates of UAE" followed by an open-ended question like "what is your perception on the level of competency preparedness of the new graduates of UAE?" probing questions raised from the answers received which elicited further in-depth answers and continued with other interview questions as the conversation evolved and progressed.

Data collection and data analysis were done concurrently from the beginning of data collection. In this study, to better understand the aspects of competency preparedness, individual interviews were carried out face-to-face in a convenient place in the hospital during different shifts of the day based on the willingness of the participants. Interviews were conducted with various level of participants in each hospital, until the data saturation was obtained in the each of the specific hospital. This method of performing the data collection and analyzing it concurrently and comparing with the previously collected data and trying to categorize them into themes and sub-themes are called constant comparative analysis by Boeije (2002), this method is also widely used in studies involving grounded theory and also when multiple researchers are involved in the study to improve the interceding reliability(Kolb, 2012; Klose & Seifert, no date).

The interview process was conducted with the consultation of Knowles's andragogy theory (1984) as outlined in Figure: 3.6. The interview guide of the questions is developed (see Appendix B); however, the probing questions were asked from the answers received from the participant. The interview guide facilitates to explore the perceptions of the participants furthermore to obtain a deeper understanding of the competency preparedness and the practice expectations in relation to QSEN competencies and JCIA standards, among the graduate nurse interns.

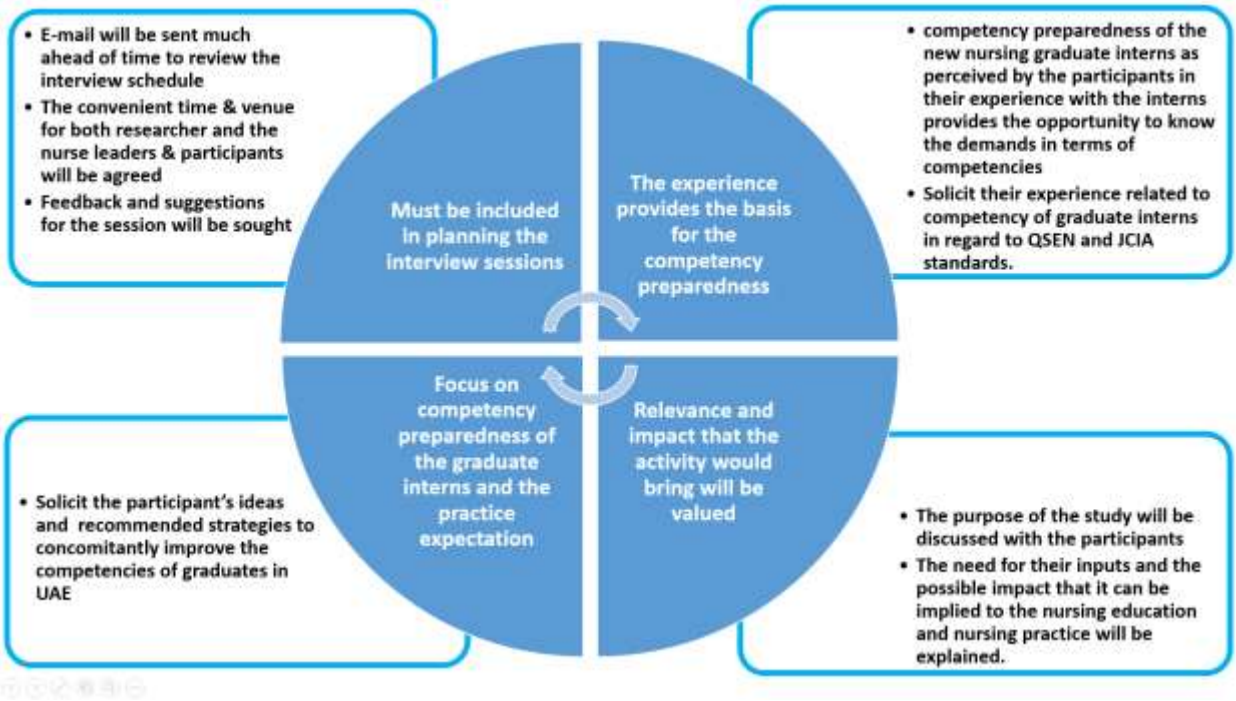


Figure 3.6 : Interview structure in consultation with Knowles's (1984) adult learning theory

The qualitative data obtained during the interviews were transcribed soon after the meeting. The transcripts were checked again with the recording and also checked again with the participants to ensure information accuracy. The data analysis was started after the first interview and done concurrently after every interview till the last interview until the data saturation was obtained. NVIVO 12 software was also used for analysis. Data saturation is used in research and has been accepted widely as a methodological principle in a qualitative study (Nascimento et al., 2018). It indicates that based on data collection that the data collected and analyzed so far is enough and further data collection and analysis is unnecessary further (Cooksey, 2020). Saunders et al. (2018) highlight that saturation should be obtained and operationalized in a way that is consistent with the research questions, theoretical position, and the analytical framework adopted and should not lose coherence and potency.

The data analysis in a qualitative study is predominantly carried out by performing thematic analysis. It is the method of identifying, analyzing, and reporting the patterns termed as themes within the data. Though it organizes and describes the data set, more importantly, it interprets various thematic analysis and highlights the rationale behind various decisions regarding the study and its method (Brule, 2020). The study followed Braun and Clarke's (2006) six steps of thematic analysis to perform the qualitative data analysis as illustrated in Table. 3.4.

Table: 3.4 Illustration of application of the 6-step Guide to Good Thematic Analysis of Braun and Clarke (2006).

Steps	**Procedure for Each Step**
1.Familiarization	Transcribing: soon after the interview, the data was transcribed, compared again with the recording, and checked the accuracy, reading, and re-reading; noting the initial codes.
2.Generating the initial codes.	Coding the interesting and the significant features in the data systemically along with the data set, collating data relevant to each code.
3.Searching for Themes	Collating and grouping the codes into the potential themes, gathering all data relevant to each theme.

4.Involved Reviewing Themes.	Checking if the themes are related to the extracted pieces of data that are coded in the complete data set to generate the thematic map.
5.Defining and Naming the Themes.	Ongoing analysis to refine the specific characters for each theme and clearly naming the theme appropriately.
6.Producing the report	The final opportunity for analysis selecting the appropriate extracts, discussing of analysis, related to the research question or literature; produce the report.

The first step was “familiarization with the data”, the data that was obtained from the interviewing of the preceptors, unit managers, clinical resource nurses, Assistant Director of Nursing, and the Chief Nursing Officers were transcribed and then read multiple times to become familiar with the data. The second step is “coding”, the researchers labeled and coded with specific short forms and color-coded the important concepts that were identified. The coding process helped the researcher to identify and categorize discussions directing towards answering the research questions. The researcher then collated all the identical codes and appropriate data extracts together. The third step was “searching for themes” the researcher gathered the codes and identified potential themes. The researcher then “Reviewed the themes” and “Named them”. These steps guided the researcher to be consistent in grouping the extracts in the appropriate theme and also naming the collated coded data consistently. The final step

was “writing up” which involved merging the review from the analytical narrative and the extracts of data.

3.4 Data Analysis

The data that were obtained for answering the research questions were both quantitative and qualitative data and analyzed using the SPSS Version 26 and presented as descriptive statistics. Concerning the qualitative data that is obtained is analyzed and categorized into different domains, which will provide the researcher, the gap that is present by the hospital personnel regarding the level of preparedness of competencies. The response data that was obtained using the instrument were in both paper-based and online surveys to enhance the maximum response rate. The responses from the paper-based tool were transcribed into a Microsoft Excel sheet and then coded electronically into the SPSS 26. There were only 1% missing data found that was not included in the study. It is vital to ensure that the quality of the data is good before proceeding to the analysis as the quality may influence the result and the interpretation thereafter (Jaya et al., 2017). The demographic variables and the perceptions of the subjects were critical to the findings in this study.

The response data that was obtained using “The Nursing Practice Readiness tool” utilized descriptive statistics including frequencies, measure of central tendencies also called as averages, means, percentages, and standard deviations. To summarize the demographic data, the researcher needed the information about how many times a particular variable occurs, and also along with the frequency the percentage is also used to represent the variables related to the personal information. As it was discrete data, where the participants could tick or click like gender that has categories of Male /Female, educational qualifications with the categories of

diploma, degree, post-graduate diploma, masters, and doctorate. For the readers, percentages are easier to understand than the frequencies, as the frequencies will not provide much meaning as there is no reference point, so calculating the percentages are calculated here along with the frequency statistics (Cooksey, 2020). In addition, the APA standards require the researchers to report the descriptive statistics even for those studies that primarily focuses on the inferential statistics. Owing to the requirement the researcher calculated the means and standard deviations for the variables that are involved in this study. The means indicate the summary of the variables across the study and the standard deviations were calculated by the researcher to understand and highlight how much each participant varied around that mean.

In the second part of the questionnaire, the respondents circled or marked in the paper and pen-based questionnaire and the level of competency preparedness currently observed in the new graduates and the expected competency preparedness for the same competency statements and respond by circling or marking as before. The tool has a Likert scale with levels of competency intended to capture from Non-competent, less competent, moderately competent, very competent, and excellently competent which were analyzed using SPSS. Version 26.

The second set of data collected is analyzed to find the t value. The t score is the ratio between the perceptions that as expressed by the participants as the current and expected competency preparedness of new graduates. The larger the t score, the more difference is between the data provided as expressed by the participants which will indicate the gaps in the competency preparedness in relation to the competency statements under the six different domains. The smaller the t-score, the more similarity is indicated among the current and expected competency preparedness, where the inference would be that the new graduate nurses are prepared as expected related to the competency preparedness. The t test indicates the difference between

groups and also it further indicates the researcher the probability if those differences that is measured in means could have occurred by chance with a p- value that accompanies every t-value. The low p- values are good as it will indicate that the data did not occur by chance. Here in this study, the researcher will analyze the paired sample t-test, which will compare the means from the same participants expressing their perception in relation to the current and expected competency preparedness among the new graduate nurses.

3.5 Delimitation

The study is new to the field of nursing education in this part of the world. As the nursing profession and the education system is still in the developing stage, the proposed study is intended to provide inputs that would encourage the nursing academic field to plan strategies to improve competency development based on the results of the study on the level of preparedness and the expectations as perceived by the hospital staff, who is one of the vital stakeholders in the nursing education. The study will unravel the expectations and the importance of integrating the Joint commission international accreditation standards and the Quality and safety for nursing education competencies in the nursing curriculum. The educators in the nursing academic field can draw the insight and propel towards developing the graduate nurses who are job-ready and can hit the floor to run at the earliest in terms of being prepared in the expected competencies at the entry-level.

The study can also be an initiative to bridge the theory and practice gap, where the researcher has been in the dual role in the academic field and practice field will be able to recommend the strategy for both the arenas. The future cohorts of graduates can be benefited by being practice-ready. This in turn will, directly and indirectly, decrease the turnover rate and also the number

of graduates leaving the profession due to reality shock at the time of internship period, where the performance is not able to meet the demand in the service sector of the hospitals. The researcher intended to prepare a consolidated list of entry-level competencies and later would undertake the responsibility of preparing the entry-level competency standards and practice measurable elements document and recommend to the UAE nursing and midwifery council to be adopted in the colleges of nursing in UAE.

Further scope of the study is presented below under the categories of purpose, population, samples, duration, and geographic location /setting. The purpose of the study was to explore the level of satisfaction among the hospital personnel in the nursing field regarding the competency preparedness of the new graduates from the universities of UAE only. The population and the sample of the study include the hospital personnel of the department of nursing that includes the registered nurses, unit managers, clinical resource nurses, ADON's and chief nursing officers of the hospital in SEHA in the emirate of Abu Dhabi, United Arab Emirates.

The study was initiated in the year 2018 with the data collection started in 2019 and until September of 2020. Further to the period, the data collection was discontinued as the researcher felt that the batch of students who would join the hospitals as new graduates would have had their clinical training and learning influenced by the COVID 19 pandemic situation, so the perception of the preceptors on the competency preparedness of new graduates from UAE who joined after September 2020 were exempted from the study. Due to various logistics that were involved in the accessibility, it was difficult to obtain permission to conduct the study in the other emirates, hence the study was limited to Abu Dhabi emirate only including the hospitals in the areas of Abu Dhabi, Al Ain, and Al Dhafra.

3.6 Pilot Study

The pilot study was carried out before the main study with twelve preceptors, two-unit managers, and two nursing leaders. Ismail et al. (2017) affirm that the pilot study is a small-scale research project carried out prior to the full-scale study. It is intended to help the researcher to test in reality how the research process is practicable and enhances the decision about carrying out the study in the best possible way to arrive at an answer to the research questions of the study. The purpose of the pilot study is conducted to refine the methodology (Williams, 2019). During the pilot study, the survey tool, The Nursing Practice Readiness Tool (NPRT), purpose of the pilot study was to calculate the internal survey consistency, check the adequacy of data collection tools, determine if the tools answered the posed questions, and decide if the terms required any clarifications. Conducting the pilot study was an essential step to ensure clarity of the instrument's questions, eliminate ambiguities or difficulties in wording, assess the time taken to complete the instruments, and identify the items that could be misunderstood or may not be answered (Ismail, Kinchin & Edwards, 2017).

The feedback received from the participants required few modifications in the tool like it is time-consuming and they felt some were repeating, though under different domains and some competencies were removed recently from their scope, so the modifications included minimizing the tool's competency statements from 60 to 45 and the "Naso-gastric tube insertion which was a part of competency statement was removed. The internal consistency of the survey items was measured by calculating the Cronbach's alpha as shown in (Table 3.3) for the 43 items measuring the level of satisfaction and the degree of perceived and expected competency preparedness on entry to practice.

The 43 competency statements are categorized under different domains of clinical competencies as in the below table 3.3 as Clinical Knowledge with six competency statements, Technical Skills with 11 competency statements, Critical Thinking with eight competency statements, Communication with six competency statements, Professionalism with six competency statements and Management of Responsibilities with six competency statements. Cronbach's alpha for each of these categories was calculated separately for different aspects of capturing data like measure 1 indicates the values for the data indicating the current satisfaction level of the participants regarding the competencies of the new graduates on entry to health care setting. Measures 2 and 3, indicate the data that is collected to explore the perception of current and expected competency level of new graduates respectively. Also, the interview questions did not capture the complete data and the participants appeared to be not following the question, so the researcher modified the interview questions to add more clarity.

The reliability statistics for expected and current level of competency for the pilot study are presented in Table 3.5 The reliability statistics for the current level of competency, where the Cronbach’s alpha for the domains is listed down. For the domain, clinical knowledge with six competency statements, the Cronbach’s alpha was 0.78, for the technical skills consisting of eleven competencies and the critical thinking domain with eight competency statements, followed by communication skills domain with six competency states had the Cronbach’s alpha value is .935 .895 and .873 respectively. The Cronbach’s alpha value above 0.7 assures reliability. Here in the pilot study data that was used to compute the Cronbach’s value was between 0.7 to 0.9 indicating reliability. The last two domains of professionalism and management of responsibilities with six competency statements each presented with the value of 0.9 indicating high reliability.

Table: 3.5 Pilot Study Reliability Statistics

Reliability Statistics: Perception of Current level of Competency

Competency Domain	Cronbach's Alpha	N of Items
Clinical Knowledge	.783	6
Technical Skills	.917	11
Critical Thinking	.864	8
Communication	.753	6
Professionalism	.842	6
Management of Responsibilities	.929	6

Reliability Statistics: Expected Level of Competency

Competency Domain	Cronbach's Alpha	N of Items
Clinical Knowledge	.884	6
Technical Skills	.935	11
Critical Thinking	.895	8
Communication	.873	6
Professionalism	.946	6
Management of Responsibilities	.925	6

The reliability statistics for the pilot study data of the expected competency level indicate that all of the domains with its competency statements have Cronbach's alpha ranging between 0.8 to 0.9, indicating that the data is reliable as the value is above 0.7 as presented in Table 3.3. A confirmatory factor analysis was performed to check the positive correlation of the variables to their respective constructs. The reliability and validity for the quantitative data of the main

study will be checked using construct validity where the correlation of the variables to their respective constructs and the uniqueness among the different constructs are checked using convergent validity and discriminant validity respectively. Utilizing convergent validity and discriminant validity along with reliability checks that includes Composite reliability and Cronbach's alpha which will be given in Chapter 4.

To find the trustworthiness of the qualitative data, and to validate the data, the transcribed manuscripts were reviewed multiple times. The data coding process was reconducted by some field experts and the whole process was reviewed by some field experts. Extracted codes were reported and discussed with the participants and agreed upon. In order to obtain any variability, the data that were coded and subthemes and themes formulated, the scripts of the interviews, extracted codes, sub themes and themes were validated by colleagues and field experts who were not present during the data collection and transcription and the data coding process was accurately evaluated. In addition, dedicating sufficient time to collect data from appropriate personnel focusing on the objective and the research questions along with partial impartial view further adds to the reliability of the research. In order to maintain the generalizability across various other environments, the results of the research were presented to a number of nursing personnel in the different hospital settings, and also to academic educators in different nursing institutions who had not participated in the study, and they were asked to review and judge the similarity between the results of the research and their own experiences.

3.7 Reliability, Validity and Trustworthiness

The data trustworthiness has four key components: credibility, transferability, dependability, and confirmability (Taherdoost, 2016). Credibility, as a general concept,

covers trustworthiness and expertise. Credibility is an important factor to determine trustworthiness. It refers to if the study findings are accurate and reflect the perception of the participant (Ginsca, Popescu & Lupu, 2015). To maintain the credibility in this study, the researcher discussed the findings with some of the participants to ensure that the participants' perception of the competency preparedness of the new graduates was captured accurately. Also, the researcher's experience as a nursing administrator and recruiter and chief nurse educator for the city in a state of India for one of the premiere corporate hospitals. Researcher is also a registered Nurse and academician of one of the top 10 hospitals across the globe where the institution is known globally for their effective nursing education and optimum competency preparedness of the graduates have guided the researcher to be engaged in-depth in the study and also in the data collection to explore far and wide on the topic with accuracy and reliability.

Transferability refers to how much of the findings of the study can be applied or generalized to other groups or contexts (Hellstrom, 2008). In this study, the transferability was addressed by providing a detailed description of the interviewed participants (Creswell et al., 2007). The demographic data were presented and discussed to help the readers understand the context of the study, characteristics of the participants which will enable and enhance the readers' decision to utilize the study findings and compare them to a similar context. Dependability refers to the stability of data over time and conditions (Lishner, 2015). It further refers to the consistency and reliability of the research findings and the degree to which research procedures can be reviewed by the readers' any time (Funder et al., 2014). In this study, a clear description of the study purpose, design, and participants were presented, which may help other researchers to replicate the study in a similar context and obtain similar results.

Besides, dependability was established using time, person and space triangulated along with some peer and senior faculty members who also reviewed the findings to maintain the objectivity of data (Creswell et al., 2007). Conformity is the answer to how the findings of the study have been determined by the subjects and the context of the study, overcoming the biases, motivation, and perspectives of the investigator Guba (1994), which was restated by many other researchers in different terms meaning the same trustworthiness (Tobin & Begley, 2004; Cialdini & Goldstein, 2004). The conformity in this study was established by conducting 42 interviews to achieve adequate data that provided in-depth data encompassing all aspects holistically to provide a meaningful and accurate interpretation. The data was precisely transcribed as stated by the participants. Also, maintaining the findings' credibility and transferability served to establish the additional data conformity (Ginsca, Popescu & Lupu, 2015).

To utilize the findings to enhance the nursing education in the UAE to produce BSN graduates with the required competency preparedness, certain steps detailed below were taken. Firstly, the appropriate tool was chosen, and it was modified with the author's permission and the content validity was assessed by consulting with the expert panel. Although the suggested number of content experts varies between the authors, Lynn (1986) and Zamanzadeh (2015) suggest at least five experts could be sufficient to ensure content validity. The expert panel was determined by certain characteristics like experience with the new graduate nurses, professional certificate in nursing, significant years of contribution to the field of nursing, and holding a prestigious title or role in the field of nursing as below and they were requested to review the modified tool, highlighting the modifications done. They were asked to review the tool, the modified part in particular, and comment on the relevancy and clarity. The reviewed document included comments like, "*good, essential, not essential, to be modified, to be*

reworded, it's ok and good to go". Three rounds of the review were done until the reviewers did not have any comments requiring change. Secondly, an extensive review of the literature on new graduate nurses' readiness to practice was done. Thirdly the researcher performed a pilot study to check the survey and interview questions' validity and practicability.

3.8 Ethical Considerations

In the study, before the conduction and proceeding to the data collection, the ethical clearance was obtained from SEHA-HAAD (Health Authority of Abu Dhabi). The survey tool and the process were reviewed and endorsed by the institution review board of SEHA- HAAD (health authority of Abu Dhabi) and individual ethical approvals were obtained from three hospitals individually and other two hospitals accepted the SEHA-HAAD approvals and the ethical approval from other three hospitals and communicated through email, their approval to proceed with the data collection in their hospital. (Appendix: C). Participation was strictly voluntary. All participants were informed about the study and requested to sign the informed consent form for the paper-based data collection.

For the online survey, accepting and clicking to proceed to the survey was considered as voluntary participation after reading the description of the study and the directions to fill the questionnaire which was given on the first page of the study. Clear communications of the intent of the study with the assurance of anonymity and reporting of aggregate results were also mentioned. The following principles will be applied: Confidentiality and anonymity – for the quantitative part of the study a number would be assigned to each participant: during the qualitative part of the study pseudo names/code numbers assigned, will be used; Voluntary participation, no external pressure would be conducted, and a participant can withdrawal from

the study could happen at any time; No incentive for participation will be promised to participants.

There was no foreseeable risk, or any form of harm involved in the study as the study was intended to explore their perception of the competency preparedness of the new graduate and moreover, the study did not involve any intervention. However, it is taken into consideration that there might minimally discomfort in an effort to answering the questions in the survey spending 10-15 minutes but does not cause any risk for activities of daily living or mental stress. If the participant felt any stress or strain in filling the questionnaire, it was open for them to discontinue to participate in the survey at any stage of answering the survey.

If the participants expressed any concerns, it was immediately attended to, like providing an office room away from their workplace or accepting to do the survey, not during the workdays or their off days and in some particular shift duties, etc. some participants who had concern mentioning any identification details were also respected. The data sheets obtained were coded with numerical and alphabetical codes indicating the hospital. concerning the data protection and retention, the data sheets were only handled by the researcher and no one else. The online survey response data and the data entered in the excel worksheet stored encrypted with the password and access to others were denied. All the paper-based survey tools were kept under strict security in a locker that is well secured in the researcher's locked office. The data will be stored for five years from the date of publication of the study.

3.9 Summary of the Chapter

This chapter has provided an overview of the research methodology employed in this study to identify the level of satisfaction of the competency preparedness among the new graduates of UAE and also the degree of competency preparedness that was currently observed and also the expected level of competency preparedness of those competency statements mentioned in the tool. This study was guided by Benner's "From Novice to Expert". Non-experimental, concurrent mixed methods, a cross-sectional study is the research design that was utilized to obtain in-depth and valid data. Before conducting the study, ethical clearance was obtained from SEHA. The participants for the study were the preceptor nurse, unit manager, clinical resource nurse, and nursing leadership to capture their perceptions about the competency preparedness of new graduates.at the time of their entry into the health care settings. The findings will be presented in the next chapter.

CHAPTER 4

RESULTS, ANALYSIS AND DISCUSSION

Chapter 4.

Results, Analysis and Discussion

4.1 Overview of the Chapter

There is a pressing need to understand the new nursing graduates' expected competency preparedness and their current preparedness to address the theory-practice gap and bridge concerns. New graduate nurses comprise more than 10% of the hospital's nursing staff. It has already been studied and reported that the academicians also have agreed that there is much to be done to prepare the students to be adequately practice prepared, especially to be able to work in complex care environments (Berkow et al., 2008). In this chapter, the researcher will present the results and analysis for exploration of hospital nursing personnel's perception regarding the new graduates' competency preparedness on entry to health care setting. This study aimed to explore entry competency performance levels and expected competency levels from six different perspectives: nurse preceptor, charge nurse, unit manager, clinical resource nurse, Assistant Director of Nursing and the Chief Nursing Officer in the hospital.

The study's main objective was to explore the hospital nursing personnel and leadership's perceptions about the new baccalaureate nursing graduates' competency preparedness. The study's branching objectives were (i) To examine the expected level of competency preparedness as perceived by the nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders, (ii) To examine perceptions of nurse preceptors, unit managers, and professional development nurses and hospital nurse leaders on the current level of competency preparedness of new graduate nurses, (iii) To identify the skill levels and practice expectations of the new graduate nurses, which nurse preceptors, unit managers,

professional development nurses, and hospital nurse leaders perceive as most important, (iv) To identify the competencies, that nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital (v) To determine the gaps in new graduate nurses' competency preparedness and which of them are reported to have wider gaps and (vi) To determine the strategies suggested by the hospital nurse leaders, unit managers, and professional development nurses to enhance the competency preparedness and concomitant practice expectations of new graduate nurses. To explore the answers for the research objectives, the pathway for the data analysis as illustrated in Figure 4.1 was carried out.

Data Analysis Pathway

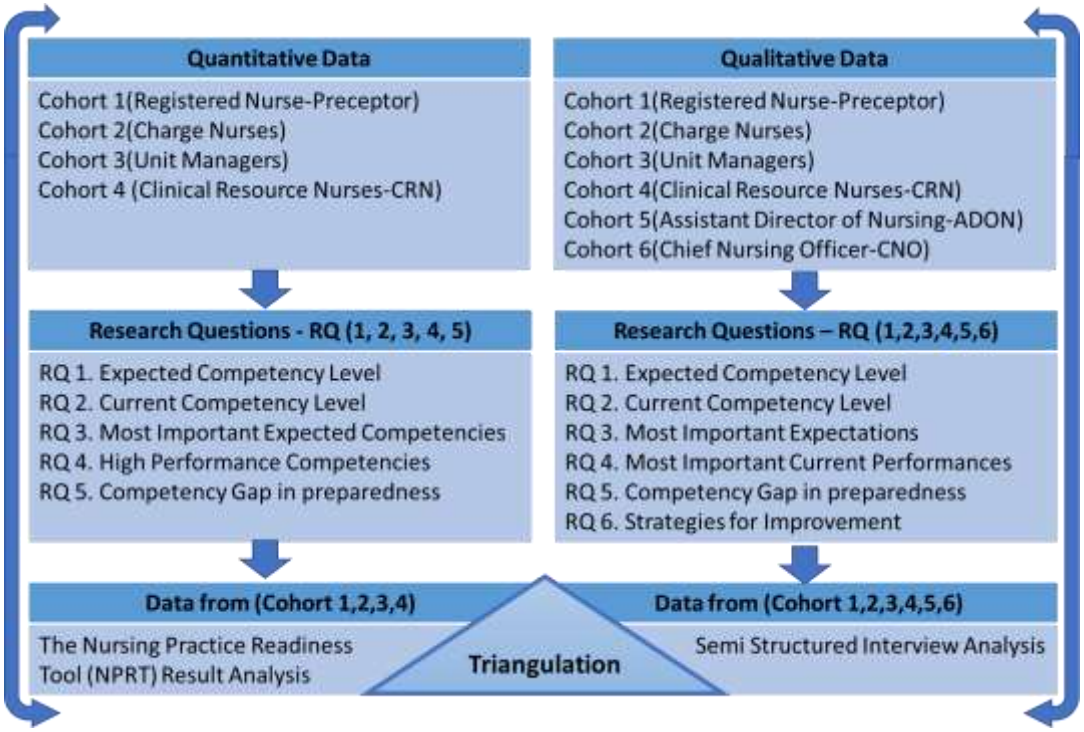


Figure 4.1: Illustration of the Pathway for Data Analysis.

The data analysis comprises analysis of quantitative data involving four cohort participants namely the registered nurses, charge nurses, unit managers and clinical resource nurses to find the answer for the questions one to five, which is mainly focusing on identifying the expected and the current competency level, on entry to health care setting, among the new nursing graduates, as perceived by the hospital nursing personnel, using the responses obtained from the Nurse practice readiness tool. The qualitative part of the study involves six cohorts, which involves two additional cohorts, the Assistant Director of Nursing (ADON) and the Chief Nursing Officers (CNO), whose responses are obtained using the semi-structured interviews, analyzed and presented in the qualitative data result analysis part, which later in this chapter will be triangulated with the quantitative findings to add credibility and validity for the data of the study.

This study adopts a descriptive, non-experimental, concurrent triangulation mixed methods approach. This chapter contains the data analysis answering the research questions presented in six sections namely, Quantitative Data Analysis Results, Summary of Quantitative Data Analysis, Qualitative Data Analysis Results, Summary of Qualitative Data Analysis, Triangulation and Summary of the Chapter. The quantitative analysis section is presented with the discussion related to the response rate, validity and reliability of the quantitative data, demographic information, quantitative data describing the critical analysis, discussion, and the interpretation of quantitative data. The qualitative data analysis section presents the response rate, analysis of qualitative data briefing with critical analysis, discussion, and interpretation. The triangulation section presents the triangulation of quantitative data and qualitative data. The summary sections provide the key takeaways of each of their respective sections. Table 4.1 shows the data analysis types employed for different research questions.

Table 4. 1 Overview of type of Quantitative and Qualitative data analysis related to research questions

Research Question.	Quantitative Analysis Type and Tests	Qualitative Analysis
1.Expected competency level	Descriptive Data Analysis- Mean	Thematic Analysis
2.Current competency level	Descriptive Data Analysis- Mean	Thematic Analysis
3.Most important expected competencies	Sorting the Mean	Thematic Analysis
4. Highest current competencies	Sorting the Mean	Thematic Analysis
5. Competencies with Gap	Important – Performance Analysis, Mean Difference and Paired t Test	Thematic Analysis
6.Strategies for competency preparedness	--	Thematic Analysis

4.2 Quantitative Data Analysis Results and Discussion

The study's quantitative component involves the data collection with the Nursing Practice Readiness Tool (NPRT), which was found appropriate to gather data about the competency preparedness among the new graduates as perceived by the hospital nursing personnel. The hospital nursing personnel includes the nurse preceptor, unit manager, clinical resource nurse, and the hospital leadership comprises nursing personnel in top management positions like the chief nursing officer, assistant nursing director in the nursing practice sector. The researcher

used this questionnaire that contained three sections: demographic data, and forty-three competency statements under six different domains, namely Clinical knowledge, technical skills, Critical thinking, Communication, Professionalism, Management of responsibilities that captures the perception of the participants regarding the current competency preparedness among the new graduates and the expected level of competency preparedness.

The data from the questionnaires that provided usable responses were imported to SPSS Version 26 and both descriptive and inferential statistics were used to analyze the data. The descriptive statistics included frequency distribution, measures of the central tendency (mean, median), variability (standard deviation) and measures of relationship (Yellapu, 2018). The parametric procedures used were: Paired t- test to find the gap between Expectation and current performance, Post Hoc One-Way ANOVA to compare the data provided by different designated sample persons and importance-performance matrix was computed to investigate the relationship between the expected performance and current performance for each competency as perceived by the preceptors, charge nurses, unit managers and clinical resource nurses.

4.2.1 Response Rate

The questionnaire was sent to a total of 104 subjects from five hospitals with cover information after briefing them about the study during their huddle in the morning shift nurses and evening shift. Each of the hospitals of SEHA in the emirate of Abu Dhabi was approached after the ethical approval was obtained from SEHA corporate office and individual ethical approvals were obtained for each of the five hospitals. Followed by obtaining ethical consent, the Nursing Education department coordinators were notified in each of the hospitals, who coordinated the

other proceeding for data collection by the researcher in their facility. In this study, participants with six different position titles were identified to be contacted for data collection, of which participants in nursing leadership titles namely Assistant Director of Nursing and Chief Nursing officer were not included in quantitative data collection. Table 4.2 summarizes the overall return rate of participants included in quantitative data collection.

Table 4.2: Summary of participants' overall return rate included in quantitative data collection

Hospital	Questionnaires Sent	Questionnaires Returned	% Returned	Excluded from Analysis	% Usable for Analysis
A.	62	53	85.4	4	79
B.	15	23	93.3	1	86.6
C.	23	21	91.3	2	82.6
D.	18	9	100	--	100
E.	5	5	100	--	100
Total	123	111	90.2%	7	84.5%

Among the 123 identified participants, who were the preceptors, unit mangers, charge nurses, clinical resource nurses and fulfilled the study's inclusion criteria preceptors, the questionnaires were distributed as paper-based copy and online survey link as per their preferences.

One hundred and eleven of them returned the questionnaires with a response rate of 90.2 %. Seven responses were excluded from the analyses as they were incomplete, mentioning only the current competency level among the new graduates, mentioning only the expected

competency level or mentioning both current and expected level of competencies for only a few competency domains out of six domains. Two were returned after the data analysis was completed and had to be excluded as in table 4.2.

4.2.2 Validity and Reliability of Data

The validity and reliability of the study's quantitative data involved performing construct validity and internal consistent reliability testing. A confirmatory factor analysis was performed to validate the validity and reliability of the quantitative data collected using the NPR tool are presented in Table 4.2. The construct validity included performing convergent validity and discriminant validity of the six different construct domains of the Nurse Practice Readiness Tool. The reliability was validated using Cronbach's Alpha test and Composite Reliability checks.

The validity informs how accurately a method measures what it claims to measure. If the method measures what it claims to measure, the results closely relate to the real -world values, then it is considered as valid. The construct validity checks if the test measures what it's intended to measure. To achieve the construct validity, it is essential to ensure that the indicators and measurements, here in this study tool it is the competency statements that need to be ensured if it is indicates and the measurements are carefully developed based on the relevant existing knowledge. The tool is a standardized instrument developed by experts and it is reviewed by the researcher by performing extensive literature review

4.2.2.1 Sampling Adequacy and Factor Analysis

The sampling adequacy and scope for performing factor analysis is established using Kaieser-Meyer-Olkin (KMO) test and Bartlett's test of Sphericity. Kaiser-Meyer-Olkin test allows us to ensure how suited the data is for factor analysis (Tseng et al., 2006). KMO Values between 0.8 and 1 would deem the sample adequate, the value was nearly around 1 as shown in Table 4. 3 for both expected and current performance data shows a strong sampling adequacy of the data obtained. The KMO test is used along with Bartlett's test of Sphericity, a different test that examines whether the data are normally distributed. The two tests together examine the distribution of the data and the sampling adequacy of each variable in the model tested, along with the adequacy of the model as a whole (Tseng et al., 2006). . The Bartlett's test results shown in Table 4.3 shows good significance level which in turn shows it favors performing factor analysis.

Table 4.3: KMO and Bartlett's Test

KMO and Bartlett's Test

		Expected	Current
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.920	.952
Bartlett's Test of Sphericity	Approx. Chi-Square	6407.957	7144.348
	df	903	903
	Sig.	.000	.000

The confirmatory factor analysis (CFA) is a statistical procedure that is used to test how well the measured variables represent the number of constructs or domains was performed to test how well the measured variables represent the number of constructs using SPSS-AMOS 26 software.

The factor analysis is considered as one of the strongest approaches to establishing construct validity (Eisenhauer et al., 2015). The confirmatory factor analysis was performed to perform the validity and reliability of the quantitative data. Confirmatory factor analysis (CFA) is the method for measuring latent variables (Fan et al., 2016).

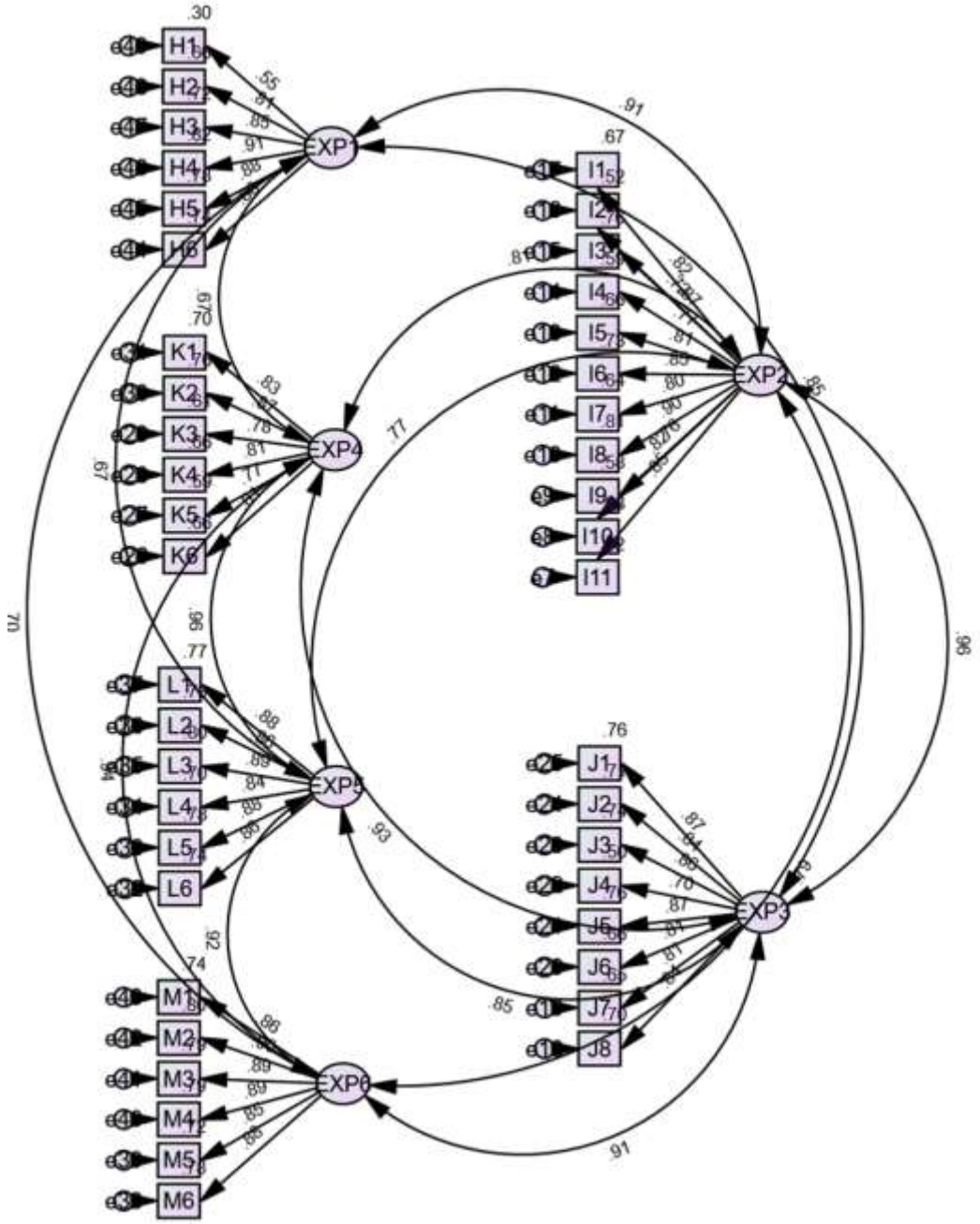


Figure 4.2: Measurement Model designed using SPSS AMOS 26 for Expected Performance showing confirmatory factor Analysis loading.

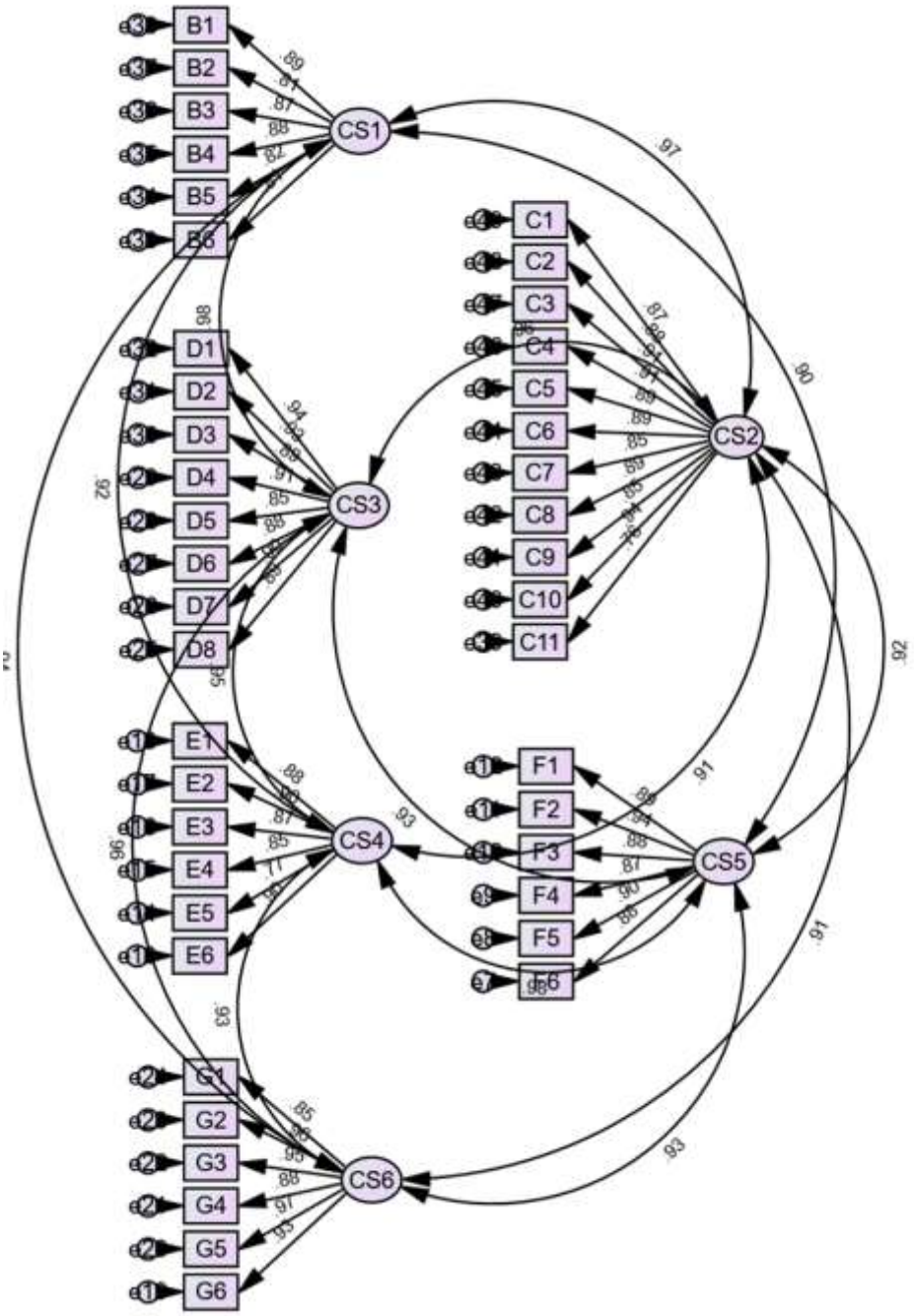


Figure 4.3: Measurement Model designed using SPSS AMOS 26 for Current Performance showing confirmatory factor Analysis loading.

The measurement model also referred as structural equation model (SEM) is powerful multivariate technique to test and evaluate multivariate relationships between the construct and the variables (Arhonditsis et al., 2006) . It is used for expected competency performance and

current competency performance designed in SPSS AMOS 26 is shown in Figures 4.2 and 4.3 respectively and the factor loading values are shown in Table 4.4. The confirmatory factor loading data was obtained by running these models. The data obtained were above 0.5 which is acceptable and most of the loadings were more than 0.7 which are desirable.

Table 4.4: Construct Validity measures – Convergent Validity and Discriminant Validity

Domains / Constructs & Competency Items	Expectation	Current Performance
	Factor Loading	Factor Loading
1. Clinical Knowledge		
1.1 Understanding of the principles of evidence-based practice	0.55	0.889
1.2 Knowledge of pathophysiology of patient Conditions.	0.814	0.809
1.3 Knowledge of pharmacological implications of medications	0.849	0.871
1.4 Interpretation of physician and interprofessional orders	0.905	0.879
1.5 Compliance with legal / regulatory issues relevant to nursing practice	0.882	0.821
1.6 Understanding of quality improvement methodologies	0.862	0.81
2. Technical Knowledge		
2.1 Conducting patient assessments, Clinical history collection, Physical assessment related to all systems	0.82	0.871
2.2 Pain assessment	0.719	0.879
2.3 Documentation of patient assessment data	0.874	0.908
2.4 Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.)	0.771	0.908

2.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	0.812	0.887
2.6 Preparing the patients to diagnostic investigation	0.852	0.891
2.7 Adherence to standard precautions including transmission – based precautions	0.802	0.852
2.8 Nursing skills related to bowel elimination	0.897	0.892
2.9 Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.)	0.759	0.848
2.10 Safe administration of medications per oral	0.823	0.936
2.11 Preparing and administering intramuscular, intracutaneous and subcutaneous injections	0.847	0.764
3. Critical Thinking		
3.1 Recognition of changes in patient status.	0.873	0.936
3.2 Lab report interpretation and reporting	0.843	0.934
3.3 Oxygenation and respiration- Assessing changes and interpretation of breathing in acute problem situation and managing & Ability to anticipate risk	0.863	0.889
3.4 Formulating Nursing care plan based on assessment findings	0.704	0.906
3.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	0.873	0.853
3.6 Decision making based on the nursing process.	0.809	0.879
3.7 Recognition of when to ask for assistance.	0.809	0.896

3.8 Recognition of unsafe practices by self and others	0.835	0.892
4. Communication		
4.1 Rapport with patients and families.	0.835	0.878
4.2 Communication with interprofessional team	0.875	0.905
4.3 Communication with physicians.	0.783	0.87
4.4 Patient education	0.812	0.848
4.5 Conflict resolution	0.77	0.772
4.6 Patient advocacy	0.809	0.9
5. Professionalism		
5.1 Ability to work independently	0.88	0.893
5.2 Ability to work as part of a team.	0.856	0.94
5.3 Ability to accept constructive criticism	0.893	0.885
5.4 Customer service	0.836	0.871
5.5 Accountability for actions	0.882	0.903
5.6 Respect for diverse cultural perspectives	0.863	0.884
6. Management of Responsibilities		
6.1 Ability to keep track of multiple responsibilities	0.861	0.845
6.2 Ability to prioritize	0.897	0.956
6.3 Delegation of tasks	0.891	0.955
6.4 Completion of individual tasks within EXPECTED time frame	0.886	0.876
6.5 Ability to take initiative	0.851	0.969
6.6 Conducting appropriate follow-up	0.885	0.934

The study's quantitative part involved the data collection with the Nursing Practice Readiness Tool (NPRT), which was found appropriate to gather data about the competency preparedness among nursing interns.

4.2.2.2 Construct Validity

The construct validity is essential to validate that the survey instrument covers every aspect of the measured variable (Said, Badru & Shahid, 2011). The construct validity of the measured model was done using the measures namely, convergent validity and discriminant validity using factor analysis loading data obtained from SPSS 26. Table 4.5 presents the measures of Construct Validity.

The Average Variance Extraction (AVE) is the measure to check convergent validity of constructs reflectively measured, which shows, how much the measure correlates positively inside a construct. The AVE values of the constructs measured reflectively are: Expectation Constructs - E1 (0.671), E2 (0.668), E3 (0.685), E4 (0.664), E5 (0.754), E6 (0.772). Performance Constructs - C1 (0.718), C2 (0.769), C3 (0.807), C4 (0.745), C5 (0.803),C6 (0.853). The AVE value is above the accepted value of 0.5 showing an acceptable status of convergent validity of the collected data.

The Discriminant Validity (DV) is the measure to check whether the different constructs are distinguishable (Hair et al., 2013). The DV values of the constructs measured reflectively are: Expectation Constructs - E1 (0.961), E2 (0.978), E3 (0.685), E4 (0.972), E5 (0.960), E6 (0.974). Performance Constructs - C1 (0.969), C2 (0.987), C3 (0.985), C4 (0.0.973), C5 (0.980), C6 (0.986).

Table 4.5: Construct Validity measures of the measured model – Convergent Validity and Discriminant Validity

Domains / Constructs	Expectation		Current Performance	
	Convergent Validity (AVE*)	Discriminant Validity (DV)	Convergent Validity (AVE*)	Discriminant Validity (DV)
1. Clinical Knowledge	0.671	0.961	0.718	0.969
2. Technical Knowledge	0.668	0.978	0.769	0.987
3. Critical Thinking	0.685	0.972	0.807	0.985
4. Communication	0.664	0.960	0.745	0.973
5. Professionalism	0.754	0.974	0.803	0.980
6. Management of Responsibilities	0.772	0.976	0.853	0.986

The Fornell-Larcker criterion is best suited to check the discriminant validity of the reflective constructs. The criterion for passing the test is that the DV value of the construct should be greater than its highest correlation with any other construct. The correlation values are shown in Table 4.6. When compared with correlation Table 4.6, the criteria for discriminant validity is seen to be met, establishing acceptable construct validity.

Table 4.6: Correlation between the Constructs to validate Discriminant validity

Domain / Construct	<-->	Domain / Construct	Correlation Values	
			Expected	Current
Technical Skills	<-->	Critical Thinking	0.963	0.963
Technical Skills	<-->	Communication	0.811	0.915
Technical Skills	<-->	Professionalism	0.775	0.92

Technical Skills	<-->	Management of Responsibilities	0.79	0.912
Critical Thinking	<-->	Communication	0.928	0.954
Critical Thinking	<-->	Professionalism	0.85	0.934
Critical Thinking	<-->	Management of Responsibilities	0.913	0.962
Communication	<-->	Professionalism	0.964	0.983
Communication	<-->	Management of Responsibilities	0.939	0.934
Professionalism	<-->	Management of Responsibilities	0.918	0.935
Technical Skills	<-->	Clinical Knowledge	0.906	0.973
Critical Thinking	<-->	Clinical Knowledge	0.85	0.98
Communication	<-->	Clinical Knowledge	0.671	0.919
Professionalism	<-->	Clinical Knowledge	0.673	0.903
Management of Responsibilities	<-->	Clinical Knowledge	0.698	0.945
Technical Skills	<-->	Critical Thinking	0.963	0.963
Technical Skills	<-->	Communication	0.811	0.915
Technical Skills	<-->	Professionalism	0.775	0.92

4.2.2.3 Data Consistency and Reliability

Internal consistency best describes the reliability based on inter-correlations of the observed indicator variables. Hair and colleagues (2013) suggested the composite reliability (Pc) is a good measure of internal consistency as it estimates on the basis of the number of items in the scale along with Cronbach's alpha which does not do so. The composite reliability values of 0.60 and above are acceptable whereas the values below 0.60 indicate lack of internal consistency.

Table 4.7: Reliability Statistic Cronbach's Alpha and Composite Reliability

Domains / Constructs	Expectation		Current Performance	
	Cronbach's Alpha	Composite Reliability	Cronbach's Alpha	Composite Reliability
1. Clinical Knowledge	0.919	0.923	0.936	0.938
2. Technical Knowledge	0.955	0.957	0.973	0.973
3. Critical Thinking	0.944	0.945	0.97	0.971
4. Communication	0.921	0.922	0.945	0.946
5. Professionalism	0.949	0.948	0.96	0.961
6. Management of Responsibilities	0.952	0.953	0.971	0.972

The composite reliability values were: Expectation Constructs - E1 (0.923), E2 (0.957), E3 (0.945), E4 (0.922), E5 (0.948), E6 (0.953). Performance Constructs - C1 (0.938), C2 (0.973), C3 (0.971), C4 (0.946), C5 (0.961), C6 (0.972). The composite reliability values are above 0.6, which is in the acceptable range. Also, the Cronbach's Alpha values for both expectation constructs and current performance were found to be greater than 0.7 which is desirable, as shown in Table 4.7, establishing a strong reliability in addition to strong Composite reliability values.

4.2.3 Demographic Information

The Nursing Practice Readiness Tool (NPRT) was employed in this study to collect the data. The data analysis was commenced by determining the frequency distribution of participants of the study. Table 4.8 shows the frequency and percentage breakdown of the demographic

information of the participants participated in the quantitative part of the study. The demographic variable and quantitative data that was obtained for the study included: (1) Hospital, (2) Age, (3) Nationality, (4) Education, (5) Designation and (6) Years of experience. There were six hospitals that were contacted to obtain permission for data collection for the study and out of which, five hospitals provided permission and ethical approval to proceed with the study and one hospital declined access. So, the data was collected from five hospitals in the emirate of Abu Dhabi.

Among the hospitals that participated in the study, the highest participation was from Hospital A, where 49 (47.1%) of the participants were from Hospital A, followed by 19 (18.3 %) of the participants from hospital C, 18 (17.3%) of them participated from Hospital D, and from hospitals B and E there were 13(12.5%) and 5(4.8%) of the participants respectively. The total number of participants were 104, with 80 (76.9 %) nurse preceptors, 9 (9.6%) being charge nurses, 10 (9.6%) being unit managers, and five (4.8 %) were professional development nurses known as clinical resource nurses.

Besides, the top management position holders who participated only in the qualitative part of the study were the Assistant Nursing Directors, Chief nursing officers, Nurse consultants of UAE, Corporate Nursing Director. Together there were eight of them who participated in the study. The range in age of participants in the study was from 21- 30 yrs. to 51- 60yrs. The majority of the participants were from the age group 31 to 40 yrs., where 62 (59.6 %) out of 104 participants fell under this range, followed by 25 of them (24%) were from the range 41 to 50 years of age.

Table 4.8: Demographic Characteristics of the Nursing Staff and Nursing Administrators Sample

Demographic Characteristics	Frequency	Percentage
Hospital		
1. Hospital A	49	47.1
2. Hospital B	22	12.5
3. Hospital C	19	18.3
4. Hospital D	9	17.3
5. Hospital E	5	4.8
Age		
1. 21 to 30 Years	11	10.6
2. 31 to 40 Years	62	59.6
3. 41 to 50 Years	25	24.0
4. 51 to 60 Years	6	5.8
Nationality		
1. Emirati	1	1.0
2. Indian	44	42.3
3. UK	2	1.9
4. Philippines	35	33.7
5. Jordan	12	11.5
6. Egypt	2	1.9
7. Sudan	3	2.9

8. Syria	1	1.0
9. Somalia	2	1.9
10. GCC	1	1.0
11. Others	1	1.0

Education

1. Diploma	4	3.8
2. BSN	92	88.5
3. MSN	7	6.7
4. Ph.D.	1	1.0

Designation

1. Unit Manager	10	9.6
2. Charge Nurse	9	8.7
3. Preceptor / RN	80	76.9
4. Clinical Resource Nurse	5	4.8

Years of Work Experience

1. 0 to 5 Years	3	2.9
2. 6 to 10 Years	43	41.3
3. 11 to 15 Years	20	19.2
4. 16 to 20 Years	25	24.0
5. 21 to 25 Years	9	8.7
6. 26+ Years	4	3.8

Regarding the nationality of the participants, there was only one Emirati citizen who participated in the quantitative part of the study; there were 44 (42.3%) participants from India in the study, two (1.9 %) were from the UK, from the Philippines there were 35 (33.7%), 12 (11.5%) were from Jordan, from Egypt and Somalia there were two (1.9%) participants, three (2.9%) of the participants are from Sudan, Syria and other GCC countries (not specified) and there was one (1.0%) participant and there was one (1.0%) participant who did not reveal their nationality.

The participants' educational qualification was a Diploma for four (3.8%) of the participants. 92 (88.5%) of the participants held a Baccalaureate degree in Nursing, seven (6.7%) of the participants were masters prepared, and one (1.0%) of the participants had a PhD. The job profile held by the participants were distributed as follows: Among the participants, there were 10 (9.6%) unit managers, nine (8.7%) of them were Charge Nurses, Registered Nurses (RN) as Preceptors were 80 (76.9%) of them and Clinical Resource Nurses were five (4.8%) of the participants. The years of experience of the participants were: three (2%) of the participants had 0 to 5 years of experience, 43 (41.3%) of the participants had 6 to 10 years of work experience, 20 (19.2%) had 11 to 15 years of experience, 25 (24.0%) of the participants had 16 to 20 years of experience, 21 to 25 years of experience range had 9 (8.7 %) of the participants, and four (3.8%) of the participants had more than 26 years of experience. In summary, most of the subjects participated from the hospital A, and hospital E had only five participants.

The reason that there are discrepancies in the number of participants in each of the hospital is due to the number of graduates recruited and had placements in each of those hospitals. The number of nurses who had been the preceptors for the new graduates was related to the number

of new graduates posted in the hospital that explains the reason for hospital A having the maximum participants. In regard to the age group of the participants, the majority of them were between 31 to 40 years and the participants were largely from India and Philippines. Most of the participants who were the preceptors were baccalaureate prepared and had 6 to 10 years of experience.

4.2.4 Research Question Analysis using Quantitative Data Results

The data analysis begins with the descriptive statistics, following which the analysis of the quantitative data is performed in an effort to answer the research questions of the study. Among the six research questions, the first five research questions can be answered by the quantitative data analysis and are discussed in this quantitative data analysis part, whereas the last research question was addressed with the semi structured interview and the responses are analyzed in the qualitative data analysis part following the thematic analysis.

The research questions are as follows:

Research Question 1. What is the expected level of competency preparedness as perceived by the nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders?

Research Question 2. What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the current level of competency preparedness of new graduate nurses?

Research Question 3. What skill levels and practice expectations of the new graduate nurses, do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as most important?

Research Question 4. Which are the competencies that nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital?

Research Question 5. What are the gaps in new graduate nurses' competency preparedness and which of them are reported to have wider gaps?

Research Question 6. What strategies do the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggest to enhance the competency preparedness and concomitant practice expectations of new graduate nurses?

The means of the responses in the six domains were obtained and are shown in Tables 4.3 to 4.7. The research questions 1, 2 ,3 4, and 5 are answered by conducting two sets of analysis. The first set of analysis was quantitative analysis and the second level of analysis used the interview responses into thematic analysis to develop themes that supported the quantitative results. The research question 6 is analyzed with qualitative analysis and are discussed in the qualitative data analysis part later in this chapter.

4.2.4.1 Research Question 1. - The Expected Level of Competency Preparedness.

RQ1. What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the expected level of competency preparedness of new graduate nurses?

The Nursing Practice Readiness Tool (NPRT) was used to identify the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the expected level of competency preparedness of new graduate nurses. The six domains namely

1. Clinical Knowledge with 6 competency statements, 2. Technical skills with 11 competencies, 3. Critical Thinking with 8 competencies, 4. Communication with 6 competencies, 5. Professionalism with 6 competencies and finally 6. Management of Responsibilities with 6 competencies. The descriptive statistical analysis was performed to determine the competency levels of new graduates were perceived by the hospital nurse preceptors, unit managers, professional development nurses, as the expected level and the current performance levels for the domain 1 which is the Clinical knowledge. This domain consists of six competency statements and the descriptive statistics for this first domain is shown in table 4.9.

Table 4.9: Descriptive Statistics of Domain 1- Clinical Knowledge

Domain 1: Clinical Knowledge

Descriptive Statistics of Expected Performance, Current Performance and Gap as difference

Domains / Constructs & Competency Items	**Expected Performance**			**Current Performance**			**Difference**		
	Mean	Median	SD	Mean	Median	SD	δ-Mean	δ-Median	t-Value
Clinical Knowledge									
1.1 Understanding of the principles of evidence-based practice	3.43	3.0	0.703	2.83	3.00	0.990	0.500	0.0	7.176
1.2 Knowledge of pathophysiology of patient Conditions.	3.51	4.0	0.758	3.09	3.00	0.956	0.404	1.0	4.430
1.3 Knowledge of pharmacological implications of medications	3.54	4.0	0.958	2.83	3.00	1.028	0.654	1.0	7.404

1.4 Interpretation of physician and interprofessional orders	3.60	4.0	0.901	2.93	3.00	1.168	0.673	1.0	6.616
1.5 Compliance with legal / regulatory issues relevant to nursing practice	3.55	4.0	0.932	2.89	3.00	1.214	0.692	1.0	7.546
1.6 Understanding of quality improvement methodologies	3.34	3.0	0.835	2.60	3.00	1.111	0.740	0.0	7.374

Among the competencies related to clinical knowledge, the competency of interpretation of physician and the interprofessional order had the highest expectation with the mean of 3.6. Subsequently, compliance with legal / regulatory issues relevant to nursing practice and knowledge of pharmacological implications of medications is the next highest level of expected competency with the mean of 3.55 and 3.54. The competencies with lowest expectation related to clinical knowledge were reported for understanding of the principles of evidence-based practice with the mean of 3.43 and 3.34 was the mean and least expected for understanding of quality improvement methodologies. Among the current performance of the competencies perceived by the hospital nursing personnel, it was found that the highest performance among the competencies of clinical knowledge was reported for the competency of knowledge of pathophysiology of patient conditions with the mean of 3.09, but the mean difference between the expected and the current competency is of 0.4 which is the lowest gap. The high gap was found in the competencies of knowledge of pharmacological implications of medications, Interpretation of physician & interprofessional orders and compliance with legal / regulatory issues relevant to nursing practice with the mean difference of 0.6. Though the understanding

of the quality improvement methodologies was the lowest among the competencies in the expectation, the performance for the same was also low with the wide gap of 0.7 as mean.

Table 4.10: Descriptive Statistics of Domain 2 - Technical skills.

Domain 2: Technical Skills

Descriptive Statistics of Expected Performance, Current Performance and the Gap.

Domains / Constructs & Competency Items	Expected Performance			Current Performance			Difference		
	Mean	Median	SD	Mean	Median	SD	δ-Mean	δ-Median	t-Value
Technical Skills									
2.1 Conducting patient assessments, Clinical history collection, Physical assessment related to all systems	3.77	4.00	0.937	3.28	3.00	1.047	0.490	1.0	4.633
2.2 Pain assessment	3.85	4.00	0.833	3.34	3.00	1.094	0.510	1.0	6.216
2.3 Documentation of patient assessment data	3.76	4.00	1.000	3.38	3.00	1.072	0.385	1.0	3.718
2.4 Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.)	3.80	4.00	0.829	3.16	3.00	1.133	0.635	1.0	7.078
2.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	3.84	4.00	0.956	3.02	3.00	1.314	0.817	1.0	8.101
2.6 Preparing the patients to diagnostic investigation	3.87	4.00	0.789	3.33	3.00	1.092	0.538	1.0	6.399

2.7 Adherence to standard precautions including transmission – based precautions	3.53	4.00	0.934	2.93	3.00	1.201	0.596	1.0	6.614
2.8 Nursing skills related to bowel elimination	3.53	4.00	1.070	3.06	3.00	1.213	0.471	1.0	5.323
2.9 Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.)	3.67	4.00	1.065	3.09	3.00	1.150	0.587	1.0	5.340
2.10 Safe administration of medications per oral	3.82	4.00	1.059	3.22	3.50	1.277	0.596	0.5	5.310
2.11 Preparing and administering intramuscular, transdermal and subcutaneous injections	3.54	4.00	0.869	3.38	3.00	1.108	0.163	1.0	1.781

In regard to the competencies of technical skills, eleven competency statements are included. The descriptive statistics related to the competencies' expected and current performance were computed as illustrated in Table 4.10. The difference between the means of expected level of competency and current level of competency performance indicates the presence of a gap. Among the competencies in the technical skills domain, Preparing the patients for diagnostic investigation, Pain assessment and Interpretation of assessment data (e.g., history, exam, lab testing, etc.) had the means of 3.87, 3.85 and 3.84 respectively.

The current performance for those competencies are 3.00, 3.34 and 3.02. while focusing on the gap for the competencies in the technical skill domain, it was found that interpretation of assessment data (e.g., history, exam, lab testing, etc.) was found to have the highest gap which is 0.8. followed by the gap of 0.6 in performing clinical procedures like performing sterile

dressing and IV therapy. Pain assessment, Preparing the patients to diagnostic investigation, Adherence to standard precautions including transmission –based precautions and Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.) and Safe administration of medications per oral with the gap of 0.5. The least gap (0.1) is identified in the competency of preparing and administering intramuscular, transdermal and subcutaneous injections

The Critical thinking domain consists of eight competency statements, and among those competencies, the highest expectations were reported in the competencies of oxygenation and respiration that includes assessing changes and interpretation of breathing in acute problem situation, managing and ability to anticipate risk, formulating Nursing care plan based on assessment findings and recognition of when to ask for assistance with the mean of 3.6. and almost of the competencies are equally reported as important and expected as illustrated in table 4.11.

Table 4.11: Descriptive Statistics of Domain 3 - Critical Thinking

Domain 3: Critical Thinking

Descriptive Statistics of Expected Performance, Current Performance and the Gap

Domains / Constructs & Competency Items	**Expected Performance**			**Current Performance**			**Difference**		
	Mean	Median	SD	Mean	Median	SD	δ-Mean	δ-Median	t-Value
Critical Thinking									
	3.56	4.00	0.912	2.89	3.00	1.253	0.663	1.0	7.527
3.1 Recognition of changes in patient status.									
3.2 Lab report interpretation and reporting	3.43	3.50	0.973	2.77	3.00	1.331	0.663	0.5	6.825

3.3 Oxygenation and respiration- Assessing changes and interpretation of breathing in acute problem situation and managing & Ability to anticipate risk	3.64	4.00	0.954	3.08	3.00	1.290	0.567	1.0	5.283
3.4 Formulating Nursing care plan based on assessment findings.	3.63	4.00	0.860	3.17	3.00	1.056	0.462	1.0	4.098
3.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	3.58	4.00	0.992	3.00	3.00	1.191	0.577	1.0	6.388
3.6 Decision making based on the nursing process.	3.39	3.00	0.875	2.79	3.00	1.121	0.606	0.0	6.306
3.7 Recognition of when to ask for assistance.	3.65	4.00	0.833	3.13	3.00	1.150	0.519	1.0	5.936
3.8 Recognition of unsafe practices by self and others	3.59	4.00	0.877	3.09	3.00	1.071	0.500	1.0	5.338

On the other hand, these three competencies are also reported as highest performing competencies with the means of 3.00-3.10. The lowest performance was reported in decision making based on the nursing process and laboratory report interpretation and reporting. The gap between the expected competency level and the current performance competency levels widest in the competency of recognition of changes in patient status, lab report interpretation and reporting followed by decision making based on the nursing process with gap reported as 0.6 as the highest gap. Focusing on the competencies for the communication domain includes

six competencies. Among that, the highest expectation for these competencies is reported in rapport with patients and families followed by communication with interprofessional team with the mean of 3.9 and 3.8 respectively. Interestingly, it is observed that the highest performance is also reported for the said competencies with the mean of 3.53 and 3.45, the descriptive statistics for this domain for both expected level of competencies and the current competency performance level as illustrated in table 4.12.

Table 4.12: Descriptive Statistics of Domain 4: Communication.

Domain 4: Communication

Descriptive Statistics of Expected Performance, Current Performance and the Gap.

Domains / Constructs & Competency Items	Expected Performance			Current Performance			Difference		
	Mean	Median	SD	Mean	Median	SD	δ-Mean	δ-Median	t-Value
Communication									
4.1 Rapport with patients and families.	3.99	4.00	0.930	3.53	4.00	1.198	0.462	0.0	5.636
4.2 Communication with interprofessional team	3.82	4.00	0.868	3.45	4.00	1.173	0.365	0.0	4.225
4.3 Communication with physicians.	3.63	4.00	0.803	3.09	3.00	1.200	0.538	1.0	5.366
4.4 Patient education	3.79	4.00	0.772	3.33	3.50	1.056	0.462	0.5	5.097
4.5 Conflict resolution	3.39	4.00	0.929	2.82	3.00	1.130	0.577	1.0	6.051
4.6 Patient advocacy	3.48	3.00	0.812	2.99	3.00	1.235	0.490	0.0	4.595

Professionalism is the fifth domain constituting the six competencies. The descriptive statistics for both expected competency level and the current performance level along with the gap computed are illustrated in Table 4.13. It is identified that respect for diverse cultural perspectives was regarded as very important among the competencies of professionalism with

the mean of 3.95. In addition, it is found that the next highly regarded competency is the ability to work as part of a team and customer service with the mean of 3.85 and 3.81.

Related to the mentioned expectation, it was found that the current performance level was 3.46 in respect for diverse cultural perspectives, in regard to the ability to work as part of a team and customer service, the performance level mean is 3.5 and 3 respectively. Another notable finding is customer service, ability to work independently, accountability for actions were rated low among the other competencies in professionalism domain indicating the need for improvement in those areas related to competency preparedness as the new graduates enter the health care setting.

Table 4.13: Descriptive Statistics Domain 5: Professionalism

Domain 5: Professionalism

Descriptive Statistics of Expected Performance, Current Performance and the Gap

Domains / Constructs & Competency Items	**Expected Performance**			**Current Performance**			**Difference**		
	Mean	Median	SD	Mean	Median	SD	δ-Mean	δ-Median	t-Value
Professionalism									
5.1 Ability to work independently	3.73	4.00	0.884	3.13	3.00	1.275	0.606	1.0	6.010
5.2 Ability to work as part of a team.	3.85	4.00	0.932	3.43	3.50	1.290	0.413	0.5	5.382
5.3 Ability to accept constructive criticism	3.71	4.00	0.821	3.16	3.00	1.080	0.548	1.0	6.433
5.4 Customer service	3.82	4.00	0.845	3.29	3.00	1.163	0.529	1.0	5.838
5.5 Accountability for actions	3.81	4.00	0.882	3.29	3.00	1.180	0.519	1.0	6.335

5.6 Respect for diverse cultural perspectives	3.95	4.00	0.949	3.46	4.00	1.261	0.490	0.0	5.235

Management of responsibilities is the last domain with six competency statements. Ability to keep track of multiple responsibilities and ability to prioritize are the most expected competency among those competencies in this domain with the mean of 3.60 and 3.63. The high gap between the expected and the observed level of competency was identified for the competency, Completion of individual tasks within expected time frame as illustrated in table 4.14.

Table 4.14: Descriptive Statistics of Domain 6: Management of Responsibilities

Domain 6: Management of Responsibilities Descriptive Statistics of Expected Performance, Current Performance and the Gap

Domains / Constructs & Competency Items	**Expected Performance**			**Current Performance**			**Difference**		
	Mean	Median	SD	Mean	Median	SD	δ-Mean	δ-Median	t-Value
Management of Responsibilities									
6.1 Ability to keep track of multiple responsibilities	3.60	4.00	0.819	3.14	3.00	1.092	0.452	1.0	5.237
6.2 Ability to prioritize	3.63	4.00	0.904	2.93	3.00	1.272	0.702	1.0	7.348
6.3 Delegation of tasks	3.53	4.00	0.836	2.79	3.00	1.204	0.740	1.0	8.264
6.4 Completion of individual tasks within expected time frame	3.55	4.00	0.912	2.70	3.00	1.198	0.846	1.0	9.945
6.5 Ability to take initiative	3.50	4.00	0.965	2.93	3.00	1.225	0.567	1.0	6.349

6.6 Conducting appropriate follow-up	3.41	3.00	0.899	3.01	3.00	1.170	0.404	0.0	4.200

The overall descriptive statistics for the domains of the tool namely Clinical knowledge, technical skills, critical thinking, communication, professionalism and management of responsibilities are presented in Table 4.15. The gap between the current competency level and the expected competency levels are computed indicating gaps in all the domains. The highest gap is identified in the clinical knowledge domain (0.612) and the management of responsibilities domain (0.620). Followed by that, the gap is found to be in domain of critical thinking (0.569), technical skills (0.526) and professionalism (0.518). The least gap (0.48) is found to be in the domain of communication.

Table 4.15: Descriptive Statistics of Competency Domains Means

Competency Domains	**Expected competency level mean**	**Current competency level mean**	**Mean Difference (δ-Mean)**	**Paired t-Test (t-Value)**
1. Clinical Knowledge	3.47	2.86	0.612	11.314
2. Technical Skills	3.73	3.20	0.526	10.557
3. Critical Thinking	3.56	2.99	0.569	21.639
4. Communication	3.68	3.20	0.482	16.792
5. Professionalism	3.81	3.29	0.518	20.996
6. Management of Responsibilities	3.54	2.92	0.620	8.762

4.2.4.2 Research Question 2 - The Current Level of Competency Preparedness.

RQ2. What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the current level of competency preparedness of new graduate nurses?

To answer this research question, the Nursing Practice Readiness Tool (NPRT) was used to identify the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the current level of competency preparedness of the new graduate nurses. The tool has six domains with 43 competency statements. The respondents were asked to indicate the current level of competency among the new graduate nurses, as they enter the health care setting. The competency statements in the tool were rated on a five –point Likert type scale: 1 (Non-Competent) 2, (Less Competent), 3 (moderately Competent), 4 (Very Competent), 5 (Excellently Competent). Hundred and four participants responded to the question related to the current competency level of new graduates. Table 4.3 displays the mean, median and standard deviation of the level of competencies of the new graduates for each of the 43 competencies. The discussion answering the research questions 1 and 2 will be continued along in this section.

Domain 1 – Clinical Knowledge

In regard to competencies of the first domain, which is clinical knowledge, that is among the six domains of the Nursing Practice Readiness Tool (NPRT), the participants have mentioned that they expect none to be in the non-competent and less competent / advanced beginner level of competency, and as per the expectation of the competency preparedness of the new nursing graduates, none were in this level among the new graduates' current competency level. This is

illustrated in Figure: 4.4 as distribution of competency statements in expected and current level of competency preparedness distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness in clinical knowledge domain.

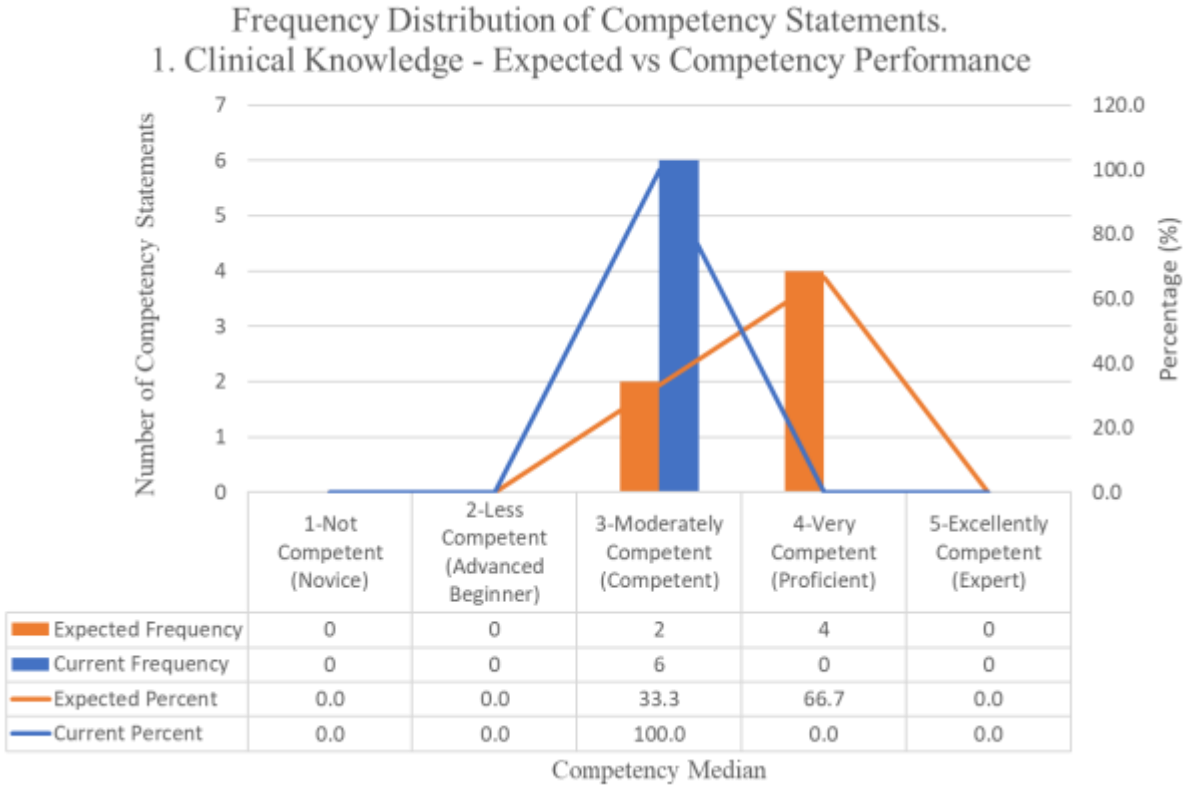


Figure: 4.4 Distribution of competency statements in expected and current level of competency preparedness: Clinical Knowledge Domain.

Besides, 33.3% of the competencies only are expected to be in competency level of moderately competent / competent level while it is reported that 100 % of competencies are in this level among the new graduates' current competency level on entry to practice. Whereas, 66.7 % of the competencies are expected to be in competency level of very competent / proficient level, while on the contrary, it is reported that none of competencies are in this level among the new graduates' current competency level. Furthermore, none of the competencies are expected to be in competency level of excellently competent / expert level and none were found to be in this level among the new graduates' current competency level.

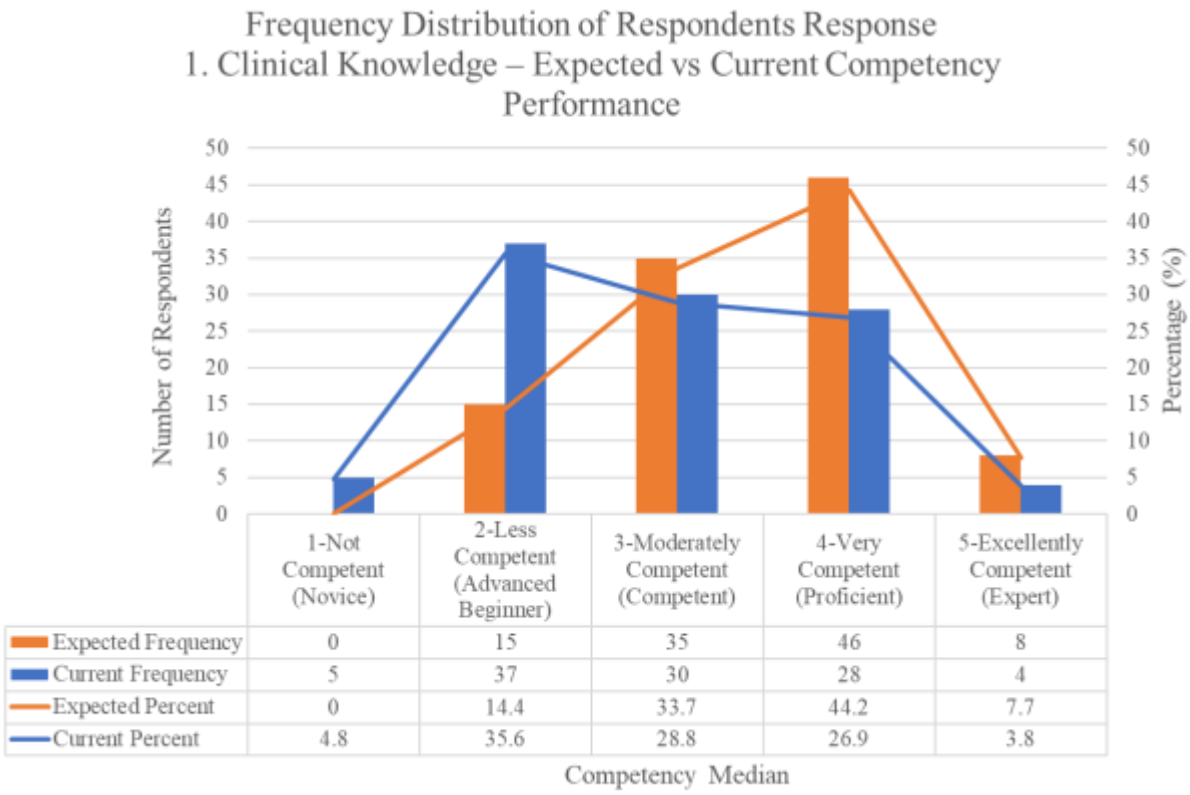


Figure: 4.5 Distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness in clinical knowledge.

Among the 104 participants who responded to the Nursing Practice Readiness Tool (NPRT), 44.2% mentioned that they expected the competencies in the clinical knowledge domain to be in the proficient / very competent level of competency preparedness as they enter the practice setting as new graduate. Alongside, 33.7% of the participants expected the competencies in the same domain to be moderately competent / competent level of competency preparedness. Whereas the participants who perceived that the current competency preparedness for the new graduates as reported by the participants in these two levels of competency preparedness are 26.9% and 28.8 % respectively. Most of the participants (35.6%) reported that the competency level of the new graduate in this domain of clinical knowledge is in the less competent / advanced beginner level as illustrated in the Figure: 4.5 as distribution of responses of hospital

nursing personnel, for expected and current level of competency preparedness in clinical knowledge.

Domain 2 – Technical Skills

The frequency distribution of proficient level/ very competent level by respondents' responses is shown in Figure: 4.6 as distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness in technical skills. Among the participants, 48.1% mentioned that they expected the competencies in the technical skills domain to be in the proficient / very competent level of competency preparedness as they entered the practice setting as new graduate.

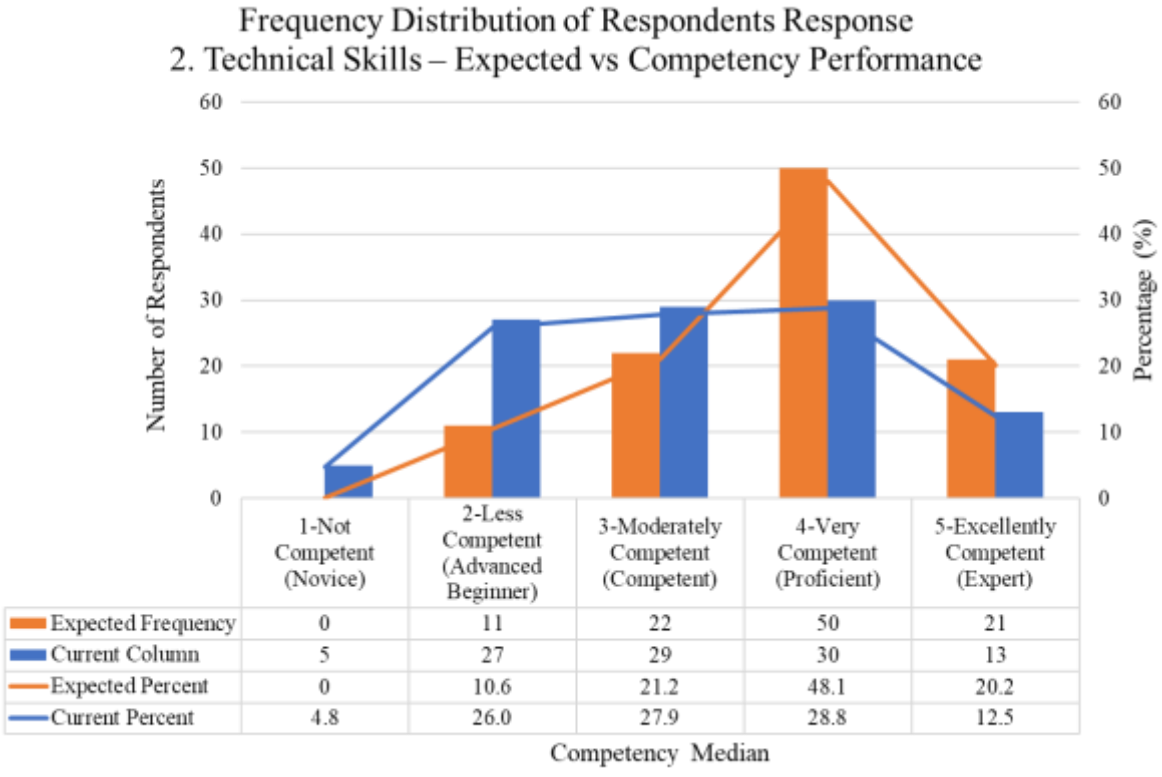


Figure 4.6 Distribution of responses by the hospital nursing personnel, for the expected and current level of competency preparedness in technical skills among new graduates

Alongside, 21.2% and 20.2% of the participants expected the competencies in the same domain to be moderately competent / competent level and excellently competent /expert level of competency preparedness respectively. Whereas the participants who perceived that the current competency preparedness for the new graduates as reported by the participants in these two levels of competency preparedness were 27.9% and 12.5 % respectively. A majority of the participants (28.8%) reported that the competency level of the new graduate in this domain of technical skills.

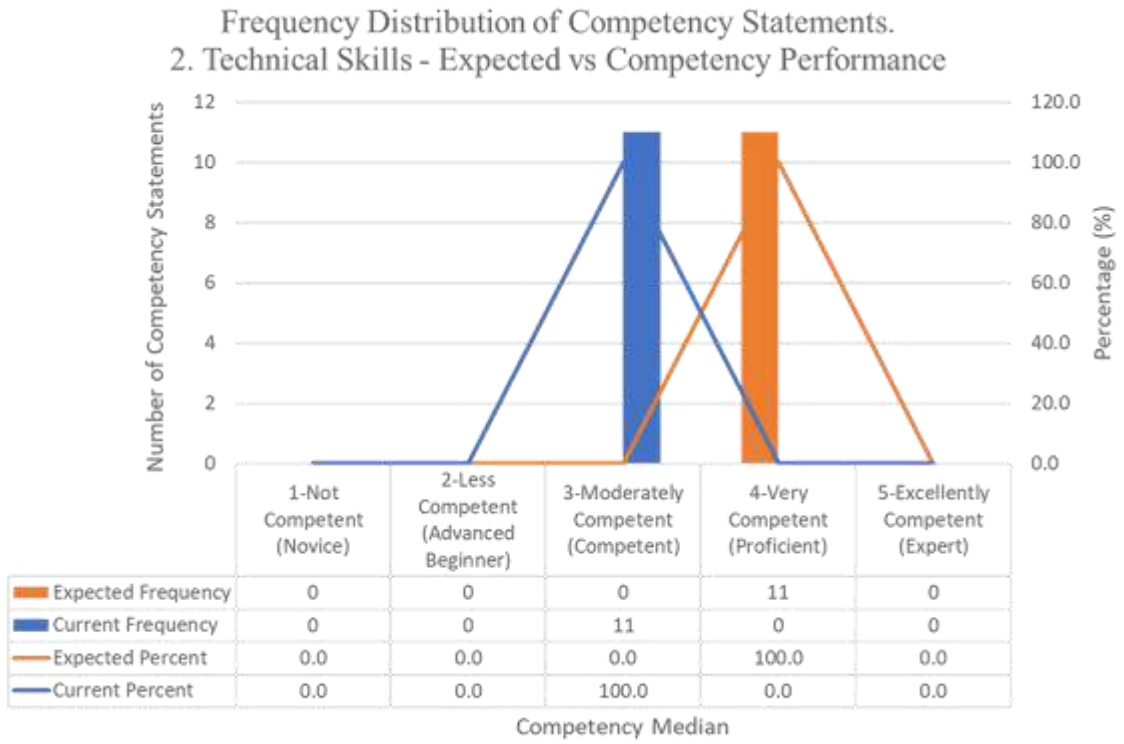


Figure: 4.7 Distribution of competency statements in expected and current level of competency preparedness: Technical Skills Domain.

The distribution of competency statements in expected and current level of competency preparedness distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness for Technical Skills Domain is depicted in Figure 4.7.

Regarding the competencies in the domain: technical skills, which is the second domain among the six domains of the Nursing Practice Readiness Tool (NPRT), the participants mentioned that they expected none of the competencies to be in the non-competent level of competency, less competent / advanced beginner level of competencies and as expected none of the current level of competencies fell in this level of competency. Interestingly, none of the competencies were expected to be in moderately competent / competent level, but contrastingly, 100% of competencies are in this level among the new graduates' current competency level. Furthermore, 100% of the competencies were expected to be in competency level of very competent / proficient level while it is reported that 100% of competencies are in this level among the new graduates' current competency level on entry to practice. In addition, none of the competencies, both in expected level and current level of competencies, were in the excellently competent / expert level.

Domain 3 – Critical Thinking

In regard to the third and the most important domain, called critical thinking domain among the six domains of the Nursing Practice Readiness Tool (NPRT), the participants mentioned that they expected none to be in the non-competent level of competency, whereas 3.8% of the competencies are in this level among the new graduates' current competency level. In addition, 10.6 % of the competencies were expected to be in competency level of less competent / advanced beginner, but contrastingly 32.7% of competencies are in this level among the new graduates' current competency level. Furthermore, 35.6% of the competencies are expected to be in the competency level of moderately competent / competent level while it is reported that 26% of competencies are in this level among the new graduates' current competency level on entry to practice. In addition, 40.4% of the competencies were expected to be in competency

level of very competent / proficient level while it is reported that 27.9% of competencies are in this level among the new graduates' current competency level. Moreover, 13.5% of the competencies were expected to be in competency level of excellently competent / expert level, while it is reported that 9.6% of competencies are in this level among the new graduates' current competency level. As depicted in Figure 4.6, Expected and current level of competency preparedness of new graduates for the competencies in the Critical thinking domain as reported by hospital nursing personnel. Among the participants, 40.4% mentioned that they expected the competencies in the critical thinking domain to be in the proficient / very competent level of competency preparedness as they enter the practice setting as new graduate. Besides, 35.6% and 13.5% of the participants expected the competencies in the same domain to be moderately competent / competent level and excellently competent /expert level of competency preparedness respectively. Whereas, participants who perceived that the current competency preparedness for the new graduates in the proficient / very competent level is only 27.9 % of them. Moreover 32.7% and 26.0% of the participants mentioned that the current competencies in the technical skills were observed to be in less competent /advanced beginner and moderately competent /competent level respectively. Most of the participants (32.7%) reported that the competency level of the new graduate in this domain of technical skills was in the moderately competent/ competent / level, as illustrated in the Figure 4.8. The figure depicts the distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness in Critical Thinking.

In regard to competencies of the critical thinking domain of the Nursing Practice Readiness Tool (NPRT), the participants mentioned that they expected none of the competencies to be in the non-competent and less competent / advanced beginner level of competency, and as per the expectation of the competency preparedness of the new nursing graduates. Positively, none of

the competencies were reported to be in this level among the new graduates' current competency level.

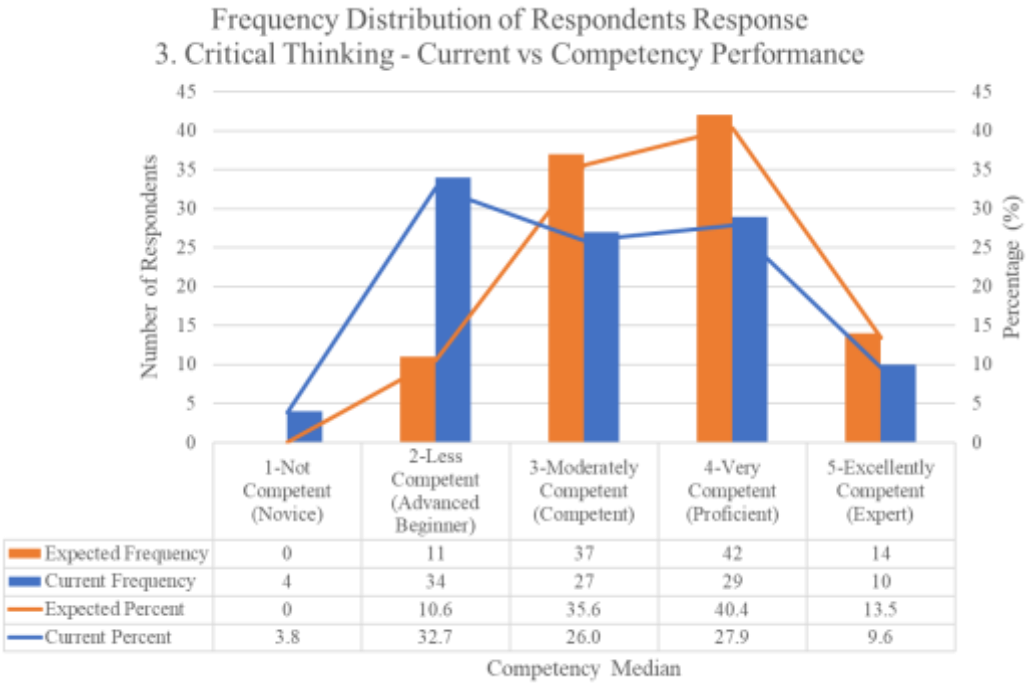


Figure 4.8: Distribution of responses by the hospital nursing personnel, for the expected and current level of competency preparedness in critical thinking among new graduates.

In addition, only 25% of the competencies only were expected to be in competency level of moderately competent / competent level while it is reported that 100% of competencies are in this level among the new graduates' current competency level on entry to practice, as depicted in Figure 4.9. where the figure illustrates the distribution of competency statements in expected and current level of competency preparedness in critical thinking domain.

Furthermore, notably 75% of the competencies were expected to be in the competency level of very competent / proficient level, while on the contrary, it is reported that none of competencies are in this level among the new graduates' current competency level. Furthermore, none of the

competencies were expected to be in competency level of excellently competent / expert level and none were found to be in this level among the new graduates' current competency level.

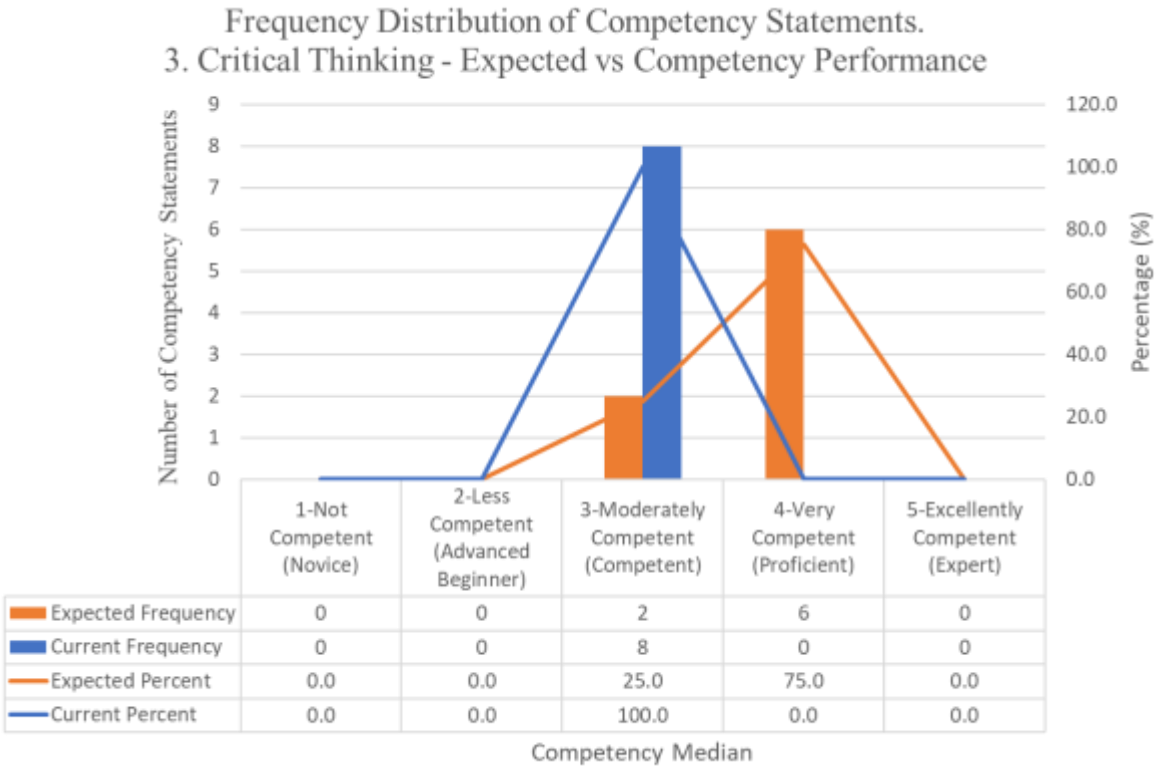


Figure: 4.9 Distribution of competency statements in expected and current level of competency preparedness: Critical Thinking Domain.

Domain 4 – Communication

The distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness in communication is illustrated in Figure 4.10. In regard to the fourth domain which is communication, among the six domains of the Nursing Practice Readiness Tool (NPRT), the participants mentioned that they expected none to be in the non-competent level of competency, whereas 6.7% of the competencies are in this level among the new graduates' current competency level. In addition, 2.9% of the competencies were expected to

be in the competency level of less competent / advanced beginner, but contrastingly 15.4% of competencies are in this level among the new graduates' current competency level.

Furthermore, 37.5% of the competencies were expected to be in the competency level of moderately competent / competent level, while it is reported that 33.7% of competencies are in this level among the new graduates' current competency level on entry to practice. In addition, 41.3% of the competencies were expected to be in competency level of very competent / proficient level, while it is reported that 27.9% of competencies are in this level among the new graduates' current competency level. Furthermore, 18.3% of the competencies were expected to be in competency level of excellently competent / expert level while it is reported that 16.3% of competencies are in this level among the new graduates' current competency level.

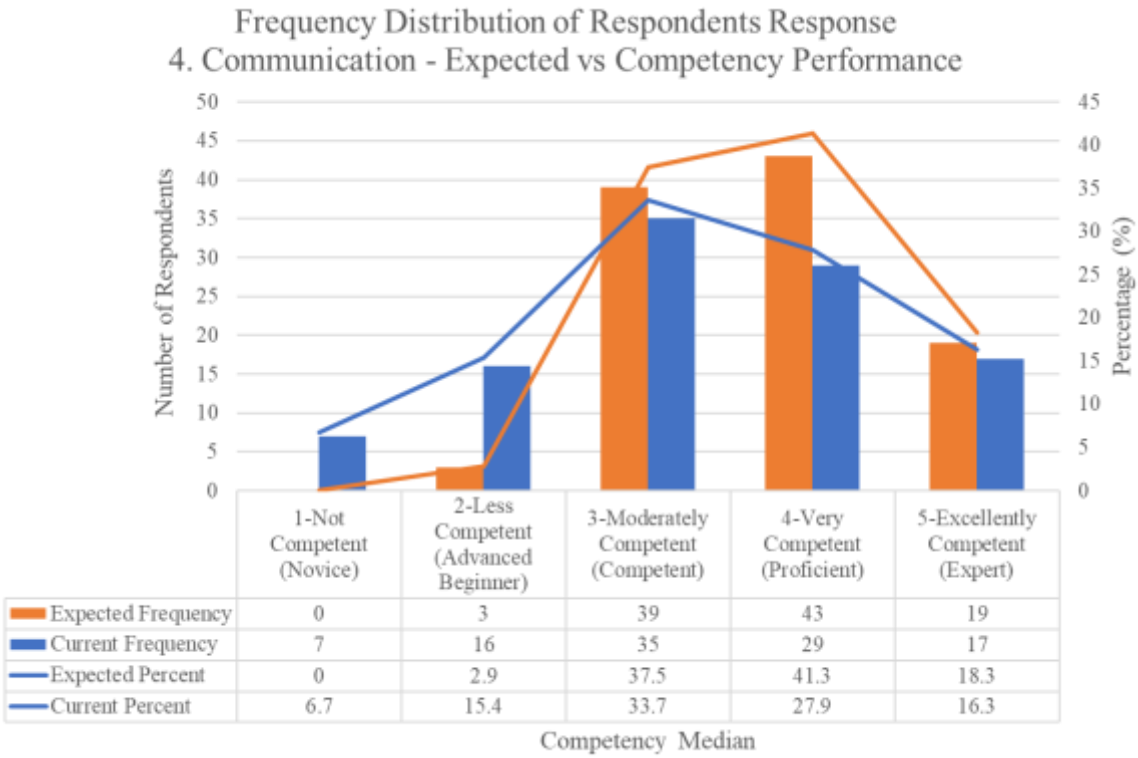


Figure 4.10 Distribution of responses by the hospital nursing personnel, for the expected and current level of competency preparedness in communication among new graduates.

Among the participants, 41.3% mentioned that they expected the competencies in the communication domain to be in the proficient / very competent level of competency preparedness as they enter the practice setting as new graduate. Besides, 37.5% and 18.3% of the participants expected the competencies in the same domain to be moderately competent / competent level and excellently competent /expert level of competency preparedness respectively. Whereas the participants who perceived that the current competency preparedness for the new graduates in the proficient / very competent level was only 33.7 %. Moreover, 15.4% and 33.7% of the participants mentioned that the current competencies in the technical skills were observed to be in less competent /advanced beginner and moderately competent /competent level respectively. A most of the participants (33.7%) reported that the current competency level of the new graduate in this domain of communication is in the moderately competent/ competent / level.

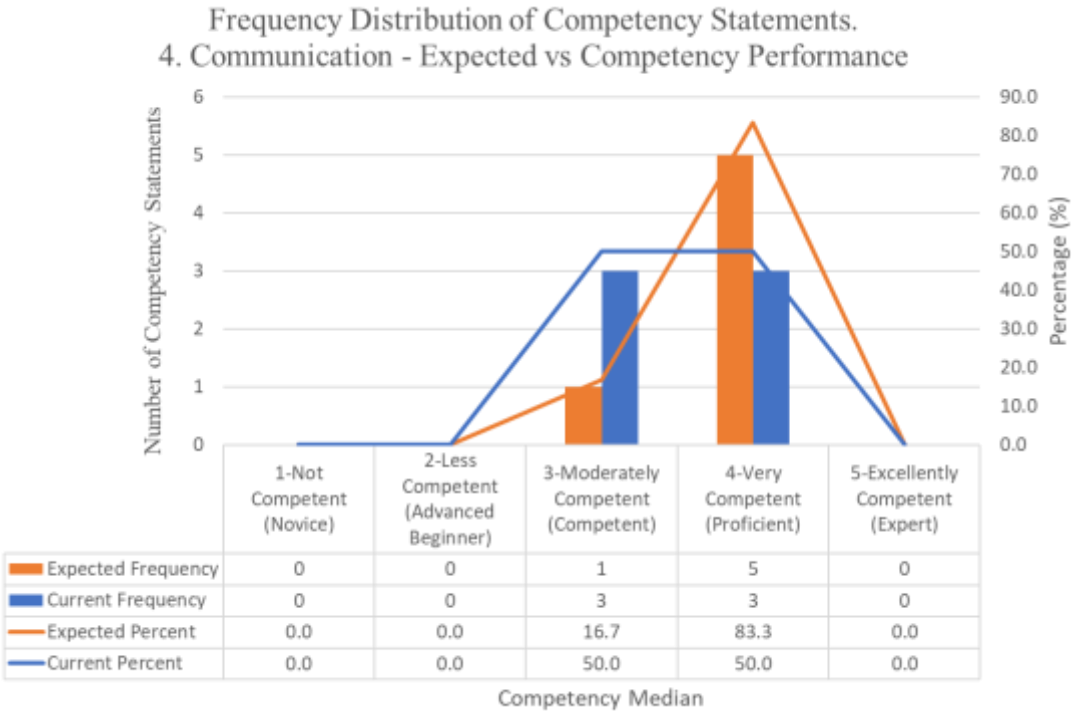


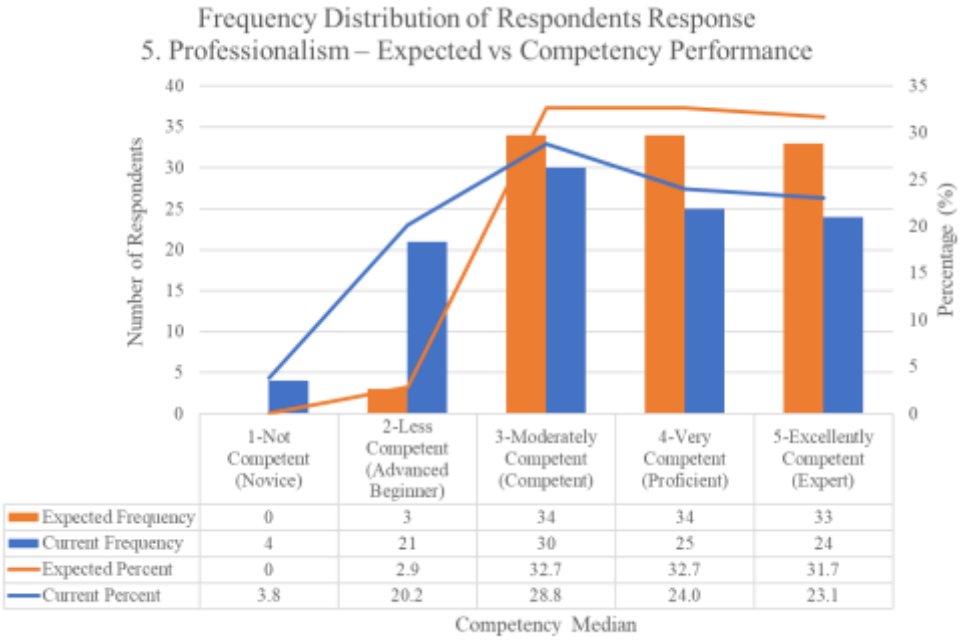
Figure: 4.11 Distribution of competency statements in expected and current level of competency preparedness: Communication Domain.

In regard to the communication domain, 83.3% of the competency statements listed in this domain were reported to be expected in very competent / proficient level and 16.7 % of the competencies were expected to be in moderately competent/ competent level, as illustrated in Figure 4.11 as the distribution of competency statements in expected and current level of competency preparedness distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness for communication domain. Whereas the current level of competency preparedness is reported to be 50% in both of the mentioned competency levels on entry to practice as perceived by the participants.

Domain 5 – Professionalism

Among the participants, 32.7% mentioned that they expected the competencies in the professionalism domain to be in the proficient / very competent level and moderately competent / competent level of competency preparedness as they enter the practice setting as new graduate. Besides, 31.7% expected the entry-level competency preparation to be in excellently competent /expert level. Whereas the participants perceived that the current competency preparedness for the new graduates was in the moderately competent / competent level and proficient / very competent level was only 28.8% and 24.0% respectively. Moreover, 20.2% and 23.1% of the participants mentioned that the current competencies in the professionalism domain were observed to be in less competent /advanced beginner and excellently competent / expert level respectively.

Most of the participants (28.8%) reported that the current competency level of the new graduate in this domain of professionalism was in the moderately competent/ competent / level as illustrated in Figure 4.12.



Figure; 4.12. Distribution of responses by the hospital nursing personnel, for the expected and current level of competency preparedness in professionalism among new graduates.

Figure 4.12 shows the expected and current level of competency preparedness of new graduates for the competencies in the professionalism domain as reported by hospital nursing personnel. In regard to the fifth domain which is professionalism, among the six domains of the Nursing Practice Readiness Tool (NPRT), the participants mentioned that they expected none to be in the non-competent level of competency, whereas 3.8% of the competencies are in this level among the new graduates' current competency level. In addition, 2.9 % of the competencies are expected to be in the competency level of less competent / advanced beginner but contrastingly 20.2% of competencies are in this level among the new graduates' current competency level.

Furthermore, 32.7% of the competencies were expected to be in the competency level of moderately competent / competent level, while it is reported that 28.8% of competencies are in

this level among the new graduates' current competency level on entry to practice. In addition, 32.7% of the competencies were expected to be in competency level of very competent / proficient level, while it is reported that 24.0% of competencies are in this level among the new graduates' current competency level. Furthermore, 31.7% of the competencies were expected to be in competency level of excellently competent / proficient level, while it is reported that 23.1% of competencies are in this level among the new graduates' current competency level.

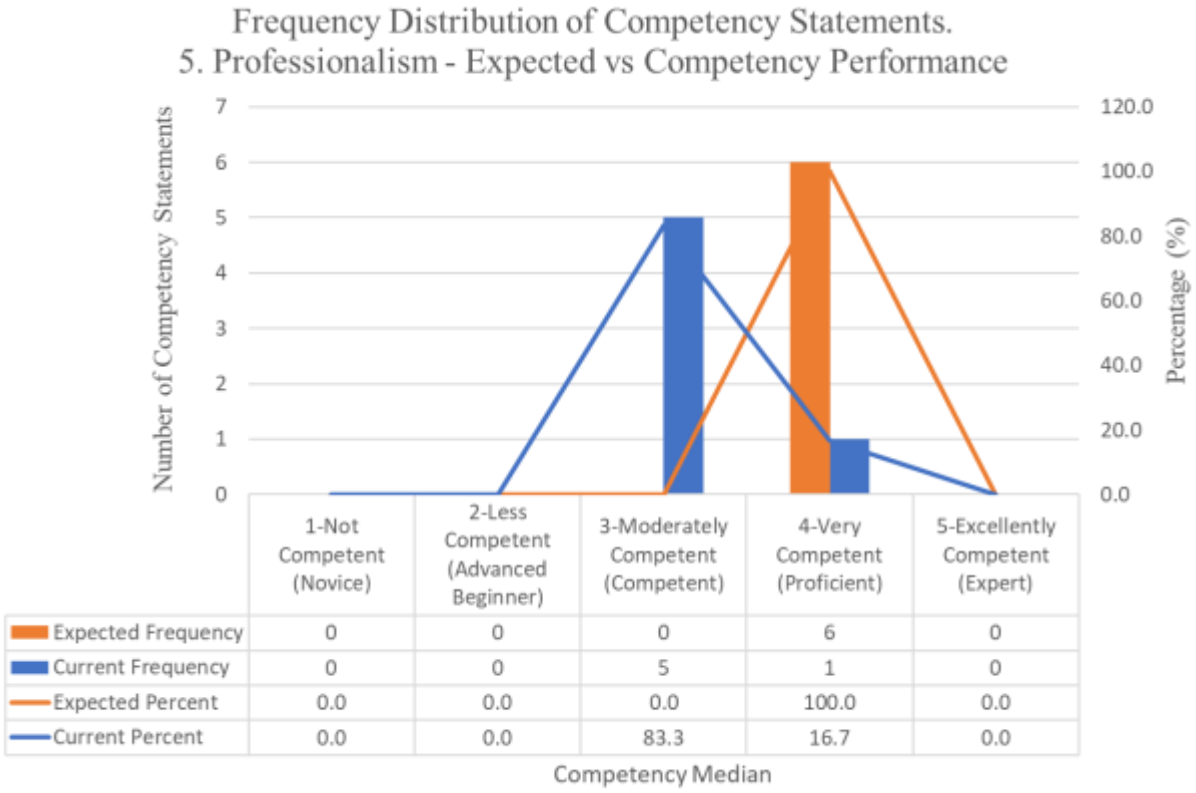


Figure: 4.13 Distribution of competency statements in expected and current level of competency preparedness: Professionalism Domain.

Contemporaneously, viewing the distribution of competency statements as reported by the participants reveals that out of the competency statements related to the professionalism domain, they expected all of them (100%) to be in very competent/ proficient level of competency preparedness. On the contrary, only 16.7 % of the current competencies fall in this class and 83.3% of them are reported to be in the moderately competent /competent level as

illustrated in figure 4.13. The illustration is the distribution of competency statements in expected and current level of competency preparedness distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness for Professionalism skills domain.

Domain 6 – Management of Responsibilities

In regard to the sixth and last domain, which is the management of responsibilities, among the six domains of the Nursing Practice Readiness Tool (NPRT), as illustrated in Figure 4.14, where it shows the distribution of responses of hospital nursing personnel, for expected and current level of competency preparedness in management of responsibilities. The participants mentioned that they expected only 1.9% competencies to be in the non-competent level of competency, whereas strikingly, it was reported that 13.5% of the competencies are in this level among the new graduates' current competency level. In addition, 8.7% of the competencies are expected to be in competency level of less competent / advanced beginner but contrastingly 26.9% of competencies are in this level among the new graduates' current competency level.

Furthermore, 33.7% of the competencies were expected to be in the competency level of moderately competent / competent level, while it is reported that 28.8% of competencies are in this level among the new graduates' current competency level on entry to practice. In addition, 44.2% of the competencies were expected to be in competency level of very competent / proficient level, while it is reported that 26.9% of competencies are in this level among the new graduates' current competency level. Furthermore, 7.7% of the competencies were expected to be in competency level of excellently competent / proficient level, while it is reported that 3.8% of competencies are in this level among the new graduates' current competency level.

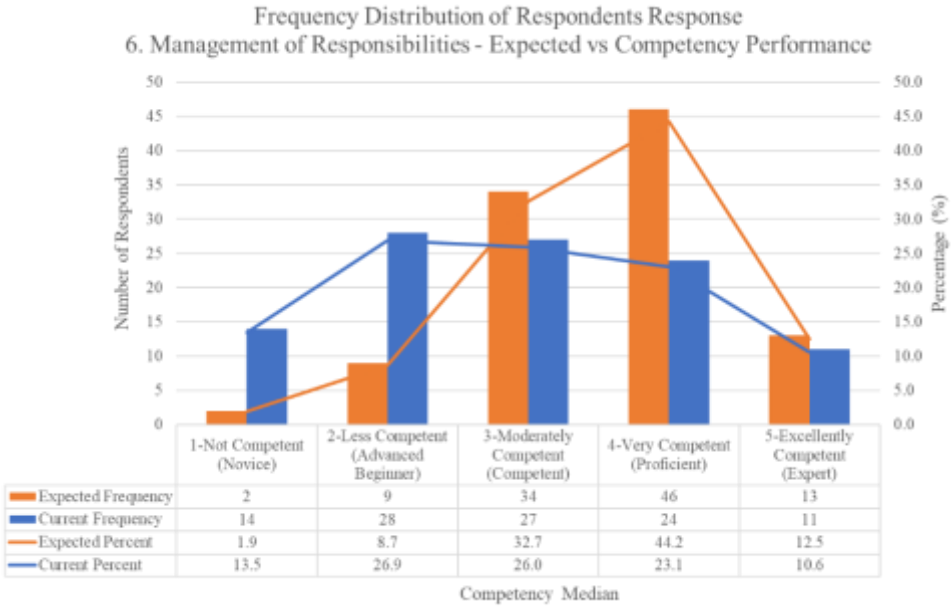


Figure 4.14: Expected and current level of competency preparedness of new graduates for the competencies in the management of responsibilities domain as reported by hospital nursing personnel.

Distribution of competency statements in expected and current level of competency preparedness of Management of Responsibilities domain is depicted in Figure 4.15. In regard to competencies of the first domain, which is clinical knowledge, that is among the six domains of the Nursing Practice Readiness Tool (NPRT), the participants mentioned that they expected none to be in the not-competent/ novice level and less competent / advanced beginner level of competency, and as per the expectation of the competency preparedness of the new nursing graduates.

Positively, none of the competencies were in this level among the new graduates' current competency level. Besides, only 16.7% of the competencies only were expected to be in competency level of moderately competent / competent level, while it is reported that 100% of competencies are in this level among the new graduates' current competency level on entry to

practice. whereas, 83.3% of the competencies were expected to be in competency level of very competent / proficient level, while on the contrary it is reported that 50% of competencies are in this level among the new graduates' current competency level.

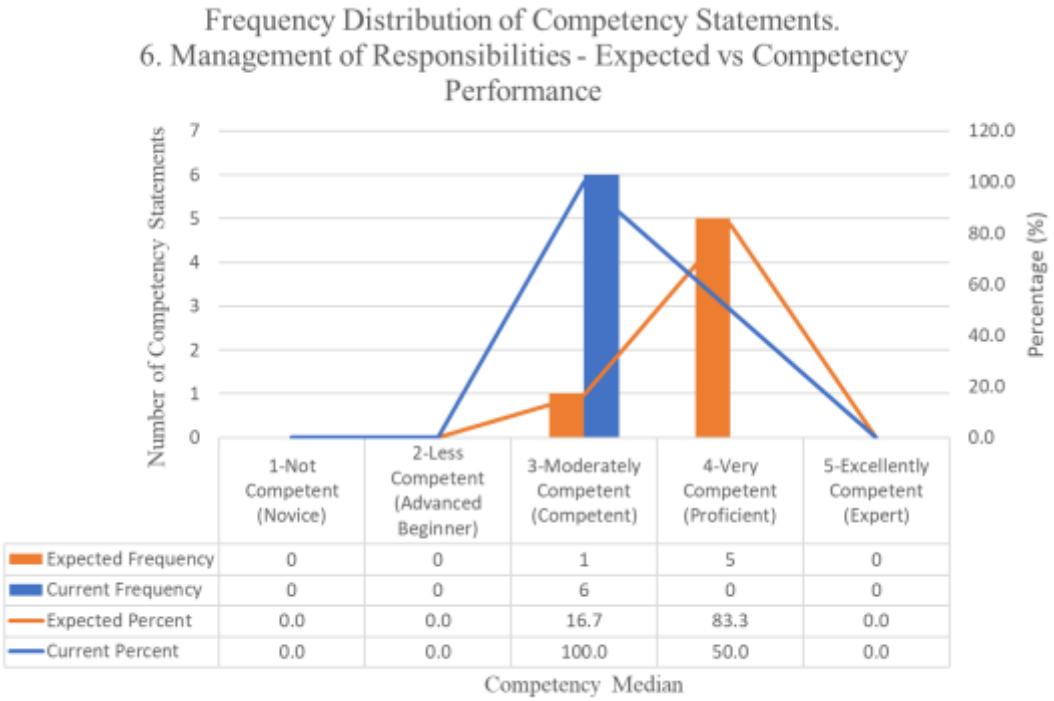


Figure: 4.15 Distribution of competency statements in expected and current level of competency preparedness: Management of Responsibilities Domain.

Furthermore, none of the competencies were expected to be in competency level of excellently competent / expert level and none were found to be in this level among the new graduates' current competency level

Overall Summary Analysis comprising all the six domains.

Overall, among the 43 competency statements in the Nursing Practice Readiness Tool (NPRT), that was used to collect the quantitative data, none of the competencies were expected to be possessed by the new graduate nurses in the Novice / Not competent level, Expert/ excellently

competent level and the advanced beginner level / less competent level of competency preparedness, as reported by the hospital nursing personnel namely, preceptor, charge nurses, unit managers and clinical resource nurses.

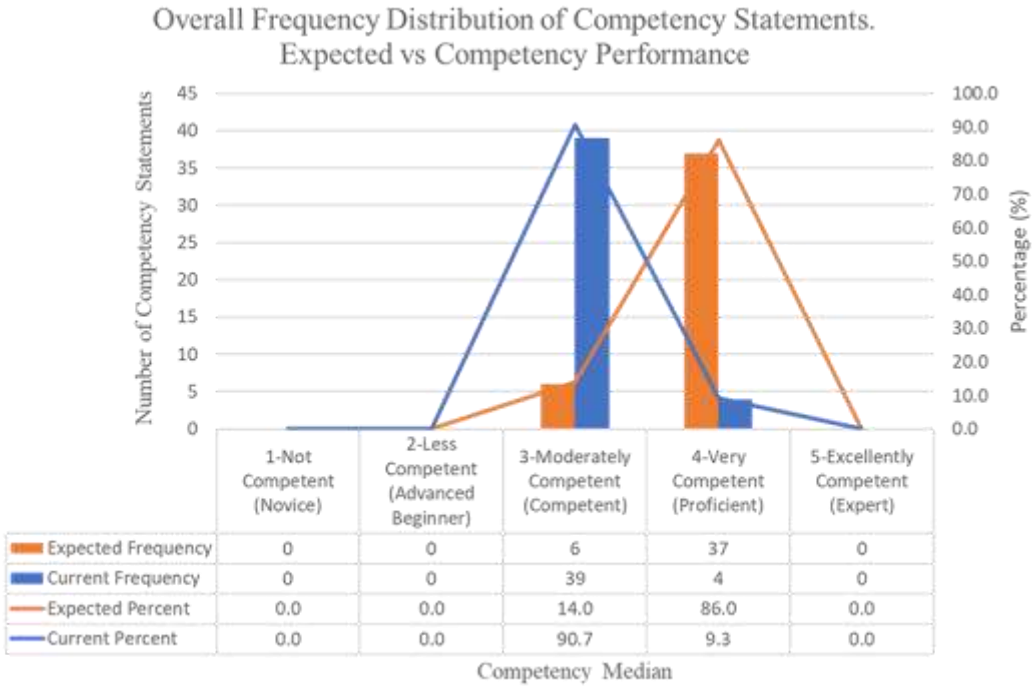


Figure: 4.16 Distribution of competency statements in expected and current level of competency preparedness: Overall.

It is also notable that only 14% of the competencies were expected to be in the moderately competent/ competent level, whereas 86% of the competencies were expected to be in very competent/ proficient level of competency preparedness as an entry-level competency preparedness as depicted in figure 4.16 titled: overall expected and current level of competency preparedness of new graduates as reported by hospital Nursing personnel.

On the other hand, the current level of competency preparedness as perceived by the hospital nursing personnel, namely Preceptor, charge nurses, unit managers and clinical resource nurses, indicates that 90.7% of the competencies were observed to be in moderately competent and only 9.3% were in the competency level of being proficient as the new graduates enter the hospital setting.

4.2.4.3 Research Question 3 – Most Important Competencies for Preparedness.

RQ3. What skill levels and practice expectations of the new graduate nurses do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as most important?

The researcher conducted descriptive statistical analysis to determine which skill levels of the new graduate nurses were perceived by nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders as most important. The means of the responses for the 43 competencies of the six domains in the Nursing Practice Readiness Tool (NPRT) were obtained. The higher mean responses for the competency statements included in the tool indicated the higher importance perceived by the participants. The lower mean responses for the competency statements indicated the lower importance perceived by nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders. The higher mean responses indicate that the particular competency is perceived as most important and the top 15 or most important 15 expected competencies are presented in Table 4.16.

Table 4.16: Top 15 Competencies that the Nursing Staff and Nursing Administrators feel are most important

Top 15 Expected Competency Preparedness

S. No	Domain	Competencies	Mean
1	Communication	C4.1 Rapport with patients and families.	3.99
2	Professionalism	C5.6 Respect for diverse cultural perspectives	3.95
3	Technical Skills	C2.6 Preparing the patients to diagnostic investigation	3.87
4	Technical Skills	C2.2 Pain assessment	3.85
5	Professionalism	C5.2 Ability to work as part of a team.	3.85
6	Technical Skills	C2.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	3.84
7	Technical Skills	C2.10 Safe administration of medications per oral	3.82
8	Communication	C4.2 Communication with interprofessional team	3.82
9	Professionalism	C5.4 Customer service	3.82
10	Professionalism	C5.5 Accountability for actions	3.81
11	Technical Skills	C2.4 Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.)	3.80
12	Communication	C4.4 Patient education	3.79
13	Technical Skills	C2.1 Conducting patient assessments, Clinical history collection, Physical assessment related to all systems	3.77
14	Technical Skills	C2.3 Documentation of patient assessment data	3.76
15	Professionalism	C5.1 Ability to work independently	3.73

The competency that is considered as most important and is expected by the preceptors, charge nurses, unit managers and the clinical resource nurses is rapport with patients and families with the mean of 3.99, followed by respect for diverse cultural perspectives, preparing the patients for diagnostic investigation, pain assessment and ability to work as part of a team with the means of 3.95, 3.87, 3.85 and 3.85 respectively. In addition, interpretation of assessment data

(e.g., history, exam, lab testing, etc.) with the mean (3.84), safe administration of medications per oral (3.82) communication with interprofessional team (3.82), customer service (3.82), and accountability for actions (3.81) were considered as the next most important competencies. Followed by that, the last five competencies among the top 15 important competencies are Performing clinical procedures (e.g., sterile dressing IV therapy, etc.) with the mean of (3.80), Patient education (3.79), conducting patient assessments, clinical history collection, physical assessment related to all systems (3.77), documentation of patient assessment data (3.76) and the competency of ability to work independently (3.73). all of these competencies belong to the communication domain, professionalism and technical skills domain.

4.2.4.4 Research Question 4 – High Performance Competencies

RQ4. Which are the competencies do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital?

This research question was answered by conducting the descriptive statistical analysis of the responses of the participants to the Nursing Practice Readiness Tool (NPRT) which contains 43 competency statements grouped in six domains namely clinical knowledge, technical skills, critical thinking, communication, professionalism and management of responsibilities. The higher the mean for the responses, it indicates the low mean responses for the competency statements indicates the lower current performance by the new graduate nurses as observed by the hospital personnel, Registered nurses with the role of preceptors, charge nurses, unit managers and clinical resource nurses. Table 4.17 presents the 15 competencies that were perceived by the hospital personnel as high performance by the new nurse graduates as they entered the hospital setting.

Table 4.17: Top 15 Competencies that the Nursing Staff and Nursing Administrators Sample feel that the new nursing graduates' performance is high

Top 15 Current Performance Competencies

S. No	Domain	Competencies	Mean
1	Communication	C4.1 Rapport with patients and families.	3.53
2	Professionalism	C5.6 Respect for diverse cultural perspectives	3.46
3	Technical Skills	C4.2 Communication with interprofessional team	3.45
4	Professionalism	C5.2 Ability to work as part of a team.	3.43
5	Technical Skills	C2.3 Documentation of patient assessment data	3.38
6	Technical Skills	C2.11 Preparing and administering intramuscular, intracutaneous and subcutaneous injections	3.38
7	Technical Skills	C2.2 Pain assessment	3.34
8	Technical Skills	C2.6 Preparing the patients to diagnostic investigation	3.33
9	Communication	C4.4 Patient education	3.33
10	Professionalism	C5.4 Customer service	3.29
11	Professionalism	C5.5 Accountability for actions	3.29
12	Technical Skills	C2.1 Conducting patient assessments, Clinical history collection, Physical assessment related to all systems	3.28
13	Technical Skills	C2.10 Safe administration of medications per oral	3.22
14	Critical Thinking	C3.4 Formulating Nursing care plan based on assessment findings.	3.17
15	Technical Skills	C2.4 Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.)	3.16

The first and foremost competency that the new graduate nurses showed high performance was Rapport with patients and families with the mean of 3.53, followed by the competency of respect for diverse cultural perspectives with the mean of 3.46. It is interestingly observed that the same two competencies were the ones that hospital personnel expected the new graduates to possess and be well prepared in and were the top two among the 15 expected competencies

belonging to the domain of communication and professionalism respectively. The third highly performed competency was Communication with interprofessional team with the mean of 3.45 followed by the competency, Ability to work as part of a team with the mean 3.43, Documentation of patient assessment data and preparing and administering intramuscular, intracutaneous and subcutaneous injections with the mean of 3.38.

Subsequently, pain assessment, preparing the patients to diagnostic investigation, patient education, customer service and accountability for actions with the mean of 3.34, 3.33,3.33, 3.28 and 3.28 respectively. Conducting patient assessments, clinical history collection, physical assessment related to all systems with the mean of 3.28, Safe administration of medications per oral with the mean of 3.22 followed by Formulating Nursing care plan based on assessment findings and Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.) with the mean of 3.17 and 3.16 respectively were the 15 competencies that were found to be performed by the new graduates accurately and as expected by the hospital personnel on entry to the hospitals. The research question RQ3 identifies the most important competencies that are expected by the hospital personnel and the RQ 4 identifies the competencies that has high performance level by the nursing graduates. Since the answer to this obtained by identifying the means of the response, further statistical methods were not found to be necessary.

4.2.4.5 Research Question 5 – Identified Gaps in Competency Preparedness

RQ5. What are the competencies that are identified to have gaps in new graduate nurses' competency preparedness and which of them are reported to have wider gaps?

To answer this research question, which focuses on identifying the gaps in the competency preparedness among the new graduates as reported by the hospital nursing personnel,

Importance–performance matrix was computed. This indicates the magnitude of the gap between the current competency preparedness and the expected competency preparedness. The responses of the participants in regard to the expected and current competency level were computed into the importance-performance matrix, where the competency statements as per the responses are distributed into four quadrants namely the high importance-low performance quadrant that needs immediate action as high priority, high importance-high performance quadrant, where the level of current competencies are as per the expected level of competency preparedness the competencies in this quadrant can be maintained in the same performance level.

The third quadrant is the low importance-low performance where the competencies expected are in the low expectation, as well as the performance level of competency is also in the new competency level, but efforts can be taken to improve the competency level. The fourth quadrant is the low importance-high performance quadrant where the current level of competency preparedness of the new graduates is more than the expected level and can be maintained in the same level.

Domain 1 – Clinical Knowledge

Expected Performance current Performance Analysis of Domain – 1. Clinical Knowledge is illustrated in Figure 4.17. In regard to the clinical knowledge domain, pharmacological implications of medications was identified to be the competency that the new graduates lack expected preparation on entry to health care setting needing to act to improve the competency preparedness in the academic preparation.

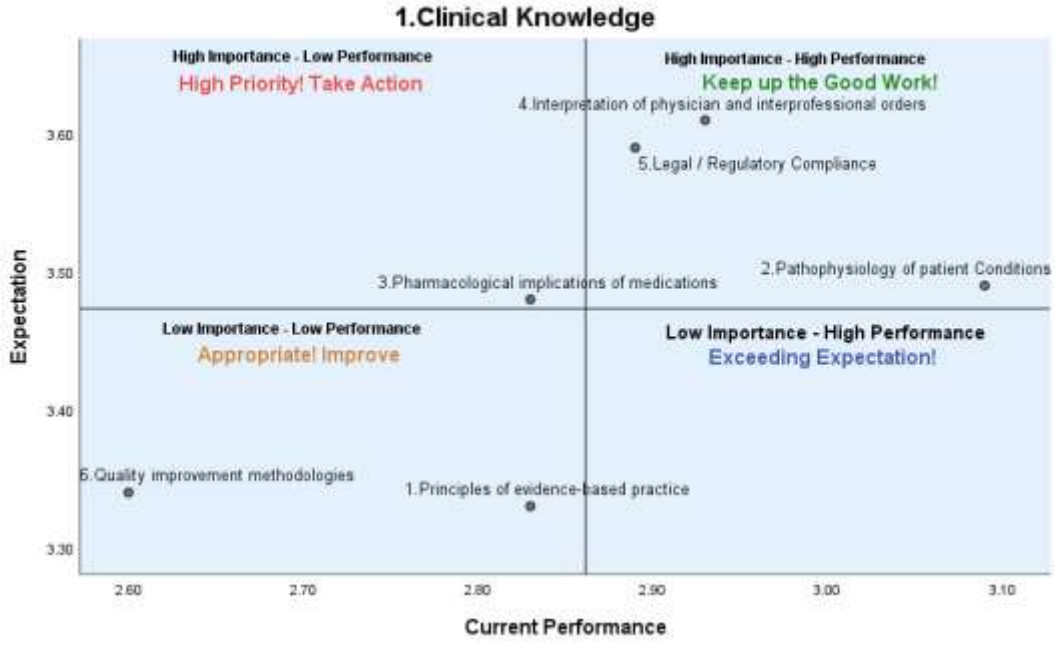


Figure 4.17: Expected Performance – Current Performance Analysis of Domain – 1. Clinical Knowledge

Compliance with legal / regulatory issues relevant to nursing practice, and Interpretation of physician and interprofessional orders and Knowledge of pathophysiology of patient Conditions were the competencies that the new graduates had been prepared for at the expected level. In the third quadrant, the current level of competency preparedness and also the expectation was also low and there were none of the competencies in the last and the fourth quadrant where the current competencies of the new graduates were exceeding the expectation.

Domain 2 – Technical Skills

Expected Performance vs Current Performance Analysis of Domain – 2. Technical skills is illustrated in Figure 4.18. In regard to the technical skills domain, Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.) and interpretation of assessment data (e.g.,

history, exam, lab testing, etc.) conducting patient assessments were identified to be the competencies that the new graduate lack expected preparation on entry to health care setting that requires action to improve the competency preparedness in the academic preparation.

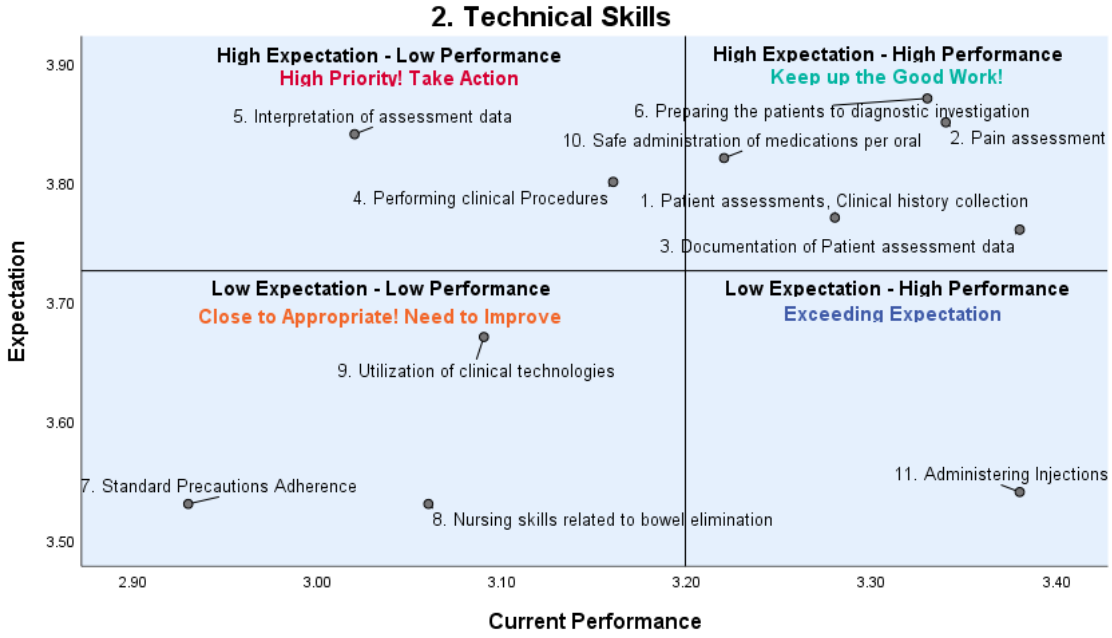


Figure 4.18: Expected Performance – Current Performance Analysis of Domain – 2. Technical Skills

Clinical history collection, physical assessment related to all systems, pain assessment documentation of patient assessment data, preparing the patients to diagnostic investigation and safe administration of medications per oral are the competencies that the new graduates had been prepared as the expected level. In the third quadrant where the current level of competency preparedness and also the expectation was also low were the competencies like adherence to standard precautions including transmission –based precautions, nursing skills related to bowel elimination, utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc. In the last and the fourth quadrant where the current competencies of the new graduates were exceeding the expectation was the competency of administration of injections.

Domain 3 – Critical Thinking

Expected Performance –Current Performance Analysis of Domain – 3, Critical Thinking is illustrated in Figure 4.19. In regard to the critical thinking domain, Recognition of changes in patient status, is identified to be the competency that the new graduate lacks expected preparation on entry to health care setting needing to act to improve the competency preparedness in the academic preparation, recognition of when to ask for assistance, Oxygenation and respiration.

Assessing changes and Formulating nursing care plan based on assessment findings interpretation of breathing in acute problem situation and managing and Ability to anticipate risk, Interpretation of assessment data (e.g., history, exam, lab testing, etc.), Recognition of unsafe practices by self and others are the competencies that the new graduates had been prepared at the expected level. In the third quadrant, the current level of competency preparedness and also the expectation was also low and Lab report interpretation and reporting, Decision making based on the nursing process. There were competencies in the last and the fourth quadrant where the current competencies of the new graduates were exceeding the expectation.

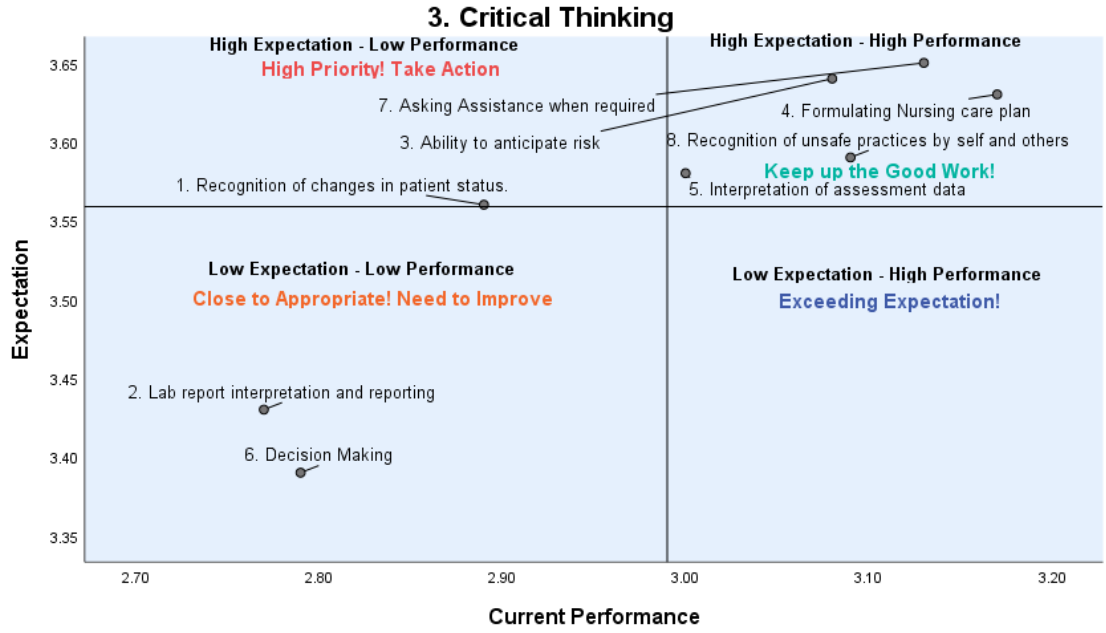


Figure 4.19: Expected Performance – Current Performance Analysis of Domain – 3. Critical Thinking

Domain 4 – Communication

Expected Performance vs Current Performance Analysis of Domain – 4. Communication as illustrated in Figure 4.20. In regard to the communication domain, none are identified to be the competencies that the new graduate lacks expected preparation on entry to health care setting and needing to act to improve the competency preparedness in the academic preparation and, none are listed in the fourth quadrant where the current competencies of the new graduates are exceeding the expectation. Whereas, rapport with patients and families, Communication with interprofessional team, Patient education, are the competencies that the new graduates had been prepared for as per the expected level.

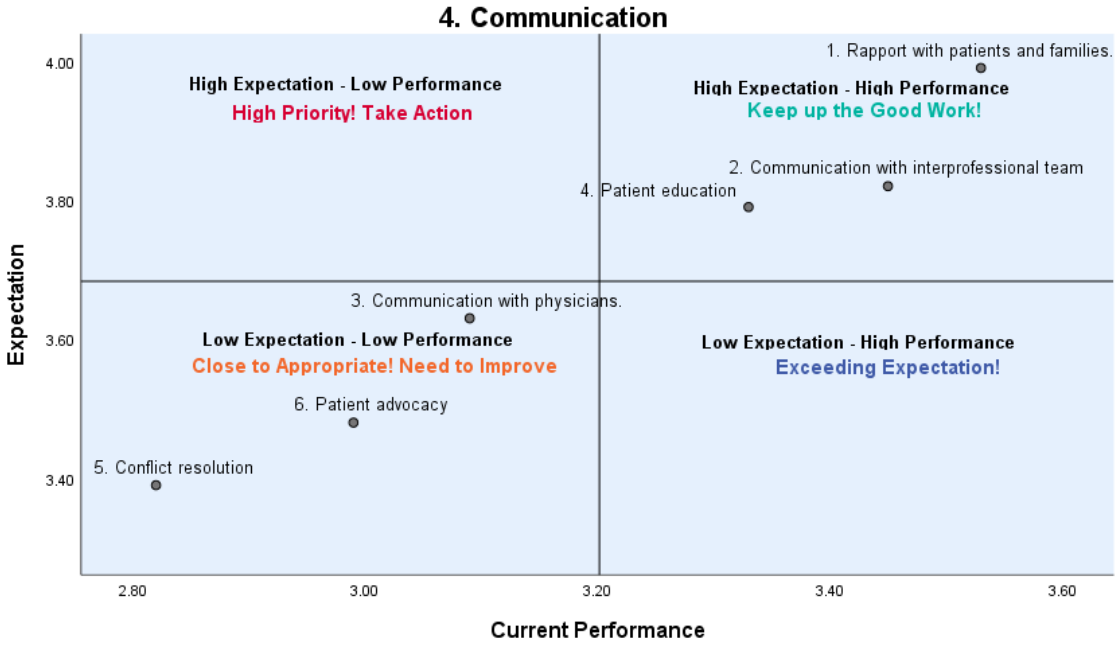


Figure 4.20: Expected Performance – Current Performance Analysis of Domain – 4. Communication

In the third quadrant the current level of competency preparedness and also the expectation was also low, where the competencies are listed which are close to the expectation but needs improvement in competency preparation are, competencies like communication with physicians., Conflict resolution, Patient advocacy.

Domain 5 – Professionalism

Expected Performance vs Current Performance Analysis of Domain – 5. Professionalism, as illustrated in Figure 4.21, as per the importance-performance matrix, related to the professionalism domain, customer service is identified to be the competency that the new graduate lacks expected preparation for on entry to health care setting needing to act to improve the competency preparedness in the academic preparation and, none are listed in the fourth quadrant where the current competencies of the new graduates are exceeding the

expectation. Whereas, ability to work as part of the team is the competencies that the new graduates had been prepared for as per the expected level.

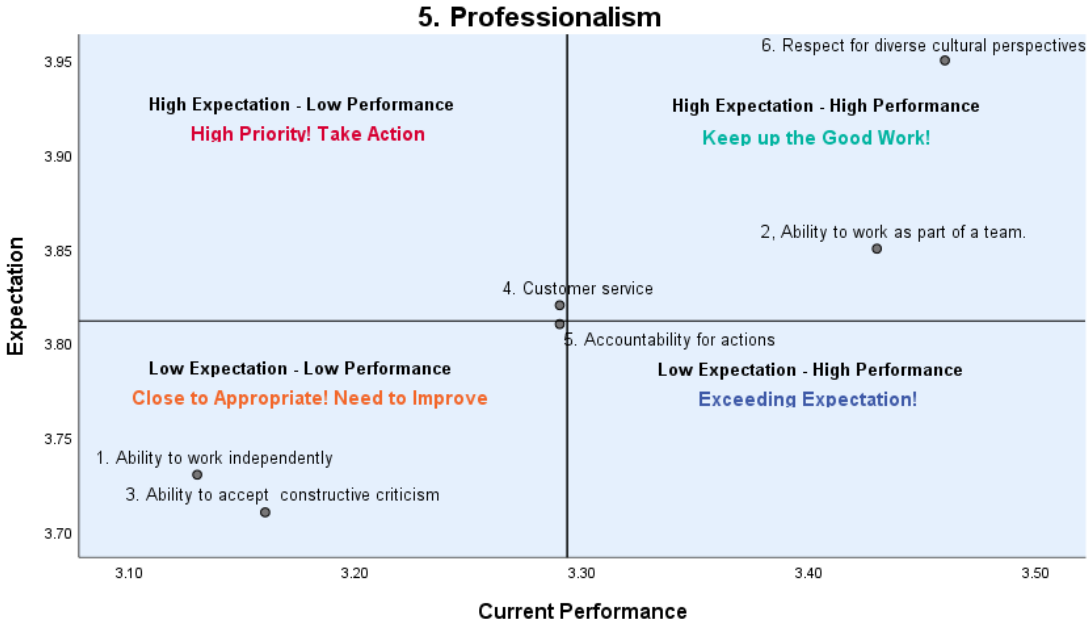


Figure 4.21: Expected Performance – Current Performance Analysis of Domain – 5. Professionalism

In the third quadrant where the current level of competency preparedness needs to be improved and also the expectation was also low or close to be appropriate, the competencies are listed are close to the expectation but needing improvement in competency preparation are, ability to work independently and ability to accept constructive criticism.

Domain 6 – Management of Responsibilities

Expected Performance vs Current Performance Analysis of Domain – 6. Management of responsibilities is illustrated in Figure 4.22. In regard to the management of responsibilities domain, completion of individual tasks within expected time frame is identified to be the

competency that the new graduate lacks expected preparation on entry to the health care setting needing action to improve the competency preparedness in academic preparation.

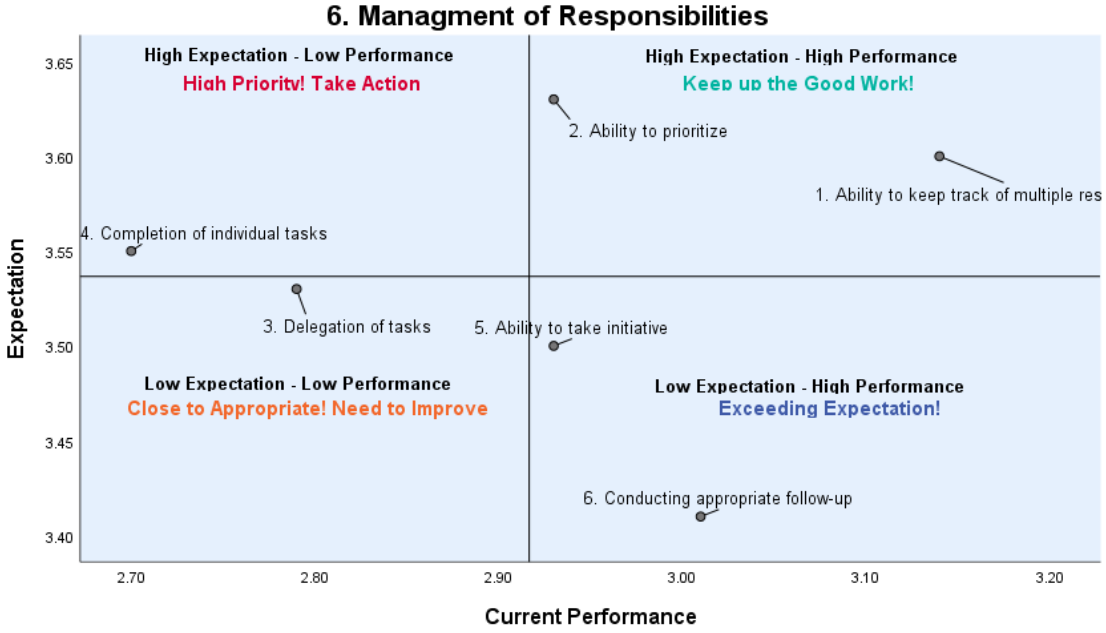


Figure 4.22: Expected Performance – Current Performance Analysis of Domain – 6. Management of Responsibilities

Ability to keep track of multiple responsibilities, and ability to prioritize are the competencies that the new graduates had been prepared at the expected level. In the third quadrant where the current level of competency preparedness is close to appropriate still needs improvement, the competency in delegation of tasks is identified. Finally, in the last and the fourth quadrant where the current competencies of the new graduates are exceeding the expectation, ability to take initiative and Conducting appropriate follow-up, is reported.

4.2.4.6 Analysis of Responses regarding Expected and Current Competency levels among participants as per the Designation

In this study as the researcher intended to determine whether four means of the responses among the four cohorts were different, so ANOVA was performed. Post hoc tests were run to confirm where the differences occurred between responses of expected and current competency levels of competency among the groups like the preceptors, charge nurses, unit managers and the clinical resource nurses. Post hoc tests are an integral part of ANOVA. ANOVA is used to test the equality of at least three group means, statistically significant results indicate that not all of the group means are equal. As per Table 4.18 the post hoc ANOVA values indicate that if the significance level is below 0.3 then it indicates that the difference is great, and they do not correlate or match.

Table 4.18: Post Hoc Anova Mean Results with respect to Designation

Tukey Method		Unit Manager	Charge Nurse	Preceptor / RN	CRN	Total Mean
1. Clinical Knowledge	Expected Level	3.6	3.70	3.37	4.4	3.47
	Current Level	2.68	3.24	2.80	3.57	2.86
2: Technical skills	Expected Level	3.75	4.22	3.61	4.60	3.72
	Current Level	2.88	3.78	3.14	3.69	3.20
3. Critical Thinking	Expected Level	3.49	4.13	3.45	4.53	3.56
	Current Level	2.46	3.67	2.94	3.65	2.99
4. Communication	Expected Level	3.40	4.22	3.62	4.33	3.68
	Current Level	2.55	3.87	3.19	3.47	3.20
5. Professionalism	Expected Level	3.45	4.24	3.78	4.23	3.81
	Current Level	2.78	3.80	3.28	3.60	3.29
6: Management of Responsibilities	Expected Level	3.30	3.94	3.48	4.20	3.54
	Current Level	2.43	3.54	2.88	3.40	2.92

Here in this study, the difference between the means of four groups were compared to identify if there were any changes in the perceptions of expected and current competency preparedness

among the four cohort of participants, namely the preceptors who are the immediate person in contact, then the charge nurses, the unit managers and the last cohort is the clinical resource nurses. If the level of significance of difference in the means are between 0.3 and less than 0.7 it means that the difference is neutral, meaning that there is not much of the difference between the perception of the expected and current level of competencies as perceived by the hospital nursing personnel are neutral. If the value is above 0.7 to 1.0 then it means that their perceptions among the cohort of participants match and there is no difference in their perception of competency preparedness of both the expected and current level.

As per Figure 4.23, in regard to the clinical knowledge domain, the expectation regarding the competency preparation level of entry to health care setting seems to be the same or minimal difference between the perception of unit manager and charge nurse, unit manager and preceptor RN. The Unit manager and preceptor pairing seems to have the same perceptions, not only related to the expectations and current performance of competency levels of new nurses concerning the clinical knowledge domain (0.778), but also in the expectations and current performance regarding the competencies in the second domain which is technical skills (0.9), third domain, critical thinking (0.9), fourth domain, the communication (0.7), and the sixth domain: management of responsibilities (0.9) seems to be within the range of 0.7-1.0 which is good indicating they both had similar perceptions.

However, in regard to the professionalism their perceptions were neutral. Whereas among the unit manager and the charge nurses' pairing, the expectations and perceptions of the current level of competency preparedness seems to be very different as presented in the table for the current competency level, expectations and current level for critical thinking, communication, professionalism and also the management of responsibilities domain.

Designation		E1	C1	E2	C2	E3	C3	E4	C4	E5	C5	E6	C6
Unit Manager	Charge Nurse	0.989	0.564	0.531	0.225	0.231	0.067	0.054	0.027	0.127	0.192	0.284	0.136
	Preceptor / RN	0.778	0.984	0.939	0.871	0.998	0.532	0.787	0.237	0.584	0.532	0.904	0.624
	CRN	0.184	0.314	0.176	0.467	0.051	0.172	0.072	0.349	0.261	0.528	0.161	0.382
Charge Nurse	Unit Manager	0.989	0.564	0.531	0.225	0.231	0.067	0.054	0.027	0.127	0.192	0.284	0.136
	Preceptor / RN	0.555	0.529	0.100	0.286	0.044	0.206	0.068	0.225	0.339	0.543	0.335	0.330
	CRN	0.312	0.923	0.804	0.999	0.757	1.000	0.992	0.889	1.000	0.989	0.936	0.996
Preceptor / RN	Unit Manager	0.778	0.984	0.939	0.871	0.998	0.532	0.787	0.237	0.584	0.532	0.904	0.624
	Charge Nurse	0.555	0.529	0.100	0.286	0.044	0.206	0.068	0.225	0.339	0.543	0.335	0.330
	CRN	0.013	0.282	0.026	0.643	0.009	0.460	0.118	0.933	0.590	0.922	0.196	0.735
CRN	Unit Manager	0.184	0.314	0.176	0.467	0.051	0.172	0.072	0.349	0.261	0.528	0.161	0.382
	Charge Nurse	0.312	0.923	0.804	0.999	0.757	1.000	0.992	0.889	1.000	0.989	0.936	0.996
	Preceptor / RN	0.013	0.282	0.026	0.643	0.009	0.460	0.118	0.933	0.590	0.922	0.196	0.735

Post Hoc Anova	Sig < 0.3	Bad
	Sig 0.3 < 0.7	Neutral
	Sig 0.7 < 1.0	Good

Figure 4.23: Post Hoc Anova Analysis on Expected and Current Competency performance among different Designated Nursing Professionals

Interestingly, it is observed that the perceptions regarding the expected level of competency preparedness and the perceived current level of competency preparedness among the unit manager and preceptor pairing seems to be the same or matching and similarly the same is observed among the charge nurse and CRN (Clinical resource Nurses).

4.3 Summary of Quantitative Data Analysis Results

This section presents the quantitative data analysis results to answer the study's research question which focuses on the competency preparedness of new graduates on entry to health care setting as perceived by the hospital nursing personnel. The descriptive data obtained from the Nursing Practice Readiness Tool (NPRT) addresses the current and expected levels of competency preparedness among the new graduates, as perceived by the hospital nursing

personnel. The hospital nursing personnel includes the nurse preceptor, unit manager, clinical resource nurse.

A purposeful sample of 104 participants from the five government hospitals of Abu Dhabi was identified to conduct the study. The demographics of the study included: (1) Hospital, (2) Age, (3) Nationality, (4) Education, (5) Designation and (6) Years of experience. The highest number of participants were from hospital A, with 47.1% of participants and the least percentage of participants were from Hospital E with 4.8% of the participants. The difference in the no of participants directly is proportionate to the no of graduates that are recruited in the hospitals as per the need and bed capacity. Most of the participants were within the age group of 59.6% and there were only 5.8% of the participants, who were the least percentage of participants within the age group of 51-60yrs.

Among the 104 participants who responded to the Nursing Practice Readiness Tool (NPRT), 44.2% mentioned that they expected the competencies in the clinical knowledge domain to be in the proficient / very competent level of competency preparedness as they enter the practice setting as new graduate. Most of the participants (35.6%) report that the current competency level of the new graduate in this domain of clinical knowledge is in the less competent / advanced beginner level.

In regard to the competencies in the technical skills domain, 48.1% mentioned that they expected the competencies to be in the proficient / very competent level, whereas only 28.8% only reported to have competencies in the expected level. Regarding the critical thinking domain, 40.4% of the participants mentioned that they expected the competencies in the critical thinking domain to be in the proficient / very competent level of competency preparedness. On

the contrary, a majority of the participants (32.7%) reported that the competency level of the new graduate in this domain of technical skills was in the moderately competent/ competent / level.

A total of 32.7 % of the participants mentioned that they expected the competencies in the communication domain and professionalism domain respectively to be in the proficient / very competent level of competency preparedness, but 33.7% and 28.8 % of them respectively reported that the current competency level of the new graduate. is in the moderately competent/ competent / level. Similarly, In regard to the management of responsibilities domain, 44.2% of the competencies were expected to be in competency level of very competent / proficient level while it was reported that 26.9% of competencies are in this level among the new graduates' current competency level.

For the new nursing graduates, on entry to the health care setting, the 15 top competencies that the hospital nursing personnel perceived as most important were identified with their highest means. These top 15 competencies are identified among the 43 competency statements, which are a part of nursing practice readiness tool. The competencies with highest mean on expectation data and identified as the top fifteen competences are listed here as follows: (1) Rapport with patients and families, (2) Respect for diverse cultural perspectives , (3) Communication with interprofessional team, (4) Ability to work as part of a team, (5) Documentation of patient assessment data, (6) Preparing and administering intramuscular, intracutaneous and subcutaneous injections, (7) Pain assessment, (8) Preparing the patients to diagnostic investigation, (9) Patient education, (10) Customer service, (11) Accountability for actions, (12) Conducting patient assessments, Clinical history collection, Physical assessment related to all systems, (13) Safe administration of medications per oral, (14) Formulating

Nursing care plan based on assessment findings and (15) Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.).

The 15 competencies, that was perceived by the hospital personnel as high performance by the new nurse graduates as the entered the hospital setting. The first and foremost competency that the new graduate nurses showed high performance in was Rapport with patients and families with the mean of 3.53, followed by the competency of respect for diverse cultural perspectives with the mean of 3.46. It is interestingly observed that the same two competencies were the ones that are hospital personnel expected the new graduates to possess and be well prepared in and were the top two among the 15 expected competencies belonging to the domain of communication and professionalism respectively. The third highly performed competency was Communication with interprofessional team with the mean of 3.45 followed by the competencies, Ability to work as part of a team with the mean 3.43, Documentation of patient assessment data and preparing and administering intramuscular, intracutaneous and subcutaneous injections with the mean of 3.38. Subsequently, pain assessment, preparing the patients to diagnostic investigation, patient education, customer service and accountability for actions with means of 3.34, 3.33, 3.33, 3.28 and 3.28 respectively. Conducting patient assessments, clinical history collection, physical assessment related to all systems with the mean of 3.28, Safe administration of medications per oral with the mean of 3.22 followed by Formulating Nursing care plan based on assessment findings and Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.) with the mean of 3.17 and 3.16 respectively were the 15 competencies that were found to be performed by the new graduates accurately and as expected by the hospital personnel on entry to the hospitals.

The responses of the participants in regard to the expected and current competency levels were computed into the importance-performance matrix, where the pharmacological implications of

medications, performing clinical Procedures (e.g., sterile dressing IV therapy, etc.) and interpretation of assessment data (e.g., history, exam, lab testing, etc.) conducting patient assessments, recognition of changes in patient status completion of individual tasks within expected time frame, were identified to be the competencies that were identified to be in the first quadrant which is the high expectation abut low performance quadrant. The competencies in this quadrant implies that the new graduate lacks expected preparation on entry to health care setting needing action to improve the competency preparedness in academic preparation.

Post Hoc Anova Analysis on Expected and Current Competency performance among different Designated Nursing Professionals revealed that significant differences were identified among the perceptions reported regarding expected and current competency preparedness among the new nursing graduates as expressed by the different nursing professionals of the hospital. It reveals that the perceptions regarding the expected level of competency preparedness and the perceived current level of competency preparedness among the unit manager and preceptor pairings seemed to be the same or matching and similarly the same was observed among the charge nurse and CRN.

4.4 Qualitative Data Analysis Results and Discussion

It is very important to understand how the academic preparation of new nursing graduates has helped in the preparedness for practice in the health care setting as the nursing curriculum is performance-based. This study was mainly undertaken to understand the preparedness of the new graduates from the hospital personnel's perceptions. For this reason, the Nursing Practice Readiness Tool (NPRT) was used to capture the quantitative data, but there are some aspects that cannot be obtained in-depth using quantitative data collection and analysis. Thus, this

mixed methods study is incorporated adopting the in-depth interview in exploring the topic of study.

Following the analysis of Nursing Practice Readiness Tool (NPRT) responses, the researcher presents in this section, the analysis of semi-structured interview responses of the participating preceptors, unit managers, clinical resource nurses of the medical-surgical units where the GNI will be posted on entry and the nursing leadership. Though the analysis of the qualitative data is presented following the quantitative data analysis, the analysis of the interviews was done concurrently. The interviews were aimed to identify their perceptions towards the competency preparedness of new graduates on entry to practice.

The individual interviews began by asking the participants a general and open question regarding their general perception about the competency preparedness of new graduates, in comparison to what they perceive to be expected competency preparedness, followed by their opinion about the contributing factors for the current level of practice preparedness and their suggested strategies to improve the same. Some other questions were asked based on the participants' statements and responses. Moreover, some supplementary questions were utilized based on the participants' comments and opinions (e.g., “would you elaborate more on this?” or “what did you mean by saying …?”) to search and complete information.

The interview sessions were audio recorded and then transcribed. The participants’ responses were assembled and coded, then analyzed into commonly shared themes that grouped and matched the same or similar perspectives. Key themes and emerging patterns were coded from multiple reviews of data five key themes namely competency expectations, overall competency status, highly satisfied competencies, less satisfied competencies, contributors for competency

gap and strategies for bridging competency and related subthemes were identified from the data analyzed. The key themes, the subthemes along with the strategies to improve the competency preparedness based on the lessons learnt from this study, are discussed below.

4.4.1 Response Rate for Semi Structured Interview

Qualitative part of the study was undertaken as a part of mixed methods research approach. This was undertaken to obtain the in-depth understanding on the focus of study which is the competency preparedness of fresh nursing graduates as they leave the academic setting and enter the health care institutions. As per the inclusive criteria, the probable participants, who were the hospital nursing personnel, in various designations like the unit RNs (the registered nurses), charge nurses, unit managers, clinical resource nurses of the medical surgical units, where the fresh nursing graduates are recruited and posted within two years from the date of interview. In addition, the Assistant director of nursing and the chief nursing officer from the nursing leadership were approached to participate in the study. The participants were from five hospitals of SEHA in Abu Dhabi where the ethical approval was obtained as illustrated in table 4.19. The total participants from the hospital A was 22, comprising 39.2% from the total participants participated in the semi structure interview. Hospital B had 12 (21.4%) participants, hospital C had 11 (19.6) participants, hospital D had 5 (8.9) participants and from hospital E, there were six (10.7) participants. In total, there were 56 participants for the semi–structured interview. In hospitals A, B and C the number of participants for the semi-structured interview was decided based on the data saturation. Participants from D and E were the total number of nursing personnel in the category in those hospitals. The discrepancy in the number of participants from the hospitals was based on the bed capacity of the hospital, the number of staff and the number of fresh graduates being recruited in those hospitals.

Table 4.19: Qualitative Analysis Demographic Data

Demographic Characteristics	Number of participants (Frequency)	Percentage
Hospital		
1. Hospital A	22	39.2
2. Hospital B	12	21.4
3. Hospital C	11	19.6
4. Hospital D	5	8.9
5. Hospital E	6	10.7
Designation		
1. Unit Manager	9	16.0
2. Charge Nurse	5	8.9
3. Preceptor / RN	24	42.8
4. Clinical Resource Nurse	7	12.5
5. Assistant Director of Nursing	6	10.7
6. Chief Nursing Officer	3	5.3

Among the 56 participants in the semi-structured interviews, there were nine unit managers, accounting for 16% of the total participants. Five (8.9%) charge nurses, 24 (42.8%) were the preceptors (RN), and seven (12.5%) were the clinical resource nurses. Among the nursing leadership, six (10.7%) were assistant directors of nursing and three (5.3%) were chief nursing

officers participated in the semi structured interview contributing to the qualitative part of the study.

4.4.2 Qualitative Data Thematic Analysis

The semi-structured interviews with the participants from four different job profile in nursing such as Registered Nurse-preceptor, unit manager ,Clinical resource nurse, Assistant director of Nursing were aimed to answer the study's research question in depth namely: What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the current level of competency preparedness of new graduate nurses?, What is the expected level of competency preparedness as perceived by the nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders?. Though these two questions were responded by the preceptors, unit managers and the clinical resource nurses as a response to the Nursing Practice Readiness Tool which has specific competency statements included in six domains, further discussions on the questions yielded much more in-depth data as expected.

The nursing leadership were exempted from responding to the NPRT as per the experience obtained during the pilot study and only semi-structured interviews were conducted with them to find answers for the mentioned research questions. The other research question focused on finding the answer is the study's fourth research question: What strategies do the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggest to enhance the competency preparedness and concomitant practice expectations of new graduate nurses? The participants' responses were assembled and coded, then analyzed into

commonly shared themes and the matching perspectives were grouped as broad themes and then the subthemes were identified as illustrated in Figure 4.24.

Figure 4.24: Thematic Analysis – Themes and Sub-themes

The six themes that were identified from the participants' interview responses were: Overall perception on competency preparedness, highly satisfied competencies, less satisfaction competencies, contributors for competency gap and Strategies for bridging the gap. They are discussed below.

4.4.2.1 Theme 1 - Overall View on Competency Preparedness

The participants' responses to the overarching open-ended question on their overall view about the competency preparedness of new graduate nurses was considered. Most of the participants mentioned their overall perception regarding the competency preparedness of the hospital

personnel was ranging between deficient or just acceptable level and there was much scope for improvement as illustrated in Figure 4.25. Most of the participants highlighted passionate and dedicated customer care which is a vital component of expected preparedness. The competency preparedness may have some deficiencies related to a few domains, but the overall perception of their competency preparedness was just acceptable. One of the participants mentioned that: "*The competency preparedness of graduate nurses is okay, in general, just the deficiencies in lots of aspects because they're coming from university, I don't think their exposure overall is waste".*

THEME – 1: OVERALL VIEW ON COMPETENCY PREPAREDNESS

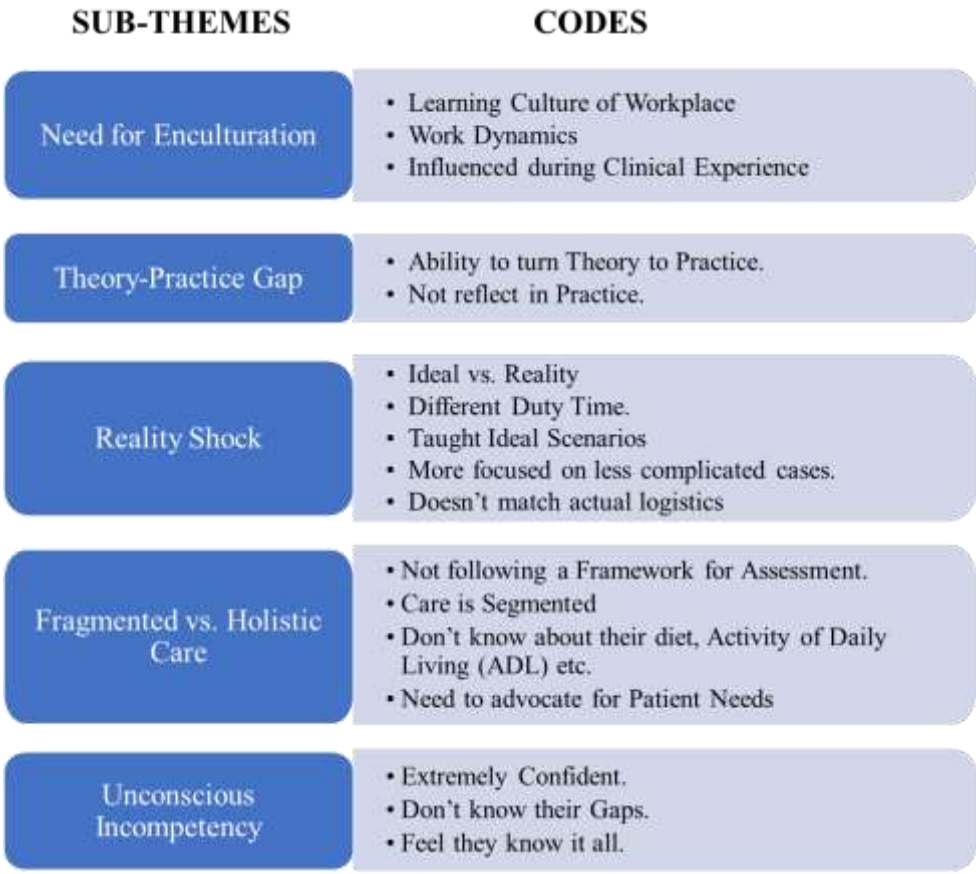


Figure: 4.25 Illustration of Theme 1- Overall view on competency preparedness, sub themes and codes

This expression was mentioned by many of the participants from the unit manager, Assistant director and also from the Chief nursing officer levels. One of them commended that, "*I think the preparation is very good for on an individual patient basis"* but added that, it is not enough to consider that the graduate nurse is fit for practice. The same participant continued saying *"for me, the most significant skills acquisition area that they need is about meeting the multiple demands by prioritizing".* Another participant remarked that performing the skills correctly and using the time effectively within the limited time was important to consider the graduate nurse as well prepared and commented: "*So it's not about, how do I look after this individual patient? Because they can do it perfectly given all the time in the world, but nobody has that. It's about how quickly and confidently they are able to perform the skills".*

Sub Theme 1.1– Need for Enculturation

One another participant brought out an altogether rich and varied view about competency preparedness and equates it to enculturation. Strouse, Nickerson and McCloskey (2018) describe enculturation as the process by which people learn the dynamics of their surrounding culture and acquire values and norms appropriate or necessary to that culture and its worldviews. In this process, the influences if successful, enculturation results in competence of the culture. Here in this context, it is about the graduate nurse being influenced during their clinical experience and be prepared to fit the practice.

The participant mentioned: *"I think competency preparedness is not just about well versed in direct clinical skills. It's about enculturation into a real life, real life work environment and I think it's about learning how to work with a whole bunch people, they choose shortcuts. And almost invariably, they are not optimal for patient safety. And are frequently sub optimal".* On the same context, Holland et al. (2010) reports from the key findings from the stakeholders

that newly qualified nurses are fit for practice and furthermore argued that the previous concern about the practice preparedness that was lacking has focused on the perceived clinical skills at the point of registration and really not on the competence to practice in general. Other participant mentioned that: "*some of them are very, very, very excited about being a nurse and loving it and wanting to learn and they're enthusiastic, while others of them, they just stand at the desk waiting to go home*." One of them added that: "*You put it in terms of percentage, how many of them are kind of waiting to leave majority of them. 75%".*

Sub Theme 1.2 – Theory-Practice Gap

Some of the participants believed that the new graduate nurses were adequately prepared in the aspects of technical skills, but when it came to applying the theoretical knowledge with the patient care they reported, that there was a Theory-Practice gap. The evaluation of the nursing curriculum should be based on the performance of its graduate nurses to perform the actual nursing, where effective application of knowledge, skills and attitudes acquired at the college is effectively practiced in the bed-side to call the graduate to be practice ready (Lee & Sim, 2019).

This is mirrored in the present study where the participants expressed: *"I think, but there is a huge theory to practice gap in terms of their ability to turn what they've learnt theoretically, into actual practice.* Another participant also mentioned about the theory-practice gap and insisted that the practice does not reflect and apply what is learnt in the theory, *"Yeah. So, it's the same for any new nurse. what you're taught in theory does not reflect in actual practice"* (participant 5). Some of them specifically mentioned about the fragmented patient care approach saying: *"And I think dealing with patient's assessment and care that's very*

segmented. And that's definitely a gap" adding *"So I'd see that that kind of integration is still not there".*

The participants also clarified that someone who has excellent grades, does not always imply that they will be excellent in the practice also, unless they integrate what they learn in the classroom into the bedside. One participant in their own words described: *"Some new graduates are 'A' student and are very intelligent, she knows everything by-heart but coming back to practice. It is difficult for her to apply or she has lost the critical thinking." Others added "but they can look only to one side she cannot look for all patients as holistic vision, but practically what she studied in the theory she's unable to put into practice."*

Sub Theme 1.3 – Reality Shock

Reality shock is a psychological phenomenon, that is resulted due to difference between reality and the individual's perception about the reality and expectations before entering the area of employment. Here in this study, the informants, who were the preceptors, professional development nurses and the nursing leadership were able to identify the reality shock experienced by the new graduate nurses. One of the participants mentioned that: "*Exactly, so when they come in as a day one in the GNI it's like it's like a reality shock for them".*

Though the students have been to the unit or the hospital before, which is at the time of student period, their involvement in the clinical exposure to gain rich experience influences the level of preparation, thereby they know the regular practice. *I think from day one, when they're on a placement, they need to be there, days, nights doing 12 and a half hour shifts shadowing the nurses actually learning what being a nurse is about.* Inadequate clinical experience during the

nursing student period makes it difficult for the fresh graduate nurse as they experience the shock of being prepared to become a professional nurse (Lee & Sim, 2019).

The same aspect was being expressed by many participants, mirrored by the response: "*they don't get the continuity and we're working with specific nurses but also they don't get the whole hand over at the end of the shift either".* The new graduate nurses are initially excited about having secured paid employment and starting their careers that they earned for. At this time, the orientation to the job takes place during this phase and this is the time the reality shock also sets in. This was primarily experienced because they find themselves caught in between the disparity between what they have been taught in the university and what they are expected to do (Wakefield, 2018; Graf et al., 2020). This sub-theme arises from another sub-theme which is 'expecting the ideal scenario' as discussed below.

Sub Theme 1.4 – Ideal Vs. Reality

The participants, while describing their general perceptions about the new graduates' competency preparedness as they entered the clinical setting, mentioned that they expected an ideal setup as they have been taught in the university. Few of the participants mentioned that: *"because the students are taught the ideal ways that you will do things, this is the procedure, this is the process. But when they come into the actual hospital situation, you know, they feel that the actual practice is different".*

Graduates are initially excited, inspired, and enthusiastic but no longer the same after orientation. They develop fear, doubt and stress when they realize that what they have been expecting to see was the ideal scenario which if far beyond the actual set up and the expectation.

Expecting the ideal scenarios often is an expression of commencement of reality shock since the new graduate nurses approach the hospital expecting the ideal scenarios similar to with what they have been familiarized in the university. *"…for many reasons like cultural practice, and the logistics, what they're taught in theory doesn't match the logistics or doesn't match the actual".* The new graduate nurse experiences the reality shock as there is a discrepancy with what is expected from her (Wakefield, 2018). Resilience is an important skill that needs to be present in the new graduate nurse to have a smoother transition.

Sub Theme 1.5 – Fragmented Vs. Holistic care

Holistic care is a very important attribute of nursing practice. It is being known from long that if it not holistic it is not nursing. Holistic included considering, honors and promoting, physical, social, emotional, spiritual, psychological and community environments in patients' lives. Though this is being stressed upon from the time of Florence Nightingale, it is still considered and become important overtime. One of the participants, while stressing this as something that is lacking in the new graduate nurses, mentioned that: *"One of the things I always stress to the nurse managers and to nurses in general would be the Roper-Logan-Tierney Model for Nursing, which is a theory of nursing care based on activities of daily living to focus on holistic assessment and care".*

The nursing care that is fragmented without integrating the assessment information with the current symptoms, preventing complications, reviewing the laboratory values and planning or prioritizing interventions is expected, as seen in the expression: *"I think dealing with patient's assessment and care that's very segmented. And that's definitely a gap".* This integrated or holistic approach is very important to provide quality nursing care. One among the many

participants who reflected this expectation mentioned that: *"Yes, yes, when they went into patient, I expect them to know their patient's name, their diagnosis, their age, their religion and their primary complaints, their signs and symptoms. And then I expect them to go through all the activities of daily living, so when talked about their nutrition or Yes, I want them to know they're on what kind of adaptive diet."*

During the discussion on their perceptions of preparedness of new graduates, a few more participants pointed out that the new graduates mention that they often do not have a holistic approach and tend to fragment the care between professionals and consider that it is not their responsibility. This was expressed by one of the participants mentioning: "*And I know some of the new nurses say Oh, that's for the dietitian to do. It got to be holistic, you learned about everything…. So, you learned about it not to be physiotherapist, but about recognizing when patients' needs are sufficient when they needed physiotherapy.*

Another participant enforced the same point saying*: "They were not trained to be the physiotherapist but for sure they learnt about when the patient needs to be ambulated, when can they be suctioned.* This expectation is a widespread expectation and requirement that is expected from all the nurses at all times, whereas this was not happening as mentioned by the participant as: *"…and they need to do the things that you need to prepare and to make sure that the patient received proper feeding, to help the patient, may be they need to consult dietitian, patient need follow-up".* One other participant was dejected in her tone when she mentioned: "*I know some are very intelligent and was a Grade A student, but coming to practice, Yeah, things are becoming kind of more compartmentalized."*

Sub Theme 1.6 – Unconscious Incompetency

Unconscious incompetency is one of the phases in the four phases of developing competence where, in this phase the person is not aware of what she do not know. Here in the study, some of the participants mentioned: *"I think sometimes when the new nurses come in, they're extremely confident in what they think they can do. Because they don't actually know what they cannot do".* The new graduate nurses when they enter the clinical setting are not aware that their clinical preparation or readiness is still lacking as evident by the statement of one of the participants who said,|: *"So when they come in, they are not really sure of their gaps. So that to me, would be major concern or gap".* This is the most vulnerable group and the dangerous stage in any walks of life.

Here in this study where it is intended to focus on competency preparedness of new graduates, it is disastrous for them not to know what they are missing since, unless they know, what they do not know, they may continue with the practice which they think is right and safe. This is reflected in the words of some of the participant who mentioned: *"I'd find students very confident nowadays, they don't know what they don't know that's an issue, Yeah, it is dangerous"*. Where the similar stand was reported by a fresh graduate who reported that she did not realize that she did not see the big picture of the condition of the patient to discharge, rather felt that the preceptor belittled her in spite of doing things right, which later they mentioned that they realized the mistake of not knowing the standard protocols (Walton et al., 2017).

The next level in learning the accepted practice and acquiring competency to the safest level of nursing practice will occur only when the new graduate acknowledges that her present

competency level does not match the expected level and there is a gap in the particular competency. Another participant mentioned: "*There is a bit of an issue where it felt like because she was qualified, she felt like she did know it, but she didn't".* Once this acknowledgement happens, the new graduate will naturally move to the next stage, which is knowing what they do not know, termed as Conscious incompetence, and thereby move forward to be fully competent or the mastery level called unconscious competence.

The main theme that emerged was overall view on competency preparedness with four sub-themes; Theory–Practice gap, Reality Shock, Fragmented Vs. Holistic Nursing care and Unconscious Incompetency as illustrated in Figure: 4.25. The participants mentioned that the overall preparation of the new graduates, though they had certain competencies that were highly appreciable as they were very good at it and some competencies had to be improved, there were certain significant characteristics of the new graduates, that was obvious like able to identify the theory practice gap in their approach.

The participants also expressed that they were able to identify the Reality shock among the new graduates as they entered the health care settings. They also mentioned that the quality of holistic nursing was compromised most of the time and they were able to comment generally on the performance that it was fragmented and compartmentalized nursing care. Unconscious incompetency also was mentioned as one word to refer to the overall competency preparedness of the graduates. The codes based on which the subthemes were developed are, for need for enculturation, the other codes were, learning culture of workplace, work dynamics, Influenced during clinical experience. For the subtheme, theory-practice gap, the codes are ability to turn theory to practice and not reflect in practice. The codes for ideal vs. reality, different duty time, taught ideal scenarios, more focused on less complicated cases and doesn't match actual

logistics are for the subtheme reality shock. The codes included, not following a framework for assessment, care is segmented, don't know about their diet, ADL etc., need to advocate for patient needs are for the subtheme, Fragmented vs. Holistic care. Table 4.20 presents the distribution of responses among the hospital nursing personnel who participated in the study.

Table 4.20: Distribution of responses among the participants: Theme 1- Overall view on competency preparedness

Theme 1: Overall View on Competency Preparedness						
Codes	**Preceptor**	**Charge Nurses**	**Unit Managers**	**Clinical Resource Nurse**	**ADON**	**CNO**
Need for enculturation					✓	✓
Theory –practice gap	✓	✓	✓	✓	✓	✓
Reality shock	✓	✓	✓	✓		
Exposed to ideal scenarios	✓				✓	✓
Fragmented care –not holistic	✓	✓	✓	✓	✓	✓
Unconscious incompetency		✓	✓	✓	✓	✓

4.4.2.2 Theme 2 - Highly Satisfied Competencies

The participants' responses to the open-ended question on what were the areas of competency that they perceived that the new graduates were competent, and they were very satisfied are considered. Most of the participants responded that though there were certain areas of competencies that had scope for improvement, there are certain other areas of competencies that the new graduates were very good and were commendable. The responses in this regard are discussed below, the sub themes for this theme along with its codes are illustrated in Figure 4.26.

Sub Theme 2.1 – Communication with Patients and Families

Some of the participants mentioned that the communication skills of the graduate nurses were commendable. Communication skills is a combination of skills that includes active listening, observing, speaking and also empathizing with the clients and their families. The participants including the nursing leaders identified communication as a strength. Many of the participants mentioned that: "*we don't have any problem with them regarding communication, in fact I should say they are very good at it".* A few others commented that: "*…with communication they are excellent, sometimes, I would rely on them to solve a conflict with the patients or if I need someone to explain about the discharge instructions or anything, I will look for them*."

THEME – 2: HIGHLY SATISFIED COMPETENCIES

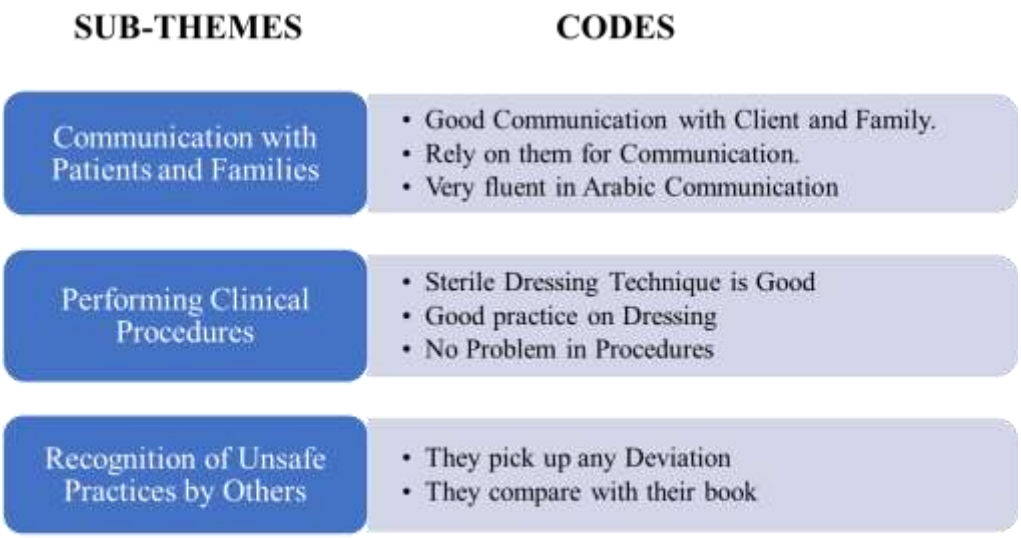


Figure: 4.26 Illustration of Theme 2- Highly Satisfied Competencies, sub themes and codes

Some of the participants mirrored the same point and those participants were both native Arabic speakers and non-Arabic speakers as well. So, it can be inferred that not only knowing the language for communication is mentioned here, but truly the skill in communication skills of the new nurses was being appreciated very much. This was clarified by some of the Arabic speaking participants also expressing the same point, saying that: *"I should say that they have a very passionate way of communicating with the patients and their families you know. I'm very happy with that."*.

On the contrary, Theisen and Sandau, (2013) reported that the new graduate nurses' communication on the whole was lacking , which included communication with physicians, health care team members, and patients and their families needing additional knowledge and skills. However, in specific communication with the patients, communication between the other nurses are identified to be superior level of competency, on the other hand communication with physicians was still a struggle, which, which is discussed in the areas of weakness which is a next sub theme.

Sub Theme 2.2 – Performing Clinical Procedures

Wound management is a common skill that is required from the new nurses, or any professionally experienced nurses and it requires skill in assessment and performance of the clean and sterile surgical dressing. Performing the dressing following the principles is vital for enhancing recovery. Many of the participants commended that the skills to perform dressing saying that: "*Very important aspect is dressing and this one, for me, they are okay. Okay. They don't have problem in sterile dressing and clean dressing, their techniques following the principles are good".* A few of the participants mentioned at the same point that the new

graduates were good in performing the dressing and added that this was able to be accomplished as they were seen to be practicing many times during their clinical experience. One of the participants mentioned that: "Because *they have practiced, we don't have problem in this area."*. This is a reinforces the fact that the skills and competence can be acquired and be well prepared when the students are able to focus on the competencies and practice them multiple times.

Some of the participants expressed that the new graduates were good in performing the technical skills. One of them said*: "I don't think it's any specific skill set that they're lacking".* Adding to that, remarkably there was one participant who mentioned that: "*Let's say from the skill wise and also from the knowledge point of view. It from their attitude point of view from the compliance of their uniforms… they have improved as compared to since many years. Let's say from the skill wise, they are good."." from the knowledge point of view. no negotiation and their knowledge absolutely fine they have up to up-to-date knowledge.*

Sub Theme 2.3 – Recognition of unsafe practices by others

The participants, while mentioning about the competencies that the new graduates possessed at the time of entry to the health care settings which are satisfied, they had a special mention of the soft skills which also are a part of competency. Some of the participants mentioned that: *"Yeah, the other thing about new graduates that is very positive is because they come in fresh, they sometimes pick up practices themselves that are not picked up by staff would be in the organization for a longer period, or, you know".* Similar thoughts mentioning that the new graduate nurses have an eye to identify something against what is the standard in certain practice standards are expressed by the participants, where one of the participants said: *"when*

the new nurses come in, because they've just been primed, they're fresh, and they compare the procedures learnt as per the book and say that's wrong", "They go, Oh, she didn't wash her hands correctly, or she missed one of the steps, they might pick that up more than people who've worked in an organization for a long period misses and try to take shortcut".

Finally, the hospital personnel that includes the preceptor, charge nurse unit manager, assistant director of nursing and also the chief nursing officer commented that the practice readiness of the new graduate nurses often focused on the deficiencies instead of general competence to practice in general. Some of the participants mentioned that competency preparedness is considered to be the central focus in the provision of smooth transition from student phase to the graduate nurse phase. The interview responses of the study participants related to the competency areas where the fresh graduate nurse is reported to be strong and have highly satisfied competency gives rise to the subthemes, communication with patients and families, performing clinical procedures and recognition of unsafe practices by others, these subthemes were framed based on the codes. Good communication with client and family, rely on them for communication and very fluent in Arabic communication were the codes that emerged into the subtheme, Communication with patients and families.

The subtheme, performing clinical procedures, emerged from the codes, sterile dressing technique is good, good practice on dressing, no problem in procedures. Finally, the subtheme, recognition of unsafe practices by others, emerged from the codes, they pick up any deviation and compare with their book as illustrated in Figure 26. Table 4.21 presents the distribution of responses.

Table 4.21: Distribution of responses among the participants: Theme 2- Highly satisfied competencies

Theme 2: Highly Satisfied Competencies						
Codes	**Preceptor**	**Charge Nurses**	**Unit Managers**	**Clinical Resource Nurse**	**ADON**	**CNO**
Communication with Patients and Families	✓	✓	✓	✓	✓	✓
Passionate in Communication		✓	✓	✓		
Dependable for Communication	✓	✓	✓	✓	✓	✓
Fluency in local language is an advantage	✓					
Helpful to resolve any conflict with patients by communication skills.	✓	✓				
Clinical Procedures					✓	✓
Wound Management	✓					
Sterile Dressing	✓			✓		
Can identify wrong practices.	✓	✓	✓	✓		
Compares with book and finds deviation in practice	✓			✓		

4.4.2.3 Theme 3 – Less Satisfied Competencies

A substantial need for improvement was shared by the participants of the study, across sizable number of competencies that were surveyed. Song and McCreary (2020), in a similar study, found that hospital personnel reported that new graduates were lacking competencies like communication, teamwork, helping role, professionalism advanced technical skills and also critical thinking skills. In this study, one of the research question focused on capturing the perceptions of the preceptors, charge nurses, unit managers, Assistant director of Nursing and

the chief nursing officers about the areas of competencies that were found to be lacking among the new nursing graduates. It was found that much of the poor satisfaction regarding the competency preparedness of new graduates was attributed to both hard skills and soft skills that are needed to provide quality nursing care and are discussed below and illustrated in Figure 4.27.

THEME – 3: LESS SATISFIED COMPETENCIES

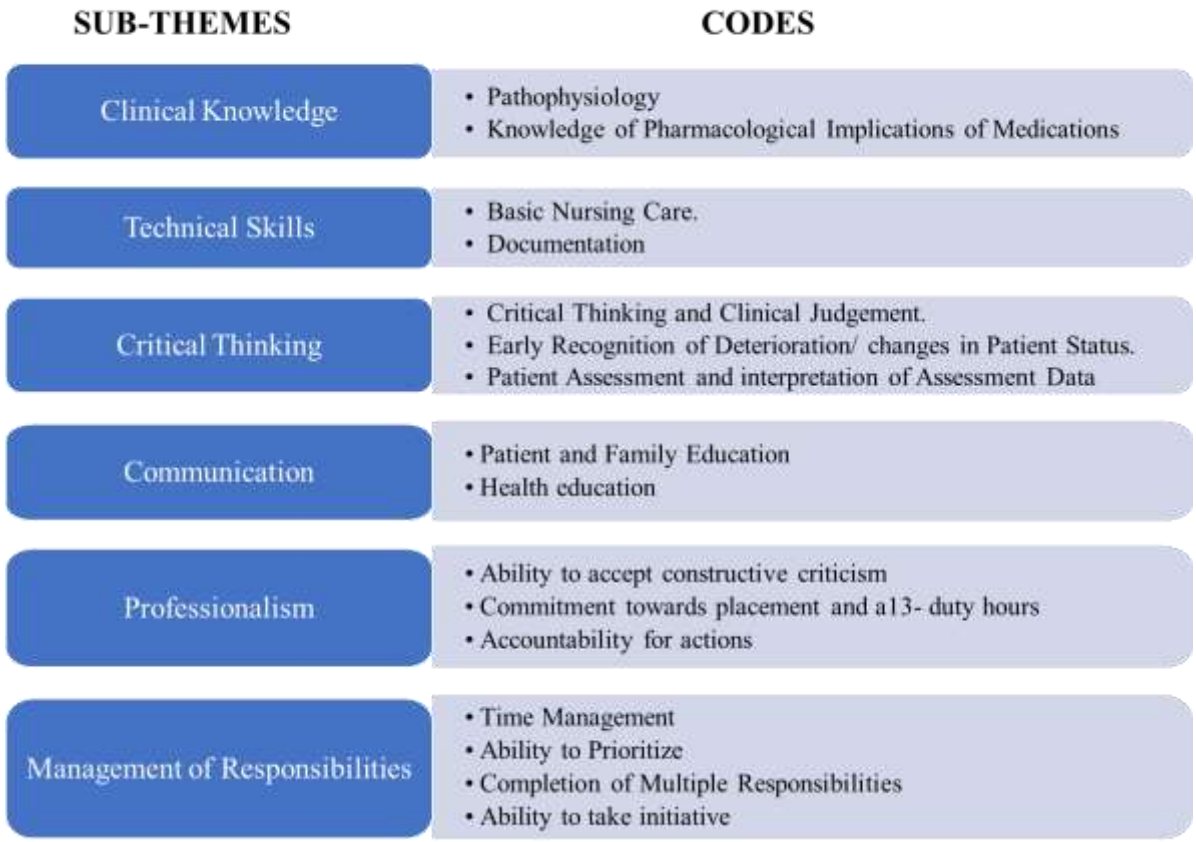


Figure 4.27 Illustration of Theme 3- Highly Satisfied Competencies, sub themes and codes

Sub-Theme 3.1 – Clinical Knowledge

In many instances and in many ways**,** like relating the laboratory and diagnostic test results with the treatment, treating acute and chronic illnesses, managing medications, and managing

general health care and disease prevention for patients requires the knowledge and understanding of the pathophysiology, which is the basis of the nursing practice. but this was identified and mentioned as one of the areas in competency that was lacking in the preparation of new graduates**.**

Some of the participants mentioned that: "*I see that as being the big gap okay, you know, that you have to consolidate what you learnt before to understand disease processes of the patients assigned under your care",* while another participant added: *"they are not able to correlate why certain tests are done with the disease processes and its pathology."* and *"knowledge of pathology will make the new nurses to be able to make assumptions, and to have a kind of a holistic approach towards patient care".* A few other participants added that: *"the care is incomplete because the new nurses lack clear understanding of diseases and their clinical manifestations on the human body to address patients' symptoms.*

A few other participants added to this point mentioning*:* "*So we see a lot of gaps in intake and output charts. And, you know, because they're not adding up the dots to say why the patient is put on intake and output monitoring, we see that the patient's intake is monitored but they will not monitor the output and then they just mention in the documentation, 'he went to the toilet'.* A few other participants mentioned the same aspect highlighting that the new graduate nurses did not have clear understanding of the rationale of certain interventions and plainly follow the protocol mentioning that: *"Oh, the reason why I've been asked to monitor output is because he's a surgical case or, you know."* Understanding and having an in-depth knowledge of pathophysiology is essential as it answers the questions "why are they experiencing this?" Why are they all of a sudden experiencing this change? What do we need to do to help them? Is this

an emergency? All of these questions need to be answered on a daily basis and intervene effectively.

Sound knowledge of pharmacology is essential to safeguard against error in medication administration. Nurses' knowledge of pharmacology provides the information necessary to competently administer medications and avoid errors**.** The participants indicated that graduate nurses had an overall lack of depth of pharmacology knowledge. Most of the participants mentioned that: "*They need to know the first line of medication, the second line of medications even if they are not the ones who are going to prescribe the medication", "When they come in. they should know, the commonly prescribed medications relate the diagnosis with the management and with the nursing management. knowing which aspect is more important is very important to know."*

A few other participants acknowledged that there were numerous drugs that they would be coming across, but there will always be some common drugs that are always meant for certain common conditions which at least need to be known well by the new graduate nurses. They said that: "*There are many new and new drugs come in. but there's always going to be PPIs, steroids, diuretics and they need to know how it works, what doses to put the patient on".* A few other participants added that*: "when they administer drugs to the patients, they must know what to monitor, contraindications, what are the other nursing elements. What records to maintain should be known, but that's a gap."* Patient safety and prevention of all patient related errors rely on competence of the nurses in practice.

It was reported by some participants that: "*they give the drugs, they don't know what parameter to check before giving this particular drug what to check after giving this particular drug".*

"Now patients want to know their drugs, if they're asking them and they can even give or tell the classifications of the drug and you know …that shows the nursing implications, but it happens at very little time". These inadequacies that are brought out by this study need to be addressed in the academic and clinical teaching. Pharmacology education was crucial for practice. Then, sound knowledge of pharmacology should ensure a safeguard against error in medication administration.

Sub-Theme 3.2 – Technical Skills

Nursing students learn about the basic technical skills in the university and also are expected to practice and fine-tune the skills only with hands-on practice with real patients during their clinical experience which would enhance the competency preparedness of new graduates as they enter the health care setting. One of the participants mentioned that: *"And then it's sad to say that, I think one of the sad things in nursing today is that basic nursing care, is been ignored".* It was expressed overall that, instead of caring for the patients in the bedside, the graduate nurses want to be inclined towards the desk job, they added: *"you know, a lot of nurses want to be in the other end of it, they want to be dealing with statistics."* Some of the participants added that: *"They are happy to administer and deal with the medication management but hesitate the basic care*".

A few others mentioned specifically about the patient call bell system not being attended to immediately saying that: "*about call bell..., they* (new graduates) *won't go and attend, to come back and give the feedback to the assigned nurses*." Another participant added that: *"they should realize that attending to the patient's call. That's a responsibility to everyone, should not wait for the nurse to go in."* Another participant mentioned that the basic nursing care with

the passion is missing: *"but they don't actually want to go in deliver good oral hygiene to patient or good bowel care, or know how to change tracheotomy and do a simple thing like, taking care of the hygienic needs, communicating with patients sitting down and saying, how are you today? And what are your problems today."*

Passion is the one which truly separates the nursing profession from other professions, identifying the basic needs of the patients and helping the patients in those needs, makes the profession to be regarded as a noble profession and the graduates need to have the passion and understand it is a calling, more than the profession, to be best at it. "*They study this PEG Tube feeding and they want to implement they must practice, but have to be alert, while giving NG feeding, have to look if the patient is in fowler's position to prevent aspiration; they are forgetting these things."* as mentioned by one of the participants while expressing her dissatisfaction regarding the competency preparedness related to meeting the nutritional needs of the patient by the new graduates as they enter the practice setting. Where a few of the participants mentioned that they needed to improve their competency regarding the blood transfusion also, while mentioning about it they said that: "*new graduate nurses need to concentrate on that blood administration. We cannot give them at least for the first one full year to work independently with the blood transfusion cases."*

Clear, accurate and timely documentation is an essential element of safe and quality nursing practice. Nursing documentation is essential for good clinical communication as well and an essential competency requirement for the new graduates, as they enter the health care setting. The participants mentioned that: "*the concern is that they are not able to document in their system and they are not aware of it you know".* Some of the participants mentioned that the medical documentation was new to the new nursing graduates, as they are not allowed to access

the documentation without the preceptor during the student period so when they are entering the setting as a graduate nurse they are not able to perform the documentation of the assessment, patient care etc. as it appears to be new for them.

One of the participant mentioned that: "*The documentation as a full-time staff, it's different, when they are coming during the student period… maybe doing a bit of pieces here with your preceptor, putting a set of vital signs. it's really different from what they need to do as a new staff. There is a huge gap there", "they have to do all that real time documentation. So, in real life, it's really difficult for them. So, this is why when they would come they will struggle".* A few other participants mentioned that: *"When they were a student, they were very comfortable, and they never had the chance to do that before, also. They're doing a little bit of a something here little bit of something there and a 3pm there they go home, limited or no access to do the documentation. Since they don't have their own login for patient documentation system (Malafi) either and most of the time it doesn't work"*. Documentation is reported as an area where the new graduates are expected to improve due to little exposure to document in the patient's medical record, it remains as the area of gap in their competency preparedness.

Sub-Theme 3.3 – Critical Thinking

Critical thinking and clinical judgement with the problem-solving involves the ability to handle the complex clinical situations where it requires critical thinking for immediate decision making. Some of the participants mentioned that; Critical *thinking is an important requirement if something happens to the patient, they must think and do, if the patient is what do you suspect, what's coming in your mind, if this patient having low Hb and low blood pressure… low… what does this mean to them will lead to correct assessment and interventions".* The nurses generally

work in an environment that is dynamic in nature and make well informed decisions considering the pros and cons of the intervention planned according to the assessment of the patient or the situation.

Many of the participants mentioned that: "*In the university, what they learn is straight forward, and what qualifies them to be Professional nurse is how they put it into practice on the units including the Anatomy & Physiology, medication management, Integrate the lab investigation with the presenting symptoms and diagnosis, this is a huge gap."* This indicates that no matter that the new graduates have had extensive training on various courses, it is imperative that knowledge is transferred into actionable skills through critical thinking and clinical judgement. Some of the participants mentioned that new graduates had difficulty with clinical decision making and this has made the participants to say that: "*the new graduates have to looking at a particular situation, deciding at that particular moment, taking some steps informing based on their assessment data, some labs or some patient symptoms etc. and think critically like that".*

In a study that included the nursing leaders and the new graduate nurses, perception of graduate preparedness, there was 8% difference in the perception of preparedness by the nursing leaders and the new graduates in the areas of critical thinking an management of responsibilities (Goldstein et al. , 2019). The participants also mentioned that they lacked competency and practice in handoff considering the vital information needed for continuity of care during shift change. *"They need to improve in giving endorsement also following the SBAR and every relevant detail must be endorsed."*

The new graduate nurse should be in a position to identify the patients who are developing complications and deteriorating clinically (Purling & King, 2012). It is very common for the

hospitalized patient to exhibit early warning signs before deteriorating. The key for timely response is the early identification of the signs of deteriorating. The hospitals in the UAE follow the Modified Early warning scoring system (MEWS) which should be familiar to the new graduate nurse and should have used it during their clinical training. This is associated to identification of symptomatic changes in the condition, organ dysfunction, increased risk of adverse effects, including transferring the patient to critical care unit, cardiac arrest and death. A plethora of studies are found that have discussed the general levels of competence on registration but lack clarification concerning the expectations (Hardman, 2018).

Many of the participants mentioned that: "*talking about assessment of patients and also an interpretation of changing patient status if he is improving or is deteriorating is a gap here."* It is reported that the patient's clinical deterioration is usually missed by the new graduate nurses, who are referred as novice or advanced beginners. Similarly, some graduates had insufficient exposure to clinical situations to process and sort the patient assessment information or had decretory judgement as that of the nurses who had more clinical exposure. One of the participants recalled that: "*one of the new nurses, I told her to take vital signs for all the patients, she failed to recognize that the BP was critically high, so after few minutes when the patient complained of dizziness and feeling weak, we had to manage urgently; isn't this critical."*. The same was recognized by Walton et al (2017) presenting the reflection by a nursing graduate in New Zealand , reporting in their own words as "when I saw the patient with labored breathing, wasn't sure how I was going to objectively describe the slight change in respiration nor I did not know how to explain my 'gut feeling'".

Patient assessment is an integral part of the nursing process. The competency level that the student obtains through the knowledge and skills from both the academic setting and also from

the clinical exposure is essential part to provide quality care to the patients**.** Many previous studies over the past reported that nursing graduates did not meet minimum competency expectations from their work area. Besides, most of the health care institutions expect the new graduate nurses in performing broader clinical skills for patients.

In regard to the patient assessment, the participants of the study reported that the patient assessment skill was lacking among the new graduates. It was mentioned that while narrating the patient a care incident: "They *should be able to assess their patient and assist them with their cough reflex,".* Another participant added: *"About their assessment related to nutritional need for a patient receiving TPN, I expect them not to just tell 60 ml /70ml and rather calculate based on daily requirements per day, based on their height, weight and BMI similar to what they would do for themselves for healthy eating options".* Clinical patient assessment course is fundamental one in the nursing curriculum. Though it is taught to the full length and breadth in the university, it is important that those skills are practiced in the clinical setting. This was reflected in the response of the participants, when one of them said: "*And a lot of patient assessment skills are not from your mentor, your culture, your teacher, and not in university level, because that's straightforward. But actual skill and learning of those skill is how they put that into practice was actually on the units".* Continuous exposure to the clinical area, continuous practice of skills especially the assessment skills from year 1 would enhance their critical thinking and lead to better clinical decision making.

One of the participants mentioned by mentioning an example that: "*the preceptor to the newly qualified nurse, she'd say, this patient is in with abdominal pain, I need you to look at this chart and tell me what you think is wrong? The answer is not acceptable.".* Another participant added: *"when I ask, this patient is in there having an appendectomy, tell me what bloods would*

be done, pre-appendectomy. I know physicians order them, but still they need to know, what would be the care what do you have to watch out for? What is the post-op signs and symptoms?" The point that is revealed is that the patient assessment skills are vital and if they are lacking, it will affect the critical thinking, clinical decision making and thereby the patient care outcome.

Sub-Theme 3.4 – Communication

Patient education is used as a comprehensive term covering both patient teaching and information work (Bergh et al., 2015)**.** In nursing it is vital to educate the patients and the family members as per the learning needs identified and assessed**.** The participants mentioned that**: "***seems patient education is not also happening according to what needs to be done in terms of preparing them for home care, or even just simple information on a daily routine or a daily day to day basis".* Nurses' role in patient education is important as it is vital for building the patients' or the significant others in the family in their knowledge and understanding about the plan of care, follow up and self- care for better adherence to the treatment and follow up.

Some of the participants mentioned that**: "***This will happen only if they are confident about the disease condition, symptoms and treatment plan. Patient home care". "it doesn't happen spontaneously, even if they do, it's just one or two sentences, but they just graduated isn't it...?! shouldn't they be fresh in their knowledge about the diseases condition medication etc. to teach their patients on it...?* indicating the gap in the role of providing patient and family education. Some mentioned that: *"I think patient education is a massive deficit and a lot of it comes with constant attempt to do it during training and ability to communicate."*, while others mentioned: *"wanting to communicate, find out what they need to know before discharge and giving*

education on it again, and I think that's, that's a big gap.". As per the participants, the area of competency in patient and family education, needs to be addressed as it empowers the patient and the family to have a positive treatment outcome.

Sub-Theme 3.5 – Professionalism

Professionalism in nursing guides the nurse's behavior in patient care and is a difficult term to define. In nursing there are set of behaviors that are deemed necessary to guide the practice. Many literature reports unprofessionalism in new graduate nurses that has numerous negative effects including decreased team work, decrease in quality patient care, decrease in effective communication, decrease in collaboration, decrease in job satisfaction, decrease in successful patient outcomes and in increase in incivility (Ghadirian, Salsali & Cheraghi, 2014). In this study, as a response to the research and interview question, what are the competencies which according to your perception does the new graduate nurses lack?, has solicited responses which included professionalism as a major theme as reported and discussed below.

Constructive feedback is a part of learning and development. The student or the new nurses ought to receive positive and negative. It is important for them to receive criticism and not take it personally which will help them to improve the nursing practices as they start their career. Some of the participants mentioned that: *"Some of them they don't like to be corrected, they feel they are graduates now and therefore competent."* A few other participants added to this and said: "*if they are told this is how it should be done or how documentation to be done, they don't want to agree, they don't like this."*

One of the participants narrated an incident where the new nurse even resisted to follow the new protocol and did not want feedback, insisting the same method that she had been following to be practiced and not resorting to the new protocol, saying that: "*To prevent needle stick injuries, we use smart needles, but they don't want to use it, saying I'm used to the syringe with needle and I will use the same. And resisting to use the new ones."* This seems to be an area of concern because, dealing with constructive feedback should be taken positively and the new nursing graduates need to be prepared on this competency related to professionalism. Learning how to receive and use the constructive feedback will eventually result in positive feedback and need to be trained to accept this.

New graduate nurses are expected to get adjusted to the duty hours and shift work and also respect the break timings. Some of the participants mentioned that they were dissatisfied with some of the new graduates saying: *"they don't report when they go for a break ... the preceptor, they don't know where they're going, you know. We all have 30 minutes, so they should be back."* Some of the participants mentioned that they had found new graduates did not opt to be working in the inpatient area with the patients. They said: "*they want to be posted in OPDs (Out-patient Department) they do not want to work in the bedside, it is important to gain clinical experience for at least 2yrs in the inpatient area and then move elsewhere."*

Nursing is considered as a calling more than the profession and the nursing degree is described as the most challenging undergraduate degree. Being the nurse and practice nursing in the bedside is difficult based on some personality traits and more importantly the competency level. This was expressed by some of the participants when they said: *"when new graduates come she is "A" student but she is not happy to work in the clinical areas, she wants to be in clinic she wants eight hours she wants this and that ...she's not happy to work in an inpatient*

or daily practice with the patients." One other participant recalled that some of the new graduates though they were excelling in the academic performance they too did not show interest to work in the clinical bedside saying that*: "Another 'A' student wanted to be in preventive medicine, where she only needs to do patient education and filling the paper and then she ended up in computer work, preparing a report and until now and some student, she is very intelligent person, but here passion is not with patient."*

Accountability can be described as answerable to oneself and others for one's own actions. Nursing was voted as the most trusted profession for the fifteenth year consecutively in the year 2016. It is vital to maintain this trust in each health care encounter. It also includes being willing to accept professional responsibility if any deviations from the standard occurs. Some of the participants said: "you *know, they will not answer the call bell, they won't if it is not from their assigned patients. They will just specifically wait for the nurse to go you know",* and a few other participants also added: *"they can go and attend, come back and give the feedback to that assigned nurse that's a responsibility to everyone you know".*

Some of the participants mentioned that the new graduates needed to be responsible and be accountable for their functions. It was mentioned that they just want to leave at the end of the shift timing, whether or not the job is done or endorsed properly to the next shift nurses. The participants said: "*If their duty time finishes by three o'clock means they don't even wait for the handover endorsement 30 minutes to finish and then leave".* Some added that: "*they will have responsibility for two or three patients, but then they'll decide to leave by half past five, for example. So, who's going to look after those three patients that you are supposed to be caring for, so they're not thinking about the team and the decisions that they make, how that impacts on the team that they're working with.".* This can cause work overload for the other staff in the

shift as the staffing will be considered for the full shift and if the new graduates do not consider this and be responsible, this may eventually disrupt the quality of care. Preparation of nursing graduates needs to include instilling the responsibility and accountability during their student period by exposing them to such duty timings and workloads during their clinical experience.

Sub-Theme 3.6 – Management of Responsibilities

New graduate nurses are expected to be responsible and manage responsibilities in order to provide safe, high quality patient care. The responses of the participants related to the competencies that the new graduates lack indicated that the new graduates lack the skill of managing the responsibilities and are reported as follows.

Time management skills will help the new graduates to complete their responsibilities within the scheduled time. This skill of being able to manage the time as per the priority and completing the nursing care within the shift each day is vital in the profession of nursing. "*Regarding management and responsibility, some of them they are taking responsibility if you assign task for them but the majority of them need a push all the time".* Time management skills are also important to avoid shortcuts in patient care, since when the new graduates feel overwhelmed with the tasks that they need to do with much of the workload with staff shortage. One of the participants mentioned that: "I *just asked her what she was doing, because I could see that she was typing in a now electronic medical record. And she said, I'm just doing a skin assessment, I was like... tell me about it. And she said, you know, everything was fine., I knew that she hadn't done and told me it should actually looked. it would be very easy to do that since the documentation is like a tick box exercise yesterday. Yes. So, if we put people under pressure, often we would choose the easy way. That's not the best way. I personally think that*

if there's anything very specifically lacking skills is that I think it's more around time management". This is a notable response in the interview that requires to be addressed. A few others added: "*So that they don't come out and take the initiative to and for care plans for, you know, anything related to the patient's care".*

Many of the participants mentioned that the new graduates took responsibilities to finish only the task that was assigned or provided to them but what was expected was to take initiatives and to have the skills of being able to decide to complete as per the priority. As mentioned by one of the participants: "*they are taking responsibility if you assign task for them and but still they need to have prioritized their things".* This was also expressed by another participant who mentioned about the prioritization that the new graduates lack by saying: *"They don't know which one the priority is and what is important for them."* Another participant said*: "I personally don't think that there's any very specific lacking skills that I think it's more around time management and prioritization of tasks. You know, they don't know whether to do this one first or that one first".* The nurses' skill and ability to prioritize the care affects the patient safety and also in providing quality patient care. few other participants added: "*It's been my experience in that there seems to be a lack of teamwork with the GNIs and professional accountability. They don't seem to see themselves as professionals in their own right, they see themselves as an extension of their mentor or their preceptor."*

The subthemes that emerged from the above input from the participants regarding the research question focusing on the competencies that were lacked by the new nursing graduates on entry to the health care setting are illustrated in Figure 4.27 and they are clinical knowledge, technical skills, critical thinking, communication, professionalism and management of responsibilities. Among the subthemes, clinical knowledge emerged from the codes, pathophysiology and

knowledge of pharmacological implications of medications. Technical skills emerged from the codes, basic nursing care and documentation. Critical thinking emerged from the codes, critical thinking and clinical judgement, early recognition of deterioration/ changes in patient status, patient assessment and interpretation of assessment data. Communication from the code patient and family education, health education. The codes: ability to accept constructive criticism, commitment towards placement, duty hours, accountability for actions led to the subtheme of professionalism. Finally, the sub theme, management of responsibilities emerged with the codes as need to push to complete task, inability to cope, working under pressure, lack of skills around management of time, need to know which task comes first and professional accountability which were categorized as Time management, Ability to prioritize, Completion of multiple responsibilities and Ability to take initiatives. The participants agreed that not all of the new graduates lack the mentioned, but overall improvement in these areas are expected to be improved in the new graduates as they enter the health care setting. Table 4.22 presents the distribution of responses.

Table 4.22 Distribution of responses among the participants: Theme 3- Less satisfied competencies.

Theme 3- Less Satisfied Competencies.						
Codes	**Preceptor**	**Charge Nurses**	**Unit Managers**	**Clinical Resource Nurse**	**ADON**	**CNO**
Big gap in knowledge of disease process.				✓	✓	✓
Unable to understand disease condition	✓	✓				
Not correlating investigations with diseases.	✓			✓		

Inability to understand manifestations related to disease	✓	✓	✓	✓	✓	✓
Intake output monitoring is incomplete	✓			✓		
Need pharmacological knowledge	✓	✓	✓	✓	✓	✓
Doesn't know the parameter to assess before and after administration of medication.	✓	✓	✓	✓		
Nursing implications of drugs	✓			✓		
Basic care is ignored					✓	✓
Ignoring the call of patients, who are not assigned	✓	✓	✓	✓	✓	✓
Tracheostomy care	✓	✓	✓	✓		
Therapeutic diet management		✓	✓	✓	✓	✓
Blood transfusion	✓	✓	✓	✓		
Critical procedures					✓	✓
Clinical documentation	✓	✓	✓	✓	✓	✓
Critical thinking	✓	✓	✓	✓	✓	✓
Patient endorsement	✓	✓	✓	✓		
Early warning assessments				✓		
Interpretation of deterioration of patient condition		✓	✓	✓		
Patient assessment	✓	✓	✓	✓		

Patient and family education	✓	✓	✓	✓	✓	✓
Resistance to change		✓	✓	✓		
Do not report when going for break	✓	✓				
Wants only day shift	✓	✓				
Wants only computer-based work					✓	✓
Want to be posted in less workload area					✓	✓
Time management	✓	✓	✓	✓		
Prioritization is a gap	✓				✓	✓

4.4.2.4 Theme 4 – Strategies for Improvement of Competency Preparedness

RQ: 4 What strategies do the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggest to enhance the competency preparedness and concomitant practice expectations of new graduate nurses?

To obtain the answer for this research question, semi-structured interviews were conducted among the preceptors, charge nurses, unit mangers, clinical resource nurses, assistant nursing director and chief nursing officer. The participants participated in the study more willingly and shared their perceptions in related to the research questions. The participants' responses were assembled and coded, the analyzed into commonly shared themes that grouped and matched the same or near matching perspectives. Two main themes were gained from the participants'

responses: Strategies for Hospitals, Strategies for Academic Institutions and Clinical Training. Their response to the question capturing their suggestion of strategies to enhance the competency preparedness and concomitant practice expectations of new graduate nurses are discussed as follows and illustrated in Figure 4.28.

The participants agreed that the preparation of new graduates was an effort that both the university and the hospitals were expected to participate in equally and responsibility laid with both the academic and practice settings.

THEME – 4: STRATEGIES FOR IMPROVEMENT OF COMPETENCY PREPAREDNESS

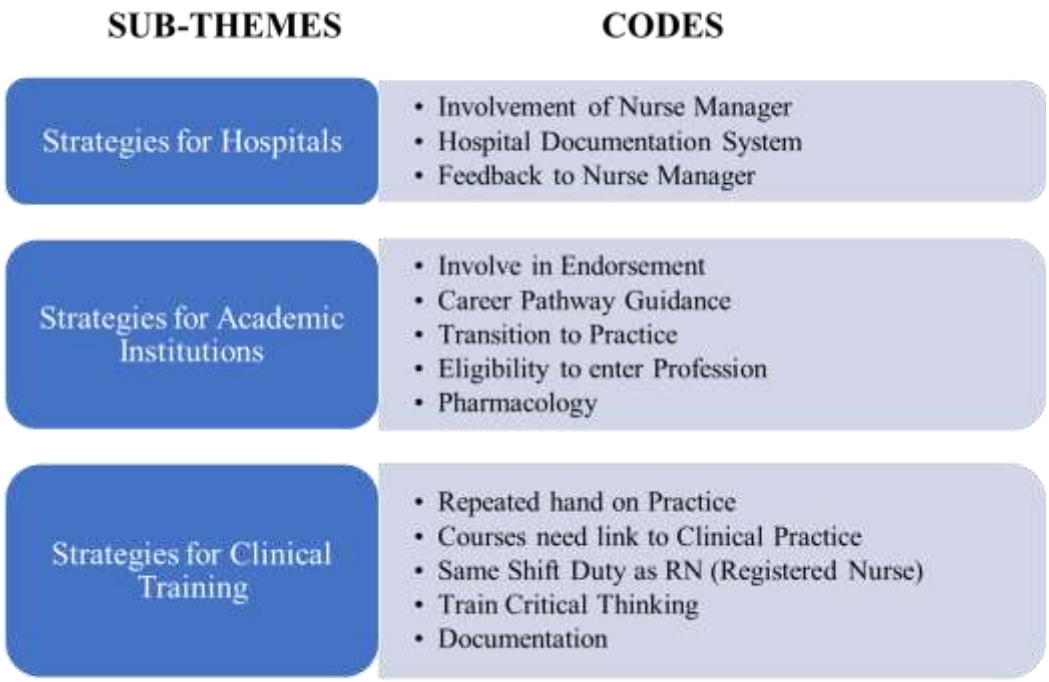


Figure 4.28 Illustration of Theme 4- Strategies for Improvement of Competency Preparedness

Sub-Theme 4.1 – Strategies for Hospitals

The expected competencies and expected levels for those competencies should be made clear and communicated to the academic institutions so that the equilibrium of expectations can be enforced through rigorous training and preparation to meet the workplace expectations. The hospitals which serve to be the clinical learning areas for training are considered to be of greater importance in preparing the nursing students to become prepared for practice. Some of the participants mentioned that the involvement of the hospital personnel was vital for the optimum clinical training to happen which will contribute in the preparation of the new graduates as they enter the health care settings. They mentioned that: *"when they come to their placement, even if it was limited time that they get for reflection during the course of the day that they have to go look up at condition and come back and feedback to the nurse manager".* A few others said: "*they have to do a little mini presentation to the nurse manager",* indicating the involvement of the unit managers in the clinical training of the nursing students.

A few other participants mentioned the importance of involvement of the preceptors in reflection session of the student during their clinical training, and they mentioned that: *"Involvement of the preceptor in the reflection could help a great deal."* Some of the participants highlighted that the students need to be made more involved in the nursing care of the patients and all the proceedings in the unit which is in the scope of Registered nurse and said that: "*Involve them in the handing over of patient information and make them feel a part of the team".* Some of the participants stressed the importance of being involved and practice the use of the documentation system used in the hospitals, called Malafi system. They said: "*they can also focus on Malafi which is hospital Information System, because now more hospitals they have integrated Information Technology documentation. Clinical documentation has to start from year one, maybe with longer clinical hours earlier access to information*

system, we can integrate documentation." Most of the participants mentioned about the strategies that they felt that the academic institutions needed to follow which are discussed as follows.

Sub-Theme 4.2 – Strategies for Academic Institutions

Despite continuous improvements in the nursing education field, the twenty first century nurses are found to enter the complex health-care environment without the skills and (Murray, Sundin & Cope, 2020). Furthermore, it is found that the nursing institutions need to have a curriculum that is focused on applying the knowledge gained in the theoretical class on the clinical exposure and provide adequate clinical experience (Lee & Sim, 2019). During the interviews, the participants mentioned about various strategies to improve the preparedness of the new graduate nurses as they enter the health care setting.

Many participants emphasized that the academic universities needed to stress upon the customer care. It was mentioned that: *"I think every nurse needs to understand we're in a service industry, and need to know how we talk to patients, how we greet them, how we provide care", "About the profession, probably the single thing that we need to get better at is the customer care" "there is a wealth of knowledge out there, if you don't know stuff, you can look it up. there are multiple mechanisms to acquire knowledge, that's easy but they must be passionate in caring".* The participants highlighted that the preparation of the nursing student to be a registered nurse, not only involved the instillation of knowledge and skills, but also they should be taught the importance of updating themselves mentioning: *"you've got to have that sort of commitment to lifelong learning."*

The participants mentioned that pharmacology was a competency that they were not satisfied with as seen among the new graduates, when they entered the health care setting, in addition they mentioned to improve on the said competency, and to provide special focus to train them on drug calculation and critical procedure like blood transfusions saying: "*The new nurses need to concentrate on medication because medication calculation especially they are weak at calculation involving mg/kg body weight, and also few important procedures like blood administration".* A few other participants added: *"We cannot give them at least first year to work independent with them with blood transfusion cases* "and *"The academic side need to give more focus on certain critical procedures"*

Some of the participants felt that the new nurses preferred to be posted in less busy areas like the out-patient department when they graduated and also they wanted to be promoted to the next level and become managers soon, without acquiring the experience in the other clinical areas and practicing the other clinical skills involving clinical decision making and the critical thinking. They said that: *"When they first come out of the university as graduates, they have to go to a surgical, Medical ward to gain the experience to go up the ranks", "they don't want to do the hard work, they all want to be managers immediately. I think that's a huge, huge gap.", "I see some being an issue like we've lots of nurses here recently graduated and they're all working in the OPD".* Some of the participants also reported a trend that the new graduates request to be posted in the surgical unit and not medical unit for the reason similar to the workload and varied clinical conditions and patients. *"Majority of new nurses that want to come out want to work and surgical, not medical. And you can understand why. Because as such, it is easier your patients come in, and you send them for surgery, and they go home", "Yeah, medical case, they're much more complex, they have a lot more chronic with them. And they are chronic, you know, admissions and diagnostics etc., which they don't want you know".*

A few other participants suggested that there has to be a policy decision that having the experience only in the outpatient department will not qualify the new staff for moving up the career ladder or be enrolled in higher education. They mentioned: *"I think that has to come from a recommendation higher that you can't move to into an OPD and I suppose then postgraduate until you've got a foundation of five, six years in clinical practice".* These responses make a great deal of strategies in regard to guiding the new graduates regarding their career guidance which can be done. The transition from being a nursing student in the nursing college to a graduate nurse and entering the hospital setting to join the workforce is not an easy period. They face a numerous new situations and challenges that they have never faced before, makes transition challenging especially if they have not had adequate clinical experience (Lee & Sim, 2019).

Strengthening the personal attributes is another important strategy that was reported as a strategy that was recommended by the hospital personnel in regard to the academic preparation of the students for entry to clinical setting. This was found as an area that needed improvement in many studies that were undertaken across the globe during the consultation of the literature. In this study, the participants mentioned that the students needed to be insisted to follow the professionalism strictly during their student period so that it becomes easier for them to follow the same even after graduation and it is vital to instill the habit of ongoing learning. They mentioned that: *"But, you know, sometimes we need to be a little bit stricter when we train. And we do try to do that, we kind of, you know, encourage them to adhere to the dress codes and everything and when they come to the units as graduates it would be there.". "I think the new nurses coming out, they really need to understand that the process of learning is not over once you get your qualifications".* Similar finding and strategies were found to be reported by

another similar study where the study summarizes that the new graduates exhibited lack of competencies and personal attributes in areas like time management, lack of experience, lack of knowledge and lack of confidence.

Many of the participants insisted the academic institution to be strict in the training. A few of the participants mentioned that: *"could there be a filter so that when you have these young people applying, you actually filter out those who can demonstrate clear passion or clear interest to work in the profession as opposed to those who think it is an easy life and have no real passion or interest."* By the above statement it is clearly understood that graduating the good nurses also depends on the attitude and commitment they have at the time of entry to the profession. So, it is important to identify the candidates, who are really fit for the profession which will be the qualification to entry to the nursing profession.

The participants insisted that huge steps need to be taken to improve the new graduates' knowledge and competencies related to pharmacology. Nurses' pharmacology education is crucial to their expected role in medication care (Latter et al., 2000) The researcher in her experience as an administrator of the hospital and also as an academician also agrees to the fact that pharmacology is an area that the universities need to focus more as they prepare their graduates to the health care field. The responses from the participants mentioned the same and also insisted that the graduates knew the common drugs at least. The participants mentioned: *"You know some of the new nurses don't know the common drugs that are used to treat some of the common disease conditions"*. It is important that nurses know about the actions of the drugs and the nursing considerations to follow before and after administration of the drug so that they will be able to provide accurate medication management for their patients.

Some of the participants mentioned that: *"They don't know why their patient is receiving that particular medication in the first place, so how can I be sure that they checked or assessed the pulse rate or blood pressure before or after administering the medication, these things to be included in every course and every clinical"*, *"they should be aware of certain common medications that are usually prescribed"*, *"From my experience I would say, I want the Universities to focus on training their graduates on pharmacological knowledge", "you know, when they're doing a drug round, you know, they must know whether it is a blood pressure medication, and specifically is it a angiotensin converting enzyme inhibitor or vasodilator etc. . you know, they must study drug to come back and tell the manager what it was."*.

It is also important that the undergraduate students take more responsibilities in monitoring and administering medications and pay attention to have the most learning during their clinical exposure in their student period. Some of the participants mentioned that specific attention be given to high alert group of medications, specific drug protocols and also to drug calculations, specifically regarding the ones, that involves the drug calculation as per the patient's body weight. The participants mentioned that: *"high alert we have to a double check …there will be mismatch here … they need to double check from the checking the medication order or the sliding scale itself and not in just administration", "I would like the academics to concentrate more on the drug calculation, especially the calculations involving mg/kg body weight"*.

Though the study and the participants' responses were focusing on the new graduate nurses' lack of competencies related to pharmacology and medication management, the literature that was consulted indicates that the deficits are not only related to the graduate nurses, but also all nurses experience difficulties in this regard. It is considered that theoretical, and clinical principles of pharmacology, are vital for practicing safe medication management, optimizing

medication use thereby improving the health outcomes of the patient. The academic and clinical preparation need to place additional focus on the pharmacology to achieve the goal of safe medication management and to have the inadequacies addressed.

Sub-Theme 4.3 – Strategies for improving Clinical Training

The majority of the participants responded that there was a need to increase the amount of clinical work to better prepare the nursing students to be ready for practice as they enter the clinical setting as graduate nurse intern. Many of the participants said that the preparation for clinical training was ideal to have that was similar to the scenarios and protocols followed in the clinical setting. In the laboratory training the students need to be exposed to situations that mimic the real-life situations that require the basic techniques contextualized as per the individual patient needs. The participants said: *"And maybe we need more practical guidelines matching the clinical setting like for example, the Lippincott procedure manual can be used to take them through to read, demonstrate, and then they get a chance to practice and then they re-demonstrate that they're competent to do."* The participants mentioned that more emphasis needed to be given for patient assessment practice. It is also important to develop traits like giving attention to detail and precise perceptiveness during the student period which will eventually help them to be better nurses in their nursing careers, especially when they enter the health care setting as new nurse graduates.

The participants mentioned that the students should be trained in such a way that they are able to appreciate the relationship between the courses that they learn and understanding their clinical application**.** It is also essential that the skills that are taught to be practiced in the clinical setting are done multiple times and practiced and rehearsed to be well versed in those

competencies. The participants said: **"***In the university, what they learn is straight forward, and what qualifies them to be professional nurse is how they put it into practice on the units including the A&P (Anatomy & Physiology), medication management"*, *"But actually, student's best clinical experience is when they learn, they must practice what they learnt, by doing is you learn how to do it, and you just need lots of repetition." "Whatever they study, they should put into practice, just studying theory and getting good grades and then not relating to clinical is not good."* A similar study was conducted in Australia to explore the five key issues and the suggested strategies which reported that clinical training hours to be increased to improve the work readiness (Hegney, Eley & Francis, 2013).

The findings of this study were also found to mirror the findings of an integrative systematic review carried out to critically appraise, and summarize reported research related to readiness to practice and types of clinical support offered to newly registered nurses and preregistration nurses that reported that more than half of the participants agreed that the clinical experiences during the academic education period was not adequate and could not prepare the students adequately. The participants mentioned: *"I think from day one, when they're on a placement, they need to be there, days, nights doing 12 and a half hour shifts shadowing the nurses actually learning what being a nurse is about", "So they don't get the continuity and we're working with specific nurses but also they don't get the whole hand over at the end of the shift either "and " I think just during their student days, they need to be doing 12 hour shifts and actually being immersed in the culture of the unit. Working with a tutor from the university every day doesn't help them because they're not getting that understanding.* What the participants expressed regarding the professionalism and practice of critical thinking is notable to take appropriate steps to enhance their clinical training. They said: *"that has to be instilled from right from the beginning the first day that there is a student at the beginning of their program*

all that kind of professional stuff has to be instilled", "critical thinking, if it was not informed to them before or if they're not trained before, how can we expect during the staff period.

The other important, and the most critical aspect, is the clinical documentation, which was mentioned as a competency that needs to be improved. The hospitals use a hospital information system for documentation for which the students have restricted access. This makes it difficult for the students and the new nurses to be not confident in the clinical documentation. The participants said: "*if they can also focus on Malafi which is hospital Information System, and this has to start from year one, maybe with longer clinical hours earlier access to information system, we can integrate documentation."*

4.5 Summary of Qualitative Results

The purpose of the qualitative part of the study was to obtain in-depth understanding of the competency preparedness of new nursing graduates as they enter the health care setting as perceived and expressed by the nursing personnel in the hospitals. The viewpoints were recorded from the preceptors of the new graduate nurses, charge nurses, unit managers, clinical resource nurses, assistant director of nursing and the chief nursing officer. The data was collected by conducting semi-structured interviews.

NVivo as well as manual transcription aided in the data analysis and coding process. The participants' responses were assembled and coded, then analyzed into commonly shared themes and the matching perspectives were grouped as broad themes and then the subthemes were identified. The four themes that were identified from the participants' interview responses were: Overall perception on competency preparedness, highly satisfied competencies, less

satisfaction competencies, and Strategies for bridging the gap. The participants from the study expressed that there was a need for the academic institutions to increase the clinical training and the competency preparedness.

The new graduates enter the health care setting immediately after the graduation and the competencies they have is in the novice and advanced beginner levels of competencies, whereas what is expected is higher than that. The overall competency preparedness reported included the subthemes, need for enculturation, theory-practice gap, reality shock, fragmented vs. Holistic care and unconscious incompetency. In regard to the competencies that the hospital nursing personnel were highly satisfied was in the areas like, communication with patients and families, performing clinical procedures and recognition of unsafe practices by others.

In contrast, the competencies that were reported to be less satisfied with were clinical knowledge, technical skills, critical thinking, communication, professionalism and management of responsibilities. Although the competency preparedness needs to be improved, the participants agreed it will be achieved with the steps taken both in the academic and the hospital settings by mentioning strategies for both the avenues which is presented in the fourth and last theme which was Strategies for improvement of competency preparedness. This theme included strategies for hospitals, strategies for academic institutions, strategies for Clinical Training. The summary of the qualitative data analysis is presented in Table 4.23.

Table 4.23 Thematic Analysis Summary Table

Themes	Sub Themes	Codes
		Learning Culture of Workplace

Overall View on Competency Preparedness	Need for Enculturation	Work Dynamics
		Influenced during Clinical Experience
	Theory-Practice Gap	Ability to turn Theory to Practice.
		Not reflect in Practice.
	Reality Shock	Ideal vs. Reality
		Different Duty Time.
		Taught Ideal Scenarios
		More focused on less complicated cases.
		Doesn't match actual logistics
	Fragmented vs. Holistic Care	Not following a Framework for Assessment.
		Care is Segmented
		Don't know about their diet, Activity of Daily Living (ADL) etc.
		Need to advocate for Patient Needs
	Unconscious Incompetency	Extremely Confident.
		Don't know their Gaps.
		Feel they know it all.
Highly satisfied competencies	Communication with Patients and Families	Good Communication with Client and Family.
		Rely on them for Communication.
		Very fluent in Arabic Communication
	Performing Clinical Procedures	Sterile Dressing Technique is Good
		Good practice on Dressing,
		No Problem in Procedures
		They pick up any Deviation

	Recognition of Unsafe Practices by Others	They compare with their book
Less satisfied competencies	Clinical Knowledge	Pathophysiology
		Knowledge of Pharmacological Implications of Medications
	Technical Skills	Basic Nursing Care.
		Documentation
	Critical Thinking	Critical Thinking and Clinical Judgement.
		Early Recognition of Deterioration/ changes in Patient Status.
		Patient Assessment and interpretation of Assessment Data
	Communication	Patient and Family Education
		Health education
	Professionalism	Ability to accept constructive criticism
		Commitment towards placement and duty hours
		Accountability for actions
	Management of Responsibilities	Time Management
		Ability to Prioritize
		Completion of Multiple Responsibilities
		Ability to take initiative
Strategies for Improvement of Competency Preparedness	Strategies for Hospitals	Involvement of Nurse Manager
		Hospital Documentation System
		Feedback to Nurse Manager

	Strategies for Academic Institutions	Involve in Endorsement
		Career Pathway Guidance
		Transition to Practice
		Eligibility to enter Profession
		Pharmacology
	Strategies for Clinical Training	Repeated hand on Practice
		Courses need link to Clinical Practice
		Same Shift Duty as RN (Registered Nurse)
		Train Critical Thinking
		Documentation

4.6 Triangulation

Triangulation is the use of more than one approach to a researching question. In the present study for the purpose of increasing the confidence in findings through confirmation of findings using more than one approach, mixed methods were employed. The main objective of triangulation in research is the combination of findings from two or more rigorous approaches in order to provide a more comprehensive view of the findings and the results that either the quantitative and qualitative approach can do it alone. (Heale & Forbes, 2013). It yields the credibility and validity of the findings. Triangulation is one of the main objective of the mixed methods research (Carter et al., 2014). In this study, in order to remain in the scope of the study, both quantitative and qualitative methods were conducted concurrently.

The phenomenon under study was the same, which was the competency preparedness level of new nursing graduates on entry to the health care setting. Table 4.24 illustrates the triangulation used in the research. A mixed methods approach that combines both quantitative and qualitative techniques is considered to be an apt research approach that can minimize the limitations of the research if each of the approach is used separately. The current study is intended to explore in depth the competency preparedness of new nursing graduates as they enter the health care setting in the view of the hospital nursing professionals including the nursing leadership. Adopting the mixed methods, where both quantitative and qualitative research approach helped in having an in-depth and comprehensive outlook. The data analysis and comparison of result of quantitative and qualitative data analysis complemented and endorsed the findings from both the research approaches.

Table: 4.24 Illustration of Triangulation used in the study.

Quantitative Research Findings	**Qualitative Research Findings**
Among the 104 participants, 44.2 % of them mentioned that they expect the competencies in the clinical knowledge domain to be in the proficient / very competent level of competency. Among the competencies related to clinical knowledge, the competency of interpretation of physician and the interprofessional order had the highest expectation with the mean of	The participants reported that they expect the new graduates to be knowledgeable many instances and, in many ways, like relating the laboratory and diagnostic test results with the treatment, treating acute and chronic illnesses, managing medications, and managing general health care and disease prevention for patients requires the knowledge and understanding of the

3.6. Subsequently, compliance with legal / regulatory issues relevant to nursing practice and knowledge of pharmacological implications of medications is the next highest level of expected competency with the mean of 3.55 and 3.54.	pathophysiology, which is the basis of the nursing practice.
Majority of the participants (35.6%) report that the competency level of the new graduate in this domain of clinical knowledge is in the less competent / advanced beginner level.	Participants mentioned that the new graduates are not able to correlate why certain tests are done with the disease processes and its pathology. The participants also reported that they expect the new nurses to have knowledge of pathology so that will make the new nurses to be able to relate the theory with their nursing car. This will help them to , and to have a kind of a holistic approach towards patient care.

Safe administration of medication competency is listed as one among the top 15 skills as per the highest mean (3.8). As per the importance-performance matrix computed, Pharmacological implications of medications falls in the high importance-low performance quadrant that needs immediate action as high priority.	The participants reported that medication management as an important competency that is expected. It is also mentioned that the graduates should be aware of the first line of medication, the second line of medications even if they are not the ones who are going to prescribe the medication. This would help the graduates to provide care understanding the pharmacological implications.
The expected mean for the Competency-Recognition of changes in patient status belonging to the critical thinking domain is 3.56, whereas the current competency level is 3.00. The critical thinking competency domain for the expected competency level is 3.5 and current competency level is 2.9 Among the participants 40.4 % of them mentioned that they expect the competencies	Recognition of critical values and ability to identify the deterioration of patient condition is reported as an expected competency and also as deficiency identified among the new graduates. They also recalled saying that they noticed, one of the new nurses, when told her to take vital signs for all the patients, she failed to recognize that the BP was critically high, so after few minutes when the patient complained of dizziness and feeling weak, they had to be managed as an emergency. This is reported as critical finding that requires attention in preparedness.

in the critical thinking domain to be in the proficient / very competent level of competency preparedness as they enter the practice setting as new graduate. 75% of the competencies related to critical thinking were expected to be in very competent and proficient level of competency. Contrastingly there were none, 0% of the competencies in this level as observed and reported currently.	Critical thinking is an important requirement as identified and reported by the participants acknowledged that critical thinking along with clinical judgment and problem-solving skills are an important competency to possess as the new graduates enter the health care setting. The nurses are expected to in work in an environment that is dynamic in nature and they should be in a position if something happens to the patient, they must think and assess correctly and provide appropriate interventions. It is also reported by the participants that there is a huge gap in assessment of patients and also an interpretation of changing patient status if he is improving or is deteriorating.
The expected mean for the competencies in the communication domain is computed to be 3.8 and current 3.2 with the difference of 0.4. Besides, 37.5 % and 18.3 % of the participants expect the competencies in the same domain to be moderately competent / competent level and excellently competent	Many of the participants mentioned that, they found the new graduates to be very good at communication. Nurses 'role in patient education is important as it is vital for building the patients' or the significant others in the family in their knowledge and understanding about the plan of care, follow

/expert level of competency preparedness respectively. Whereas the participants who perceive that the current competency preparedness for the new graduates in that level is only 33.7 % and 16.3% of them. Furthermore, 37.5% of the competencies are expected to be in competency level of moderately competent / competent level while it is reported that 33.7% of competencies are in this level among the new graduates' current competency level on entry to practice. In addition ,41.3 % of the competencies are expected to be in competency level of very competent / proficient level while it is reported that 27.9% of competencies are in this level among the new graduates' current competency level.	up and self- care for better adherence to the treatment and follow up. The participants mentioned that the new graduates are very passionate, and they could find that the way of communicating with the patients and their families are commendable. Some of the participants also mentioned that patient education is a massive deficit in it and also recommended that there should be constant attempt to do it during training.

4.7 Summary of the Chapter

This chapter presented the data that were collected using the NPRT instrument and by conducting semi-structured interviews. Both the quantitative and the qualitative analyses

provide in-depth information enhancing better understandings about the research topic. The information obtained provided answers to the six-research question of this study.

The first research question of this research study was, what is the expected level of competency preparedness as perceived by the nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders? To answer this question, the NPRT instrument was used and collected data from 104 participants, along with the semi-structured interview. Firstly, the quantitative analysis of the instrument data was presented in the descriptive statistics where the mean for the 43 competency statements ranged between 3.3 to 3.9. The means of the competency domains ranged from 3.4 to 3.8. Noteworthy finding is that 86% of the competencies are expected to be in very competent / proficient level and the remaining 14% of the competencies were expected to be in the moderately competent /competent level of competency preparedness. The qualitative analysis of the semi structured interview revealed that the hospital personnel mentioned that the overall competency preparedness is moderate

The second research question was, what are the perceptions of nurse preceptors, unit managers, and professional development nurses and hospital nurse leaders on the current level of competency preparedness of new graduate nurses? The responses from the NPRT instrument provided the data to answer this question also. The data analyzed revealed that the mean range for the competency statements related to the current competency level of the new nursing graduates on entry to health care setting are 2.6 to 3.3 and related to the domains, the mean ranges from 2.8 to 3.2. Another striking finding is that 9.3% of the competencies were currently observed in very competent / proficient level and the remaining 90.7% of the competencies are in the moderately competent /competent level of competency preparedness. From the qualitative analysis of the semi-structured interviews, the responses were grouped in main

themes like highly satisfied competencies and less satisfied competencies presented in the qualitative analysis part of this chapter.

The third research question was, what skill levels and practice expectations of the new graduate nurses do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as most important? Identifying the highest mean for the competencies, provides the answer to this question. The prominent competencies that were most important among the 43 competencies were from the communication, professionalism and technical skills domain presented in Table 4.6 of the quantitative analysis part of this chapter and the same is reflected in the qualitative analysis part as well.

The fourth research question was, which competencies do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital? The study outcomes arrive at a list that are found to be at high performance as reported by the participants which was obtained from the highest mean of the responses for the instrument related to the current performance. In the qualitative part of the data analysis, the answer to this question was presented in the theme, highly satisfied competencies.

The fifth research question was, what are the gaps in new graduate nurses' competency preparedness and which of them are reported to have wider gaps? For this question, the mean difference between the expected and current competency statements and the domain as a whole provides insight. Furthermore, the computing of the responses in Importance-performance matrix' provided precise output for this question, distributing the competencies in four quadrants, namely the high importance-low performance quadrant that needs immediate action

as high priority, high importance-high performance quadrant, where the level of current competencies are as per the expected level of competency preparedness the competencies in this quadrant can be maintained in the same performance level. The third quadrant was the low importance-low performance where the competencies expected were in the low expectation, as well as the performance level of competency was also in the new competency level, but efforts can be taken to improve the competency level. The fourth quadrant is the low importance-high performance quadrant where the current level of competency preparedness of the new graduates was more than the expected level and can be maintained in the same level. In addition, the qualitative part provides deeper insight into this aspect and presented in the overall competency preparedness theme and less satisfied competencies theme, presented here with.

The sixth and the last research question was, what strategies do the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggest to enhance the competency preparedness and concomitant practice expectations of new graduate nurses? This question was answered only with the semi-structured interview responses and was presented in the qualitative part in this chapter.

During the quantitative analysis, qualitative analysis and while triangulating the data, interestingly the investigator was able to notice that the response pattern matched with the designation. So, although it was not demanded by the research question and not an objective of the study, it is highly noteworthy the relationship between the designation and responses, in order to have a deeper understanding Post-hoc Tukey analysis was computed apart from obtaining the mean of the responses related to the competency statements. This gives the responses in relation to the comparison between the six cohort of participants, namely the

preceptors, charge nurses, unit managers, assistant director of nursing and the chief nursing officer and are presented in this chapter.

CHAPTER 5

CONCLUSION

Chapter 5

Discussion, Conclusion, Recommendations and Limitations

5.1 Overview of the Chapter

Chapter five presents the discussion, conclusion, recommendations and limitations and scope of future studies in the field. This is in continuation with chapter four where the quantitative and qualitative data results were presented, discussed, and triangulated. This chapter offers further discussions, elaborations, combined interpretation for the six research questions related to the results. The current situation of nursing shortage places a demand on the new graduate nurses, that they need to enter the hospital with adequate competency preparation including the mastery in psychomotor and critical thinking skills.

There are several challenges that are addressed in the national agenda with an overall goal of placing the UAE among the best countries in the world in terms of quality of healthcare (MOHRE, 2014, UAE Vision 2021). To focus on the national goal, move towards it and enhance the achievement of the goal, this study was intended to explore the nursing competencies for the fresh nursing graduates as they begin their professional practice in government hospitals accredited by Joint Commission International in UAE.

5.2 Discussion of the findings:

The purpose of the study was to explore the perceptions of hospital nursing personnel and the nursing leadership about current and expected competencies of the fresh nursing graduates as they enter the professional practice. A concurrent mixed-methods approach was adopted to address the purpose and provide answers to the six research questions, which were:

1. What is the expected level of competency preparedness as perceived by the nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders?
2. What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the current level of competency preparedness of new graduate nurses?
3. What skill levels and practice expectations of the new graduate nurses, do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as most important?
4. Which are the competencies, do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as high performance among the competencies currently practiced by the new nurse graduates upon entry to hospital?
5. What are the gaps in new graduate nurses' competency preparedness and which of them are reported to have wider gaps?
6. What strategies do the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggest enhancing the competency preparedness and concomitant practice expectations of new graduate nurses?

The mixed-methods approach used data from the questionnaires completed by the 104 participants from four designation categories like preceptor, charge nurses, unit managers, clinical resource nurses and semi-structured interviews conducted included two more nursing designation participants, in title of Assistant director of nursing and chief nursing officer. That made a total of 56 participants including the six designations of nursing professionals in the hospital. This study investigated the perceptions of the nursing personnel in the hospitals regarding the current competency level of the new nursing graduates of UAE. The main component of this chapter is dedicated to discussion of the research findings obtained from the

study answering the six research questions in relation to the relevant literature and providing the conclusion.

The exploration to the six research questions utilizing the mixed-methods, yielded important findings which are discussed in this section as six subsections, namely, expected level of competency preparedness of new graduate nurses, current level of competency preparedness of new graduate nurses, the most important skill levels and practice expectations, current high performance competencies, gaps in new graduate nurses' competency preparedness and strategies to enhance the competency preparedness and concomitant practice expectations are presented here with the associated literatures.

5.2.1 Discussion of the results of the Research Question 1 (Expected Level of Competency Preparedness of New Graduate Nurses):

The answer to the first research question one, What are the perceptions of hospital nurse leaders, unit managers, and professional development nurses and preceptors on the expected level of competency preparedness of new graduate nurses? was found by using the Nursing Practice Readiness Tool (NPRT). The tool had six domains namely 1. Clinical Knowledge with 6 competency statements, 2. Technical skills with 11 competencies, 3. Critical Thinking with 8 competencies, 4. Communication with 6 competencies, 5. Professionalism with 6 competencies and finally 6. Management of Responsibilities with 6 competencies. Among the 104 participants who responded to this tool, it was found that most of them mentioned that they expected the competencies in the clinical knowledge domain to be in the proficient / very competent level of competency preparedness as they enter the practice setting as new graduate. Alongside, some of the participants expected the competencies in the same domain to be moderately competent / competent level of competency preparedness. In addition, majority of

the competencies were expected to be in the competency level of very competent / proficient level.

A longitudinal study that was undertaken to study the competency levels of new graduates highlighted that new nurses are shocked to discover that their clinical work does not meet the expectation. The novices have the knowledge that is more bookish and lacks clinical experience to apply the knowledge into practice (Cheng et al., 2014). Clinical knowledge includes information about relations of particular signs and symptoms with specific diseases. This clinical knowledge is enhanced and grows with the clinical exposure with patient care encounters (Song & McCreary, 2020b). New nursing graduates are expected to possess knowledge related to basic knowledge, specialty area, disease, care , cure and rehabilitation (Kittiboonthawal et al., 2018).

In addition to patient care, nurses must also be aware of roles and responsibilities across the entire care team. Among the participants, 48.1% of them mentioned that they expected the competencies in the technical skills domain to be in the proficient / very competent level of competency preparedness as they enter the practice setting as new graduate. The increasing health care demands are demanding the new graduate nurses to be critical thinkers and be ready to practice safely and independently (Patterson et al., 2013; Brown and Crookes, 2016b). Sufficient clinical knowledge is expected in new nurse graduates along with the ability to perform the skills.

The knowledge indicates the knowledge about the theory of pathophysiology, pharmacology, natural and behavioral sciences. However, new graduates are not only expected to possess the clinical knowledge but also expected to be able to provide appropriate care with accurate skills

(Hyun, Tower & Turner, 2020). Furthermore, Hyun, et al. (2020) insist that integration of theory and skills is essential and the two essential areas where theoretical knowledge with practical skills are critically needed are in safe administration of medication.

The study revealed that the participants expressed their expectation regarding the competency preparedness of new graduates and mentioned about an important aspect called enculturation, where they expected the fresh nurses to be get the work culture of the hospital and the unit within themselves and have it imbibed in them. Strouse, Nickerson and McCloskey (2018) explain this process of enculturation as a very important process where people learn the dynamics of the surrounding culture and learn and acquire its values norms and necessary practice including its culture and worldviews. The participants mentioned that the competency is not just having or acquiring the needed skill set, it is much more than that which is enculturation into the real life, real work environment and also able to work in union with the people at work. These findings echo the findings of Kelly and Ahern (2009) who mention that preceptors expect the new graduates to be compatible with the ward routine, and is considered as very important in the transition process which was found to be an expectation among 70% of the preceptors in the study aimed to study the transition practices.

The general expectations of the hospital nursing leadership on the competency preparedness are not only just a professional standard described by the nursing body but also the joint commission international accreditation standards also mention the competency requirement as the requirement. The competencies do not only indicate the skills or ability to perform the procedure, but extend beyond that to include the policies, protocols, value attitudes, general nursing knowledge.

In regard to the expectation about the competencies of technical skills, among the participants, 48.1% of them mentioned that they expected the competencies in the technical skills to be in the proficient / very competent level of competency preparedness as they enter the practice setting as new graduate. About 40.4% of the competencies were expected to be in the competency level of very competent / proficient level and 35.6% of the competencies were expected to be in competency level of moderately competent / competent level.

5.2.2 Discussion of the results of the Research Question 2 (Current Level of Competency Preparedness of New Graduate Nurses):

The review revealed that new graduate nurses' self-assessed deficiencies included advanced technical skills, critical thinking, communication, teamwork, helping role, and professionalism, most of which were associated with “soft” skills. New graduate nurses’ possession, not only of “hard” nursing skills within the cognitive and psychomotor domains but also of soft skills that mostly lie within the affective domain, is vital to achieve higher retention rates. Because soft-skill competencies are problematic to objectively evaluate, recommendations include development and frequent application of a more objective measure such as a rubric, greater emphasis on soft skills in education, and supervised hands-on training in supportive practice settings.

The present study reports that the patient’s clinical deterioration is usually missed by the new graduate nurses, who are referred as novice or advanced beginner. Similarly, some graduates had insufficient exposure to clinical situations to process and sort the patient assessment information or had decretory judgement as that of the nurses who had more clinical exposure. Similar findings are reported where the preceptors highlighted the dependence of the new graduates on the classroom knowledge, and it compelled them to assess or look for the

manifestations that was emphasized in the curriculum. It was also underlined by them that the new graduates were unable to identify the changes in clinical status (Kantar, 2012). The finding also corresponds to other results reported where the deficiency to note new symptoms by the new graduates are observed and reported by preceptors (Benner et al., 2009).

In regard to the competencies belonging to the critical thinking domain, it was revealed by the study that the hospital nursing personnel found that the new graduates were deficient in recognizing changes in the patient status. This is one of the competencies that is highly expected by the hospital personnel to be well prepared by the new nursing graduate. This finding resonates with the observations reported by Benner et al (2009) who mentioned that 95% of preceptors observed that the new graduates had difficulty interpreting changes in the patient's health status as a part of the disease process.

In regard to the competencies concerning management of responsibilities, the competency of ability to keep track of multiple assignments and responsibilities are found to be less (mean of 3.14) in comparison to the expected level of competencies (mean of 3.6). Similar findings are reported by Murray, Sundin and Cope (2019) that the new graduates were not responsible in their assignments. The graduates' anxiety level increases due to the imbalance between their level of performance and the expected level of performance (Murray, Sundin and Cope, 2019). The same findings are reported by Song and McCreary (2020) while exploring the self-assessment by the new graduate nurses. It was found that they are deficient in not only the hard skills but also the soft skills.

The competencies include the application of theory to practice and professionalism. At the same time, the study also reported that the new graduates were also deficient in communication

skills and skills related to working effectively as a part of team which is contradictory to the study results. The mismatch in the perception of key stakeholders about competency levels. This has important implications for building new graduates' readiness for practice and highlights the importance of collaboration between key stakeholders to address competency gaps. In regard to the competencies of technical skills, many of the participants (28.8%) of them reported that the competency level of the new graduate in this domain of technical skills was in the proficient level/ very competent level. Furthermore, 100 % of the competencies were expected to be in competency level of very competent / proficient level. none of the competencies in the current level of competencies were in the excellently competent / expert level.

The study highlights that critical thinking and clinical judgement with the problem-solving involve the ability to handle the complex clinical situations, where it requires critical thinking immediate decision making. The study also indicates that no matter whether the new graduates had extensive training on various courses, it is imperative that that knowledge is transferred into actionable skills through critical thinking and clinical judgement. Some of the participants mentioned that new graduates had difficulty with clinical decision making. Contrastingly, in one of the research studies, it was reported that new nursing graduates were able to assess, analyze the patient's condition and also were able to make clinical decisions based on sound clinical judgement (Wangensteen et al., 2012; Clinton, Murrells and Robinson, 2005). It is also reported that new graduates are found to be able to anticipate problems, and able to recognizes the patient needs (Hengstberger-Sims et al., 2008).

Most of the participants highlighted passionate and dedicated customer care as a vital component of expected preparedness. The competency preparedness may have some

deficiencies related to few domains, but the overall perception of their competency preparedness was just acceptable. This is also reflected in a study conducted by Walton et al. (2018) that the fresh nursing graduates reported that their stress level increased, not because the workload was hard to handle, but because of the inability to handle the work, they tended to lose the soft skills like being compassionate, joyous, attentive and caring nature and their focus shifted from caring holistically to become task oriented. On the contrary, Holland et al. (2010), in a study that evaluated the fitness for practice, reported the key findings from the stakeholders revealed that the report on practice preparedness usually were reporting the deficiency in specific skills but not on the general practice.

5.2.3 Discussion of the results of the Research Question 3: (The Most Important Skill Levels and Practice Expectations):

Descriptive statistical analysis was performed on the study responses related to the expected competency levels for the selected competencies included in the NPRT. The survey responses reveal those highest expected competencies identified with the highest mean. The top 15 or most important 15 expected competencies were presented in Table 4.10. The competency that was considered as important and expected by the preceptors, charge nurses, unit managers and the clinical resource nurses was rapport with patients and families with the mean of 3.99. Communication was an important competency that was expected of the new nursing graduates to be prepared when they enter the hospital.

The 15 competencies that were identified as the most important competencies on entry to nursing practice, were found based on the highest mean. The second highest mentioned was the respect for diverse cultural perspectives with the mean of 3.9, followed by Preparing

patients for diagnostic investigation, pain assessment, ability to work as a part of the team, Interpretation of assessment data like history collection data, physical examination findings and lab reports, administration of oral medication safely. Communication with interprofessional team, customer service, accountability for actions, performing clinical procedures, providing education for patients and their families, conducting assessments, documentation of patient care and the ability to work independently are the most important competencies as expected.

Communication skills include the ability to converse and pass on the information in the level and language that is understandable without using technical terms (Kittiboonthawal et al., 2018). But in relation to communication with doctors, in the present study, the hospital nursing personnel reported that the new graduates did not communicate any patient's condition to the doctors directly, instead patient-related information or communication was done by the senior nursing staff and communication by the new nursing graduate to the doctors was not expected. Whereas it was expected that the new graduates communicated with the doctors, but has been found to be deficient in this skill and need to be improved (O'Shea & Kelly, 2007).

Among the participants, 48.1% of them mentioned that they expected the competencies in the technical skills domain to be in the proficient /very competent level of competency preparedness as they enter the practice setting as new graduate. In regard to the competencies included in the technical skills of the Nursing Practice Readiness Tool (NPRT), the participants mentioned that they expected 100 % of the competencies to be in competency level of very competent / proficient level. Whereas, analysis of the research by Theisen and Sandau (2013) identified several competencies that were important for new graduates, including

communication, leadership, organization, critical thinking, specific situations, organization, prioritization, time management and stress management.

5.2.4 Discussion of the results of the Research Question 4: (Current High-Performance Competencies):

The high performance that is currently exhibited by the new nurses was explored with the research question, which are the competencies, do nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders perceive as among the highly performed practiced by the new nurse graduates upon entry to hospital? The answer to this research question was obtained by both surveys using the NPRT and also with the semi-structured interviews. A similar study was undertaken by Burns and Poster (2008) with the objective of identifying the competencies that were considered as highly satisfied. The study explored and identified 10 high risk and 10 high volume conditions to identify the skills and competencies that were expected by the hospital nursing personnel of the new nursing graduates to possess on entry as professional nurses soon after their graduation.

The present study reveals that communication with the patients and their families, where the participants insisted on the good communication skills with the patients, which was helping them to rely on them was mentioned. It was also highlighted that the communication was more effective, as the new nurses were familiar with their culture and fluent in their language making it easier to approach and communicate. It was also mentioned that the fresh graduates were found to be passionate in communication, dependable in communication and they were identified to be helpful in resolving conflict with patients with their communication skills.

Another important competency the hospital nursing personnel expressed that they were satisfied in the competency was performing the clinical procedures, where specifically high satisfaction was expressed in the competencies of performing sterile dressings and other basic nursing skills. One another notable competency was the recognition of unsafe practices by others, where the participants mentioned that the new graduates were very good at identifying any deviating nursing practice as they tended to compare what they learnt from the book with the actual practice in certain procedures. Similar findings were reported, mentioning that the new nursing graduates had high performance in the basic skills and performed routine skills like administration of oral medications and performing simple dressings (Ramritu & Barnard, 2001).

The results of the present study indicate the list of competencies that were reported that the new graduates were performing well in certain competencies. Those competencies were identified both by the survey and also by the semi-structured interviews. The highest mean in the current level of competencies was provided with the list of competencies where the new graduates were found to be having high performance. The highest fifteen competencies that were identified are: rapport with patients and families, respect for diverse cultural perspectives, communication with interprofessional team, ability to work as part of a team, documentation of patient assessment data. preparing and administering intramuscular, intracutaneous and subcutaneous injections, pain assessment, preparing the patients to diagnostic investigation, patient education, customer service, accountability for actions, conducting patient assessments, clinical history collection, physical assessment related to all system, safe administration of medications per oral. formulating nursing care plan based on assessment findings and performing clinical procedures (e.g., sterile dressing IV therapy, etc.).

5.2.5 Discussion of the results of the Research Question: 5 (Gaps in New Graduate Nurses' Competency Preparedness):

The study has identified some very important findings, one of it is the areas of gaps. Knowing this is imperative as it informs the direction to move forward in terms of enhancing the competency preparedness of new nursing graduates as they enter the health care setting. The health care system is advancing at a much faster pace, especially during the last decades and nurses are being expected to have healthcare responsibilities that include knowledge and skills related to many technical skills, pharmacology, technology ,change in chronicity of diseases, population characteristics etc. that requires high levels of understanding, comprehension (Patterson et al., 2013)

The study revealed that there is gap identified in the competencies of clinical knowledge that includes competencies like understanding of the principles of evidence-based practice, knowledge of pathophysiology of patient conditions, knowledge of pharmacological implications of medications, interpretation of physician and interprofessional orders, compliance with legal / regulatory issues relevant to nursing practice and understanding of quality improvement methodologies, where the mean for the expected competencies was 3.47 and the mean for the current competencies in the same clinical knowledge was 2.86 indicating gap. On the contrary, Walton et al. (2018) mentioned that the new nursing graduates mentioned in their self-assessment that they had intellectual readiness and satisfactory knowledge on safe practice. Knowledge of biological sciences and the knowledge of disease conditions and its treatment have been found to be deficient and requiring improvement (Ramritu & Barnard, 2001).

The study throws light on the gap identified in technical skills. The competencies that were explored in this domain were: conducting patient assessments, clinical history collection, physical assessment related to all systems with the mean for expected level of competency and current levels of competency as 3.77 and 3.28 respectively. Another notable competency was performing clinical procedures like sterile dressing, IV therapy, etc. with the expected and current performance means as 3.80 and 3.16 respectively. This finding reflects the finding of a study where the gap was identified in advanced nursing skills like intravenous lines, drainage, care of airway including the suctioning, tracheostomy, isolation, complex dressing gastrostomy feedings and care of patient with PEG tube feeding (Marshburn Dianne M. & Swanson Melvin S., 2019; Ramritu and Barnard, 2001)

It was also found in this study that there is a gap existing in medication management, especially in the competency of utilization of clinical technologies including use of IV smart pumps, medical monitors, safe administration of medications per oral and preparing and administering intramuscular, transdermal and subcutaneous injections, out of which, much of the gap was not identified for the oral drug administration, whereas equal level of gap was identified and reported in use of technologies for medical management and also in administration of parenteral medication administration of medications. In a similar study focusing on identifying the work readiness of new graduates, Wangensteen et al. (2012) identified and reported similar findings that there is a deficiency found in medication management, and care of medical equipment.

5.2.6 Discussion of the results of the Research Question: 6 (Strategies to enhance the Competency Preparedness and Concomitant Practice Expectations):

The strategies that the hospital nurse preceptors, unit managers, professional development nurses, and hospital nurse leaders suggested to enhance the competency preparedness and concomitant practice expectations of new graduate nurses was explored in the sixth research question. The findings related to this study are vital and note-worthy and were elaborated in chapter 4. Some of the key findings related to this question were that the participants agreed that the preparation of new graduates was an effort that both the university and the hospitals are expected to participate in equally and are responsibility lies with both the academic and practice settings. More focus was given on increasing the clinical exposure and improving the clinical training. The findings are also considered and presented as the recommendations for both the universities and the hospitals later in this chapter.

The hospital nursing personnel, while answering this questions of the interview , mentioned the need to improve the clinical exposure and experience by allotting more hours with hands-on practice during clinical practice in the student period. Whereas Brown and Crookes (2016) pointed out that even with 2300 hours of clinical exposure and clinical training in multiple settings, students lacked confidence. Murray, Sundin, and Cope (2019) explored the practice readiness of new graduate nurses and the related transition shock and highlighted that the feeling of anxiety, feeling of insecurity, and inadequacy manifested as lack of competency (Patterson et al., 2013). This clinical knowledge is enhanced and grows with clinical exposure to patient care encounters (Song & McCreary, 2020b). The study indicates that there is a lack of clarity among the levels of competency preparedness of new graduate nurses as they enter the clinical setting. The profession and employers need to revisit their stand in regard to what

level of competencies they expect new graduate nurses to possess and what level those competencies are expected to be present.

5.3 Conclusion:

Findings suggest that newly graduated nurses perceive the increased levels of clinical competency and confidence in their self-administered report after participating in the RN residency program. In different streams of literature, employability has been defined in other, often related ways. We take an interdisciplinary approach, combining insights from research on higher education and workplace learning, taking a Western perspective. In doing so, we take a multi-dimensional, competence-based approach. Our approach to conceptualizing employability responds to research from both disciplines arguing for a need to integrate approaches to employability, for a unified overview of conceptual frameworks, and agreement on definitions of the concept.

We conclude that models of employability from these different disciplines can reinforce each other. Certain dimensions of employability are less considered in one discipline while receiving a lot of attention in the other. Hence, our work opens new avenues for conceptual and empirical research on employability in both domains. Moreover, it might influence how researchers and practitioners research and support (lifelong) learning for employability, both in higher education and in the workplace (Römgens et al., 2019; Nursing Solutions, Inc., 2020). The main focus of the nurse residency program is to alleviate the stress related to lack of clinical time, skills deficiency, and lack of confidence, which in turn can reduce the turnover rate and low job satisfaction rate among the new nursing graduates joining the workforce. (Crimlisk et al., 2017)

The key findings of the study are, the participants mentioned that the overall preparation of the new graduates, that though they had certain competencies that are highly appreciable like rapport with patients and families, followed by the competency of respect for diverse cultural perspectives, Communication with interprofessional team ,followed by the competency, Ability to work as part of a team, documentation of patient assessment data and Preparing and administering intramuscular, intracutaneous and subcutaneous injections, then it is the pain assessment, preparing the patients to diagnostic investigation, patient education, customer service and accountability for actions followed by conducting patient assessments, clinical history collection, physical assessment , Safe administration of medications per oral as they were very good at it and some competencies had to be improved, there are certain significant characteristics of the new graduates, that was obvious like, able to identify the theory-practice gap in their approach. The participants also expressed that they were able to identify the Reality shock among the new graduates as they entered the health care settings. They also mentioned that the quality of holistic nursing was compromised most of the time, and they were able to comment generally on the performance that it was fragmented and compartmentalized nursing care. Unconscious incompetency also was mentioned as one word to refer to the overall competency preparedness of the graduates.

5.4 Research Recommendations and applications:

Some recommendations emerged as a result of the collected data analysis, presentation, and discussion for the two research questions for future research. In addition, there are some suggestions for the policymakers at the healthcare systems, nursing education institutions, and the Ministry of Higher Education.

Based on the result of the study, several strategies were identified, and recommendations of the study findings are in multiple fields like hospitals, academic institutions, nursing leaders, academic institutions, and for the future studies as presented here.

The study outcome was utilized to develop and recommend a Comprehensive Nursing Entry level competency assessment tool (presented in Appendix H) which can be utilized by nursing academic educators to assess graduating students who will be entering the health care setting. The same tool can also be used by the Graduate nurse internship program coordinators in the hospital to assess their interns as they enter the hospital to identify the levels of competency preparedness to enhance the smooth transition of the nursing interns to practice and also provide training support to the competencies that are assessed and the gap identified.

5.4.1 Recommendations for Nursing Academic Institutions

Nursing academic institutions should consider including in their curriculum the strategies for clear communication and conflict management, prioritization skills, and leadership development. The institutions need to stress developing their students with good communication skills, including strategies to include critical thinking, clinical reasoning, and also adopt simulated life situations for their training, including end-of-life scenarios. The nursing universities should have the graduating students complete a competency preparedness evaluation tool.

Another important practical implication is incorporating the findings of the study, which is the expected competency level on entry to practice which needs to be incorporated into the

curriculum to enhance the competency preparedness of the new graduates. The clinical hours need to be increased to improve clinical practice and clinical training. The clinical training should make sure that the competencies that are mentioned in the entry-level competency lists and also as per the level of performance expected. These recommendations are development and enhancement of nurse residency programs, preceptorship programs, curriculum development, clinical teaching strategies and transition program as appropriate. The inclusion of additional clinical hours and simulation experience will benefit the new graduates in improving the graduate preparedness.

The competencies do not only indicate the skills or ability to perform the procedure, but extend beyond that to include the policies, protocols, value attitudes, general nursing knowledge, and clinical skills, critical thinking, clinical judgment skills, clinical decision-making skills, psychomotor skills, and cognitive skills must be introduced at the beginning of the nursing career.

The study result informs universities to design a curriculum to adapt to the needs of the hospital in relation to the competencies and the level of those competencies expected by the hospital personnel from the new nursing graduates as they enter the hospital setting. It is recommended that the nursing curriculum employs and strengthens the reflective and problem-based learning, which allows the students to reflect on their areas of strength and weakness, during their clinical experience, aspects they were able to link the theory with their clinical scenario they were exposed to, the skills and the clinical procedure observed, clinical procedures performed, new knowledge gained can be discussed during their reflection session in the clinical training along with the case discussions.

5.4.2 Recommendations for Hospitals

The results of the study recommend strategies in the new residency program, which include strategies for clear communication and conflict management, prioritization skills, and leadership development. The results that emerged from the study indicate the importance of conducting entry-level skill assessment as the new graduates enter nursing practice. The practice gap analysis that is revealed by the study will benefit the organization and the health care system as a whole. It is recommended that the clinical training that happens in the hospital, the preceptors, and the unit managers need to be involved in making the students more accountable and also enhancing theory and practice bridging and critical thinking.

The study results reveal that there is no clarity regarding the level of competency preparedness that is expected for each of the selected 43 entry-level competencies among the hospital nursing personnel, so it is highly recommended that the nursing leaders of the hospitals or the corporate governance office should develop an entry-level competency standards which can be the base for the academic institutions of nursing to build their program outcomes and therefore create graduate attributes.

The study also revealed that there are no entry-level assessments that are currently performed on the new nursing entrants. So, it is recommended that formal objective assessment needs to be developed which will serve as a basis for identifying the areas of weakness and conducting the graduate nurse internship training program focusing on those areas requiring training. It is also recommended that the clinical supervision is done by preceptors who are trained so that the students are supported enough during the clinical experiences enhancing smooth translation of theory into practice with support from experienced preceptors. This support and supervision

will help the nursing students to get engaged in the realities of nursing practice, and also facilitate the process of enculturation to easily bridge the theory-practice gap.

The study findings also provide the strategy that the clinical training, which is the responsibility of both the university and the hospital. It is wise to have the faculties of the university have a role in the hospital for better collaboration. This will not only aid in the student clinical experience but also provide adequate support in training the preceptors to handle the students, thereby the clinical learning objectives can be attained, and competency preparedness enhanced. This needs to be achieved by regular and collaborative communications between academic universities and the health care settings. This will help in delivering quality clinical experiences as per the level of understanding, comprehension and level of learning. The positive partnership and joint teaching efforts will affirm the competency preparedness of the new graduates when they enter the health care setup upon graduation.

5.4.3 Recommendation for Future Studies

The Joint Commission requires hospitals to assess the competency of employees when hired and then regularly throughout employment. The competency assessment is defined as the systematic collection of practitioner-specific data to determine an individual's capability to perform up to defined expectations (Whittaker et al., 2000). To best assess all of this, healthcare organizations should have customizable assessments and corresponding learning on tap for nurses. Those tools should be available to nurses online and in such a way that they can study at their own pace, followed by testing designed to assess each performer vs. comparing them to the entire nursing cohort (Song & McCreary, 2020b)

5.5 Applications:

The findings of the study have numerous implications for future nursing practice, specifically for nursing leaders and also, very importantly, the nursing academic institutions are presented here.

5.5.1 Applications for Hospitals

The study reveals many implications for the hospitals, which includes initiating an on-entry assessment of competencies and focusing on the areas of competencies that the new graduates lack preparedness for. This gap can be addressed in the residency programs; the results of the study also throw light on allowing hands-on practice related to patient care and also in clinical documentation. Most importantly, hospitals and the UAE NMC (Nursing and Midwifery Council) can chalk out the entry-level competency standards based on which the academic institutions could adapt their curriculum. To ensure optimum clinical teaching, preceptors must be trained. Regarding the strategies for the educational institutions, the clinical training hours can be increased, and the students can perform the same clinical hours matching the duty hours of RN to minimize reality shock and more clinical practice. To enhance critical thinking, case scenario-based course teaching involving clinical reasoning and judgment can be included.

Moreover, critical thinking can be included as an objective in every course of the nursing program and as a program objective. The competencies that are identified as low-performance competencies can be incorporated into their curriculum development and course offering. The findings of the study will enable the mentioned skills and competencies to be integrated into the curriculum and also in the graduate nurse intern preparation programs in the hospital. The

curriculum and clinical training should focus on graduates who can transfer the knowledge to practice (Brown & Crookes, 2016b). Integrative teaching enhances the content to the context and allows the theory to be transferred to practice. Among the many instructional strategies, the use of simulation is found to facilitate integration as it replicates the real situation (Dagnone et al., 2016). Incorporating the results and the recommendations into the nursing curriculum will facilitate smooth transition from the academic to the hospital setting. The study findings also support the relevance and importance of competency-based clinical training, enhancing the bridging of the theory-practice gap, improving critical thinking, and augmenting work readiness.

5.5.2 Applications for Nursing Practice

The national agenda and the shortage of national nurses presents challenges and the need for such study findings to inform the gap and take steps to enhance competency preparedness as they are prepared in the nursing universities to meet the expectations of the hospital settings so that they can transition smoothly. The study results reveal the gap that exists between the expected levels and the current performance levels for the selected competencies needed on entry to the health care setting. The results reported highlight the need for more clinical exposure and training in the hospital. The study's results are noteworthy by the hospital nursing leadership and estimate the training hours needed as the hospitals receive the new graduates and provide graduate intern training program as per the need identified. The findings of the study also advise the hospital on the budgeting of training resources, identification of the training resources available, and also ways and means to reduce the economic and fiscal stress.

The findings of the present study provide greater understandings of the competencies expected as the new nursing graduates as enter the hospital setting. This will allow the profession that includes both the academic institution and hospital settings to prepare better the nursing graduates which will, in turn, improve their retention, reduce the shortage of nurses and also improve patient outcomes and the quality of nursing care. The academic institutions are informed about the expectations in the level of competencies through the findings of the study. The well-prepared new graduates will be able to balance the ongoing nursing shortage and also reduce the turnover rates.

5.5.3 Applications for Nursing Leaders

The results of the study are very much relevant to nursing leadership in both academic and hospital settings; also, the leadership in the national governments to chalk out strategies bases on the findings of the study and improve competency of new graduates as they enter the clinical settings after graduation. The findings of the study highlight the expectations, present level of competency, the gap in performance level, competencies that are considered as highly important, list of competencies that are found to be of low performance and also the strategies suggested for both hospital setting and also for the academic universities. These study findings can be utilized to develop targeted interventions aimed at developing the competencies during their student period. It also addresses the new graduates' specific transition needs to create safe practice grounds. Being aware of the areas of deficiencies from the immediate contact to the new nurse graduates, who are the preceptors, charge nurses, unit managers, and the clinical resource nurses, will help the nursing leaders to be cognizant of the needs of the new nursing graduates and enhance smooth transition while being competency prepared as per the expectations of the hospital nursing personnel.

5.5.4 Applications for Nursing Education

The study findings are significant and noteworthy to the nursing universities and educators because the study highlights the gaps of the new nursing graduates as they graduate and enter the health care setting. The study results also list the entry-level competencies and the expected levels of performance by the new graduates as reported by the hospital nursing personnel. The study results from the targets for integration into the curriculum, so the educators can focus on those lines to prepare graduates with the competencies required and also in the level of competency expected.

5.5.5 Application to the Nursing Profession

There is little research on studying the level of competency preparedness capturing the perception from all the levels of nursing personnel, namely the preceptors, charge nurses, unit managers, clinical resource nurses, assistant director of nurses, and the chief nursing officers. This study is the first of its kind in the UAE, informing both the academic and the hospital setting the practices and strategies enhancing the competency preparedness and work readiness of the new nursing graduates. The study was undertaken using the mixed methods approach with triangulation. As revealed in chapter four, one of the most significant findings to emerge from this study is the list of competencies and the related level of competencies.

The survey that was undertaken by the study was a practical method of rating the level of competencies of new nursing graduates on entry to the health care setting. The study results also highlight the areas that require further investigation. The study results indicate the competencies where new nursing graduates are not performing as per the expected competency

level on entry, by identifying these deficiencies and gaps the nursing academic institutions, health care settings and also to include as the national strategy and thereby allocate resources to enhance competency preparedness of new nursing graduates.

The study results also document the expectations of the nursing personnel in the hospital and highlight the urgent need to conduct large-scale studies at the national and international levels. The study also paves the way for planning and offering a proper transition program which needs to focus on the gaps in the competency preparedness which in turn would reduce the number of nurses leaving the profession during the first year, where 40% of the new graduates are expected to leave the profession in the next decade (World Health Organization, 2016). Much of the focus within the literature mentions that there is less focus on transition interventions and transition strategies. This study addresses the gap.

5.6 Limitations

Though the study adds much to the body of knowledge on UAE nursing education, graduate preparedness, and work readiness, it still has a few limitations. The first and foremost is that the study was conducted in Abu Dhabi only, and the findings cannot be generalized to other emirates like Dubai, Sharjah, Ajman, Fujairah, Ras al-Khaimah, and Umm al-Quwain. Another limitation is that academic faculties and the new nursing graduates are major stakeholders of the study's area of focus, but they were not included. The lack of inclusion of the major stakeholder in the construction of the project could be a limitation. In addition, the researcher belongs to one of the nursing institutions in Abu Dhabi, which might cause bias while collecting data, including the semi-structured interview.

The study's tool consisted of 43 competency statements where the participants were expected to mention the current performance level of competency and the expected competency level, though none of the participants mentioned about the questionnaire fatigue, the researcher felt that it would have influenced the participant to have the questionnaire fatigue and thereby the participants might not have given a true reflection of their perceptions.

The study could have included more Chief nursing officers from the hospitals from where the data were collected and also from other hospitals. Another limitation is that the tool was given in multiple ways, like direct paper-based copy and online version, which could have influenced the accuracy of the response and could have impacted the response rate. The sample limitation in this study is also present in the study. Additionally, only the Government hospitals (SEHA) were included in the study, and other private hospitals did not provide access to conduct this study so is also considered as a limitation.

5.7 Scope for Future Studies

There are many opportunities for further study in the area of focus, which is the competency preparedness of nursing graduates. Additional research can be undertaken to explore the self-perceptions of new nursing graduates about their competency preparedness. Another study can involve the academic faculties' perceptions of the same. Further studies can involve entry-level objective assessments to be done and studied on the new graduates on entry. Additionally, contributing factors for poor competency preparedness can also be studied to enhance the depth of exploration and adding to the body of knowledge in this regard in this part of the world to provide valuable insights. Future research needs to focus on graduate nurse intern programs

conducted by the hospitals to meet the needs of the novice nurses and the customer population that is more contextualized.

Future studies can include all the stakeholders in both academic and health care settings to have a comprehensive view of the current competency preparedness of the new graduates and the expected competency preparedness as perceived by the nursing personnel and the nursing leadership in the hospitals. It is also found that future studies can be carried out with a team of researchers from both academic settings and the hospital setting, allowing good support in data collection eliminating the bias. The study can also be conducted in both the government institutions and also private hospitals so that complete health care settings can be studied. Furthermore, it can be evaluated to find any difference in the competency expectations between the governmental and private hospitals. There is an additional need for a robust large-scale study focusing on all the stakeholders at national and international levels.

5.8 Concluding Remarks

Findings suggest that newly graduated nurses perceive the increased levels of clinical competency and confidence in their self-administered report after participating in the RN residency program. In different streams of literature, employability has been defined in other, often related ways. We took an interdisciplinary approach, combining insights from research on higher education and workplace learning, taking a Western perspective. In doing so, we took a multi-dimensional, competence-based approach. Our approach to conceptualizing employability responded to research from both disciplines arguing for a need to integrate approaches to employability, for a unified overview of conceptual frameworks, and agreement on definitions of the concept.

We conclude that models of employability from these different disciplines can reinforce each other. Certain dimensions of employability are less considered in one discipline while receiving a lot of attention in the other. Hence, our work opens new avenues for conceptual and empirical research on employability in both domains. Moreover, it might influence how researchers and practitioners research and support (lifelong) learning for employability, both in higher education and in the workplace (Römgens et al., 2019). The main focus of the nurse residency program is to alleviate the stress related to lack of clinical time, skills deficiency, and lack of confidence, which in turn can reduce the turnover rate and low job satisfaction rate among the new nursing graduates joining the workforce (Crimlisk et al., 2017).

The key findings of the study are: the participants mentioned that the overall preparation of the new graduates, that though they had certain competencies that are highly appreciable like rapport with patients and families. Followed by the competency of respect for diverse cultural perspectives, communication with interprofessional team, followed by the competency, ability to work as part of a team, documentation of patient assessment data and preparing and administering intramuscular, intracutaneous and subcutaneous injections, Then it is the pain assessment, preparing the patients to diagnostic investigation, patient education, customer service and accountability for actions followed by conducting patient assessments, clinical history collection, physical assessment. Safe administration of medications per oral as they were very good at it and some competencies had to be improved, there are certain significant characteristics of the new graduates, that was obvious like, able to identify the theory-practice gap in their approach. The participants also expressed that they were able to identify the reality shock among the new graduates as they entered the health care settings. They also mentioned that the quality of holistic nursing was compromised most of the time, and they were able to

comment generally on the performance that it was fragmented and compartmentalized nursing care. Unconscious incompetency also was mentioned as one word to refer to the overall competency preparedness of the graduates.

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Appendix.

Appendix A: Ethical Approvals

a. Ethical Approval - SEHA Corporate (Ministry of Health – MOH)

From: Corporate Learning & Development [mailto:td@seha.ae]

Sent: Sunday, May 13, 2018 7:39 AM

To: Annie Rosita Arul Raj <Annie.Raj@fchs.ac.ae>

Cc: Corporate Learning & Development Section (HO) <CorporateT&CDSection@seha.ae>; Training and Development Department (SKMC) <TrainingandDevelopmentDepartmentskm@seha.ae>; Training and Development (RAH) <traininganddevelopmentRAH@seha.ae>; Suaad Mubarak Mubarak <SuaadM@seha.ae>; HR-Training (MFQ) <mafraqtrainingsmfq@seha.ae>

Subject: Request For Research Approval

Dear Respected ,,,

Greetings,

we are pleased to let you know on the approval of you research that was placed from your kind end, you can now coordinate with the training sections in the entities directly to accomplish the following research.

Dear Respected ,,,

Training and development sections employees / Entities

Please accomplish the research procedure for the applicant above as per attachment and coordinate directly for any inquiries regarding the content of the research.

Applicant name: Annie Rosita Arul Raj

Contact number: 0504600732

Corporate Learning & Development

قسم التعليم والتطوير – المقر الرئيسي

Corporate Human Resources Planning &Development Department

إدارة تخطيط وتطوير الموارد البشرية – المقر الرئيسي

Abu Dhabi Health Services Company - SEHA

شركة أبوظبي للخدمات الصحية - صحة

+971 2 410 2000

109090, Abu Dhabi, UAE

td@seha.ae, www.seha.ae

b. Ethical Approval -AL AIN Hospital

مستشفى العين
AL AIN HOSPITAL

AAH Research Ethics Committee

TO: Annie Rosita; annierosita16@yahoo.co.in
Lecturer
Fatima College of Health Sciences, Abu Dhabi, UAE

CC: AAH Research Ethics Governance Committee

Date: 24th June 2018

RE: **Proposed Research Study:** *Competency Preparedness of Baccalaureate Nursing Graduates and Practice Expectations at Entry Level as Perceived By the Nursing Leadership of the Hospitals in UAE*

Ref: *AAHEC-06-18-102*

Dear Ms. Annie,

On behalf of the Al Ain Hospital Research and Ethics Governance Committee, I am pleased to confirm a favorable ethical opinion for the above research on the basis described in the application form and supporting documentation.

The favorable opinion is given provided that you comply as per the context set out in your research study.

You are hereby advised to commence your research study at Al Ain Hospital. In keeping with our policy, the AAH Research and Ethics Governance Committee is kindly requesting you to report any ethical concerns/considerations that may arise during the course of your research, in a timely manner.

Annual Reports plus terminal reports are necessary and the Committee would appreciate receiving copies of abstracts and publications should they arise.

The REC approval is only valid for two years (24 months from the date of the approval letter issued) however it should be renewed yearly for the continuation of the approval. Two (2) months before expiry of the validity period, the Continuing Review Form should be submitted to REC. Late submissions may not be processed in time, and you are not allowed to continue the study without approval.

The Committee is wishing you a success for this project.

Respectfully yours,

Dr. Ghanem Ali Abdul Al Hassani
Deputy Chief Medical Officer (A)
Al Ain Hospital

Dr. Ghanem Ali Al Hassani
Chairman, AAH Research Ethics Committee
Acting Deputy Chief Medical Officer
Al Ain Hospital

إدارة الشؤون الطبية
مستشفى العين
AL AIN HOSPITAL
CMO OFFICE

P.O. Box 1006, Al Ain
Tel: +971 3 763 5888
Fax: +971 3 763 4322
www.alain-hospital.com
SEHA صحة

c. Ethical Approval -SKMC Hospital

Institutional Review Board / Research Ethics Committee

APPROVAL LETTER

31st July 2019

Ms. Majeda Sarraj Al Kabariti
Clinical Resource Nurse
Nursing Department, SKMC
Abu Dhabi, UAE

Ethics Approval Reference No: *Please quote this ref # in all correspondence*	**REC 31-07-2019 [RS-593]**
Research Title:	**Competency preparedness of baccalaureate nursing graduate and practice expectations at entry level as perceived by the nursing leadership of the hospitals in UAE.**

Dear Ms. Majeda,

Thank you for submitting the IRB Application form and the supporting documents of the above mentioned research project for IRB review.

Assessment of your proposal was reviewed through full nursing committee and by the IRB Chairman. The proposal is merely a cross sectional study is to gain insights on the competency preparedness and practice expectations of new graduates among the preceptors and nurse leaders and professional development nurses of Hospitals accredited by The Joint commission (TJC) in UAE. The ultimate aim of nursing practice is to improve the patient outcome, for this to happen the nursing education system has great responsibility to adopt appropriate strategies for them to develop competencies and be successful in their careers.

Since this research project met the standards from an ethical point of view, the IRB concurred on its approval to carry out in SKMC as designed.

Kindly note that approval was granted on the understanding that the research team complies on the applicable local laws, SKMC IRB policies and procedures and the ICH-GCP guidelines:

- ***Modifications/Amendments to the approved proposal**: Any modifications to the IRB-approved research (including changes to the informed consent document(s) must receive IRB approval prior to implementation of the changes. Substantial variations may require new submission.*
- *IRB has an authority to suspend or terminate approval of this research study if not being conducted in accordance with the IRB's requirements or has been associated with unexpected serious harm to subjects. Information collected following suspension is unapproved research and can never be reported or published as research data.*

- ***Progress Report**: It is the responsibility of the principal investigator (PI) to provide the SKMC IRB with, at least, an annual update on the progress of the research, and a final report within three (3) months after termination or completion of a research study by submitting a Progress Report Form (Attachment 1).*

- ***Retention and storage of data:** The PI is responsible for the storage and retention of the original data pertaining to the research project for a minimum period of five (5) years. Data should be stored secured so that a few authorized users are permitted access to the database.*

- *IRB/REC Office should also be notified of the arrangements for publication or dissemination of the research including any feedback to participants.*

SKMC Institutional Review Board / Research Ethics Committee (IRB/REC) are fully compliant with the International Council for Harmonization / Good Clinical Practice (ICH/GCP) Guidelines for the conduct of trials involving the participation of human subjects as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee / Independent Review Board.

- *Granted an authorization to conduct human subjects research by Health Authority Abu Dhabi (HAAD) - Research Authorization #2011.01.*
- *Received accreditation from the Office for Human Research Protections (OHRP), US Department of Health and Human Services (HHS). http://ohrp.cit.nih.gov/search/search.aspx*
    - *Institution Registration # IORG0006896 expires 23 January 2021;*
      IRB Registration # 00008262IRB
    - *Federal Wide Assurance (FWA) # FWA00018992 expires 17 May 2022*

IRB/REC members wishing you and the research team all the best towards a successful completion of this research project.

Sincerely,

Dr. Jaishen Rajah, FCPaed(SA), Crit Care, DA
Chairman, Institutional Review Board/Research Ethics Committee
Sheikh Khalifa Medical City, Abu Dhabi, UAE

Attachment: 1. Progress Report Form

JR/soumya

d. Ethical Approval- Mafraq Hospital (SSMC) -

مستشفى المفرق

Mafraq Hospital

RESEARCH ETHICS COMMITTEE
APPROVAL LETTER

Reference No:	MAFREC-167	Date:	07/04/2019

To:
Principal Investigator:
Ms. Annie Rosita Arul Raj,
Fatima College of Nursing,
Abu Dhabi, UAE.

Study Title:

"Competency Preparedness of Baccalaureate Nursing Graduates and Practice Expectations at Entry Level as Perceived by the Nursing Leadership of the Hospitals in UAE."

Dear Ms. Annie,

On behalf of ***Research Ethics Committee***, please be informed that your proposal was reviewed and approved as there are no ethical concerns of the project.

Please note that the Principal Investigator should report the Research Ethics Committee of the following:

1. Any adverse events
2. Protocol amendments
3. Informed Consent Form amendments
4. Annual progress reports
5. End of study reports

Mafraq Hospital Research Ethics Committee (REC) has been organized and operates according to the Good Clinical Practice (ICH-GCP) Guidelines.

Please note that this approval is valid for one year from the date of issuing this letter. It is your responsibility to ensure that an application for continuing review has been submitted at the required time.

Regards,

Dr. Asma Deeb
Chair of Research Ethics Committee
Chief of Pediatric Endocrinology Division
Mafraq Hospital

ص.ب: ٢٩٥١، أبوظبي - إ.ع.م تليفون: ٠٠٩٧١ ٢ ٥٠١ ١١١١، ٥٨٢٣١٠٠ فاكس: ٩٧١ ٢ ٥٨٢ ١٥٤٩
P.O. Box 2951, Abu Dhabi - United Arab Emirates Tel: +971 2 501 1111, 5823100 Fax: +971 2 582 1549

e. Ethical Approval -Al Rabha Hospital

From: Reeja Ramesh [mailto:rramesh@seha.ae]
Sent: Tuesday, June 19, 2018 12:36 PM
To: Annie Rosita Arul Raj <Annie.Raj@fchs.ac.ae>
Cc: Alica Abou El kas <aekas@seha.ae>; Imelda Camillio Israell <iisraell@seha.ae>
Subject: RE: Reg proceeding to data collection in Al Rahba hospital.

Dear Ms. Annie,

This is to kindly inform you that your application is approved by the Research & Ethics Committee.

Thank you,

From: Annie Rosita Arul Raj [mailto:Annie.Raj@fchs.ac.ae]
Sent: 18 June 2018 8:39 AM
To: Reeja Ramesh <rramesh@seha.ae>; Alica Abou El kas <aekas@seha.ae>
Subject: RE: Reg proceeding to data collection in Al Rahba hospital.

Dear Reeja & Alica,

Good morning!

Awaiting the status of my application for ethical approval plz.

Kind Regards,

Annie Rosita, BSN, R.N, R.M, MSN,
Lecturer
P.O. Box 3798 Al Maqtaa, Abu Dhabi
United Arab Emirates
Tel: 02 5078612
Fax: 02 642 1170
Mobile:
Email: annie.raj@fchs.ac.ae
Website: www.fchs.ac.ae

f. Ethical Approval -Madinat Zayed Hospital

From: Ruqaya Ismail Almansoori [mailto:rialmansoori@seha.ae]
Sent: Wednesday, June 20, 2018 7:38 AM
To: Annie Rosita Arul Raj <Annie.Raj@fchs.ac.ae>
Cc: Training (AGH) <TrainingAGH1@seha.ae>
Subject: FW: Request to proceed with data collection |

Dear Annie,

Thank you for your email.

With the reference to your email and request, kindly provide us with your survey link, and who is your target to do this survey.

Please follow up with us in order to make your research easy.

This is my direct number 028071033

Regards,

Ruqaya Ismail Almansoori
Training and Career Development Officer
Human Resources (Recuritment & Training) - Human Resources Division
Al Dhafra Hospitals
+971 2 807 0000 +971 2 807 1033 50018, Abu Dhabi, UAE rialmansoori@scha.ae www.scha.ae

رقيه اسماعيل المنصوري
ضابط تدريب وتطوير وظيفي
دائرة الموارد البشرية
مستشفيات الظفرة

g. BUID Ethical Permission

From: Ashly Pinnington [mailto:ashly.pinnington@buid.ac.ae]
Sent: Wednesday, June 12, 2019 9:41 PM
To: 2015121034@student.buid.ac.ae; Solomon Arulraj David <solomon.david@buid.ac.ae>; Christine Salvador <christine.salvador@buid.ac.ae>
Subject: Your ethics application has been approved

Annie Rosita Arul Raj [mailto:Annie.Raj@fchs.ac.ae]

Dear Annie Raj,

This email is to confirm that John McKenny approved your ethics application on the 19th November 2017.

Please use your University email address in all correspondence relating to your studies with BUiD.

You do not need to take any further action in relation to ethics approval of your thesis research.

Best regards,

Ashly

Professor Ashly H. Pinnington

Dean of Research

The British University in Dubai
PO Box 345015
Block 11, Dubai International Academic City (DIAC)

Dubai, United Arab Emirates (UAE)

Direct Line: +971 (0)4 279 1452

Email: ashly.pinnington@buid.ac.ae

Website: www.buid.ac.ae

h. Permission to use NPR Tool

Hi Annie,
Thank you for your email. Please see the Nurse Practice Readiness Tool survey questions attached.
Please cite us if you use any of the attached material.

Kindly,
Isis

Isis Monteiro | Advisory Board
Analyst, Research

655 New York Avenue NW, Washington DC 20001
202-266-6736 (Office)
monteiri@advisory.com
advisory.com

Click below to immediately access the Advisory Board's COVID-19 resources:

COVID-19 Resource Page

-----Original Message-----
From: Annie Arul Raj <2015121034@student.buid.ac.ae>
Sent: Wednesday, August 12, 2020 10:35 AM
To: Nursing Executive Center <NEC@advisory.com>
Cc: annie.raj@fchs.ac.ae
Subject: Requesting permission to use Tool reg

Dear staff member,
Greetings,
I'm a PhD student, Annie Rosita, my study is titled, competency Preparedness of Nursing students and practice expectations at entry level as perceived by the nursing personnel in the hospitals of UAE.
I'm very passionate to take this study forward and I would like you to kindly help me to get permission to use "The Nursing Practice Readiness Tool" and also require the information on the validity and reliability details of the tool.

Expecting your favorable reply at the earliest.

Thank you.

Regards
Annie Rosita

Appendix. B: Nursing Practice Readiness Tool

Graduate Nurse Interns Competency Preparedness - Survey Questionnaire

INFORMED CONSENT FORM

Dear Participant,

Thank-you very much for agreeing to take part in the interview.

The interview should take around 20- 30 minutes to complete.

All information received will be treated anonymous, with utmost confidence, and subsequently transferred to electronic password protected documentation. At the conclusion of the study, the original data will be destroyed. All your details and distinguishing factor will be kept confidential.

Participation in the study is completely voluntary. There are no benefits or disadvantage related to the participation in the study. You may discontinue your participation in this research at any time. If you have any questions about the study, please direct them to annie.raj@fchs.ac.ae. You also have a right to be informed of the completed results of the study and to be alerted of final publications: if this would be of interest to you please add your email address below.

Name : _____

Designation/Role : _____

Years of experience : _____

Contact no : _____

Email Id :

Signature: _____ Date: _____

Thank-you again for your time and information is much appreciated.

The Nursing Practice Readiness Tool (NPRT)

SECTION A: Demographic Data

Gender	Male	☐	Female	☐
Age	20 to 25 years	☐	26 to 30 years	☐
	31 to 40 years	☐	41 to 50 years	☐
	51 to 60 years	☐	60+ years	☐
Hospital Name	Al Ain Hospital	☐		
	Al Dhafra Hospitals	☐		
	Al Rahba Hospital	☐		
	Sheikh Khalifa Medical City	☐		
	Sheikh Shakbout Medical City	☐		
	Other Hospitals	☐		
Nationality	_____			
Education	Diploma in Nursing	☐		
	Bachelor of Science in Nursing	☐		
	Master of Science in Nursing	☐		
	PhD in Nursing	☐		
Designation	Charge Nurse (CN)			☐
	Preceptor / Registered Nurse (RN)			☐

	Clinical Resource Nurse (CRN)	☐		
	Unit Manager (UM)	☐		
	Chief Nursing Officer (CNO)	☐		
	Assistant Director of Nursing (ADON)	☐		
	Director of Nursing (DON)	☐		
	Other Designations _____			
Years of Experience	0 to 5 years	☐	6 to 10 years	☐
	11 to 15 years	☐	16 to 20 years	☐
	21 to 25 years	☐	25+ years	☐

SECTION B: Survey Questions

Directions to fill the questionnaire:

For each of the questions in this section, please indicate your response with a '✓' mark or "O" circle

Graduate Nurse Intern (GNI):_A new graduate nurse is defined as an individual who graduated from an entry-level registered nurse program and within 1 year.

The domain/ competencies column has the list of skills/ competency aspects listed. Answer the question with three different measure as given below:

Measure 1: The current level category of competencies.

Measure 2: The expected level category of competencies.

In the second row, '✓' mark or "O" circle the current category level of competency with which the new recruits (the new staff/the fresh graduates) enter the nursing department.

In the third row, '✓' mark or "O" circle the expected category level of competency with which the new recruits (the new staff/the fresh graduates) enter the nursing department.

The levels of competency are mentioned as below,

a. Non-Competent: ***(Novice):*** GNI has no practical experience and so no background understanding of the can only work under supervision.
b. Less Competent: ***(Advanced beginner):*** GNI has enough experience to recognize patterns and begins to set priorities and can change her/ his approach according to the needs of individual patients. Still needs supervision.
c. Moderately Competent: ***(Competent):*** GNI is organized and efficient and thus able to consider issues and plan dynamically. Not needing supervision for routine practice, the GNI seeks help from others as needed.

d. Very Competent: ***Proficient:*** GNI is able to view issues holistically rather than in parts and intuitively knows due to a deep understanding, Clearly modifies plans as dynamics change and is able advise others.

e. Excellently Competent ***(Expert):*** GNI intuitively understands because of extensive experience as theoretical and practical knowledge was tested and developed in real-life clinical situations. She has a deep background of understanding in clinical situations and is able to teach.

Graduate Nurses Skill Aspects	Measure 1: Current Competency Category				
	1.Not Competent (NC)	2.Less Competent (LC)	3.Moderately Competent (MC)	4.Very Competent (VC)	5.Excellently Competent (EC)

Graduate Nurses Skill Aspects	Measure 2: Expected Competency Category				
	1.Not Competent (NC)	2.Less Competent (LC)	3.Moderately Competent (MC)	4.Very Competent	5.Excellently Competent

Example:

Competency Statement	Expected	NC	LC	MC ✓	VC	EC
	Current	NC	LC	MC	VC ✓	EC

Survey Questions:

Domain: Clinical Knowledge						
1.Understanding of the principles of evidence-based practice.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
2.Knowledge of pathophysiology of patient Conditions.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
3.Knowledge of pharmacological implications of medications	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
4.Interpretation of physician and interprofessional orders	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
5.Compliance with legal / regulatory issues relevant to nursing practice	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
6.Understanding of quality improvement methodologies	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
Domain: Technical Skills						
	Expected	NC	LC	MC	VC	EC

7.Conducting patient assessments , Clinical history collection, Physical assessment related to all systems	Current	NC	LC	MC	VC	EC
8.Pain assessment	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
9.Documentation of patient assessment data	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
10.Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.)	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
11.Preparing the patients to diagnostic investigation	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
12.Adherence to standard precautions including transmission –based precautions	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
13.Nursing skills related to bowel elimination	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
14.Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.)	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
	Expected	NC	LC	MC	VC	EC

15.Safe administration of medications per oral Preparing and administering intramuscular, intracutaneous and subcutaneous injections	Current	NC	LC	MC	VC	EC
16.Administration of IV infusions and medications.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
17.Utilization of Information Technologies (e.g., computers, EMRs, etc.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
Domain: Critical Thinking						
18.Recognition of changes in patient status.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
19.Lab report interpretation and reporting	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
20.Oxygenation and respiration-Assessing changes and interpretation of breathing in acute problem situation and managing & Ability to anticipate risk	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
21.Formulating Nursing care plan based on assessment findings.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
	Expected	NC	LC	MC	VC	EC

22.Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	Current	NC	LC	MC	VC	EC
23.Decision making based on the nursing process.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
24.Recognition of when to ask for assistance.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
25.Recognition of unsafe practices by self and others	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
Domain: Communication						
26.Rapport with patients and families.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
27.Communication with interprofessional team	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
28.Communication with physicians.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
29.Patient education-Identifying learning needs and providing appropriate patient and family education.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC

30.Conflict resolution	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
31.Patient advocacy	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
Domain: Professionalism						
32.Ability to work independently	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
33.Ability to work as part of a team.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
34.Ability to accept constructive criticism	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
35.Customer service	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
36.Accountability for actions.	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
37.Respect for diverse cultural perspectives	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC

Domain: Management of Responsibilities						
38.Ability to keep track of multiple responsibilities	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
39.Ability to prioritize	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
40.Delegation of tasks	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
41.Completion of individual tasks within EXPECTED time frame	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
42.Ability to take initiative	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC
43.Conducting appropriate follow-up	Expected	NC	LC	MC	VC	EC
	Current	NC	LC	MC	VC	EC

Appendix. C: Pilot Study Analysis

Descriptive Statistics Measure 1: Current Competency Category (Pilot Study)

Domain –C1. Clinical Knowledge:

Descriptive Statistics Measure 1: Current Competency Category

	Mean	Median	Mode	Std. Deviation
C1.1 Understanding of the principles of evidence-based practice	3.25	3.00	3	.639
C1.2 Knowledge of pathophysiology of patient Conditions.	3.45	3.50	4	.605
C1.3 Knowledge of pharmacological implications of medications	3.40	3.00	3	.503
C1.4 Interpretation of physician and interprofessional orders	3.40	3.00	3	.821
C1.5 Compliance with legal / regulatory issues relevant to nursing practice	3.25	3.00	4	.786
C1.6 Understanding of quality improvement methodologies	3.05	3.00	2	1.050

Domain – C2. Technical Knowledge:

Descriptive Statistics Measure 1: Current Competency Category

	Mean	Median	Mode	Std. Deviation
C2.1 Conducting patient assessments, Clinical history collection, Physical assessment related to all systems	3.80	4.00	4	.616
C2.2 Pain assessment	3.75	4.00	4	.716
C2.3 Documentation of patient assessment data	3.80	4.00	4	.616

C2.4 Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.)	3.60	4.00	4	.883
C2.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	3.15	3.00	3	.745
C2.6 Preparing the patients to diagnostic investigation	4.10	4.00	5	.852
C2.7 Adherence to standard precautions including transmission –based precautions	3.40	3.00	3	.883
C2.8 Nursing skills related to bowel elimination	3.80	4.00	4	.834
C2.9 Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.)	3.70	3.50	3	.923
C2.10 Safe administration of medications per oral	3.65	4.00	3	.813
C2.11 Preparing and administering intramuscular, intracutaneous and subcutaneous injections	4.15	4.00	4	.671

Domain – C3. Critical Thinking:

Descriptive Statistics Measure 1: Current Competency Category

	Mean	Median	Mode	Std. Deviation
C3.1 Recognition of changes in patient status.	3.25	3.00	3	.716
C3.2 Lab report interpretation and reporting	2.90	3.00	3	.553
C3.3 Oxygenation and respiration- Assessing changes and interpretation of breathing in acute problem situation and managing & Ability to anticipate risk	3.40	3.00	3	.754
C3.4 Formulating Nursing care plan based on assessment findings.	3.70	4.00	4	.801
C3.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	3.55	3.50	3	.759

C3.6 Decision making based on the nursing process.	2.90	3.00	3	.718
C3.7 Recognition of when to ask for assistance.	3.60	4.00	4	.821
C3.8 Recognition of unsafe practices by self and others	3.35	3.00	3	.745

Domain – C4. Communication:

Descriptive Statistics Measure 1: Current Competency Category

	Mean	Median	Mode	Std. Deviation
C4.1 Rapport with patients and families.	4.35	4.50	5	.745
C4.2 Communication with interprofessional team	3.80	4.00	4	1.005
C4.3 Communication with physicians.	3.25	3.00	3	.786
C4.4 Patient education	4.15	4.00	5	.813
C4.5 Conflict resolution	2.85	3.00	2	.875
C4.6 Patient advocacy	3.40	3.00	3	.940

Domain – C5. Professionalism:

Descriptive Statistics Measure 1: Current Competency Category

	Mean	Median	Mode	Std Deviation
C5.1 Ability to work independently	3.20	3.00	3	1.005
C5.2 Ability to work as part of a team.	4.00	4.00	4	.858
C5.3 Ability to accept constructive criticism	3.45	3.00	3	.999
C5.4 Customer service	4.05	4.00	4	.887
C5.5 Accountability for actions	3.50	3.00	3	1.000
C5.6 Respect for diverse cultural perspectives	4.05	4.00	3	1.099

Domain – C6. Management of Responsibilities:

Descriptive Statistics Measure 1: Current Competency Category

	Mean	Median	Mode	Std. Deviation
C6.1 Ability to keep track of multiple responsibilities	3.25	3.00	3	.851
C6.2 Ability to prioritize	3.20	3.00	3	.768
C6.3 Delegation of tasks	3.00	3.00	3	.725
C6.4 Completion of individual tasks within EXPECTED time frame	3.10	3.00	3	.788
C6.5 Ability to take initiative	3.20	3.00	4	.834
C6.6 Conducting appropriate follow-up	3.50	3.50	3	.688

Descriptive Statistics Measure 2: Expected Competency Category (Pilot Study)

Domain –E1. Clinical Knowledge:

Descriptive Statistics Measure 2: Expected Competency Category

	Mean	Median	Mode	Std. Deviation
E1.1 Understanding of the principles of evidence-based practice	3.25	3.00	3	.550
E1.2 Knowledge of pathophysiology of patient Conditions.	3.50	4.00	4	.607
E1.3 Knowledge of pharmacological implications of medications	3.40	3.00	3	.883
E1.4 Interpretation of physician and interprofessional orders	3.70	4.00	4	.571
E1.5 Compliance with legal / regulatory issues relevant to nursing practice	3.50	3.00	3	.761
E1.6 Understanding of quality improvement methodologies	3.30	3.00	3	.733

Domain – E2. Technical Knowledge:

Descriptive Statistics Measure 2: Expected Competency Category

	Mean	Median	Mode	Std. Deviation
E2.1 Conducting patient assessments, Clinical history collection, Physical assessment related to all systems	3.80	4.00	4	.616
E2.2 Pain assessment	3.55	3.50	3	.759
E2.3 Documentation of patient assessment data	3.75	4.00	4	.550
E2.4 Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.)	3.60	4.00	4	.754
E2.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	3.50	3.00	3	.761
E2.6 Preparing the patients to diagnostic investigation	3.80	4.00	4	.616
E2.7 Adherence to standard precautions including transmission –based precautions	3.45	3.00	3	.887
E2.8 Nursing skills related to bowel elimination	3.70	4.00	4	.733
E2.9 Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.)	3.70	3.50	3	.801
E2.10 Safe administration of medications per oral	3.75	4.00	4	.716
E2.11 Preparing and administering intramuscular, intracutaneous and subcutaneous injections	3.75	4.00	4	.716

Statistics Domain – E3. Critical Thinking:

Descriptive Statistics Measure 2: Expected Competency Category

	Mean	Median	Mode	Std. Deviation

E3.1 Recognition of changes in patient status.	3.45	3.00	3	.510
E3.2 Lab report interpretation and reporting	3.40	3.00	3	.598
E3.3 Oxygenation and respiration- Assessing changes and interpretation of breathing in acute problem situation and managing & Ability to anticipate risk	3.45	3.00	3	.759
E3.4 Formulating Nursing care plan based on assessment findings.	3.60	3.50	3	.681
E3.5 Interpretation of assessment data (e.g., history, exam, lab testing, etc.)	3.65	4.00	3	.933
E3.6 Decision making based on the nursing process.	3.15	3.00	3	.745
E3.7 Recognition of when to ask for assistance.	3.50	4.00	4	.889
E3.8 Recognition of unsafe practices by self and others	3.45	3.00	3	.826

Domain – E4. Communication:
Descriptive Statistics Measure 2: Expected Competency Category

	Mean	Median	Mode	Std. Deviation
E4.1 Rapport with patients and families.	3.90	4.00	4	.912
E4.2 Communication with interprofessional team	3.70	4.00	4	.923
E4.3 Communication with physicians.	3.65	4.00	4	.587
E4.4 Patient education	4.10	4.00	4	.718
E4.5 Conflict resolution	3.10	3.00	2	1.021
E4.6 Patient advocacy	3.55	3.00	3	.945

Domain – E5. Professionalism:

Descriptive Statistics Measure 2: Expected Competency Category

	Mean	Median	Mode	Std. Deviation

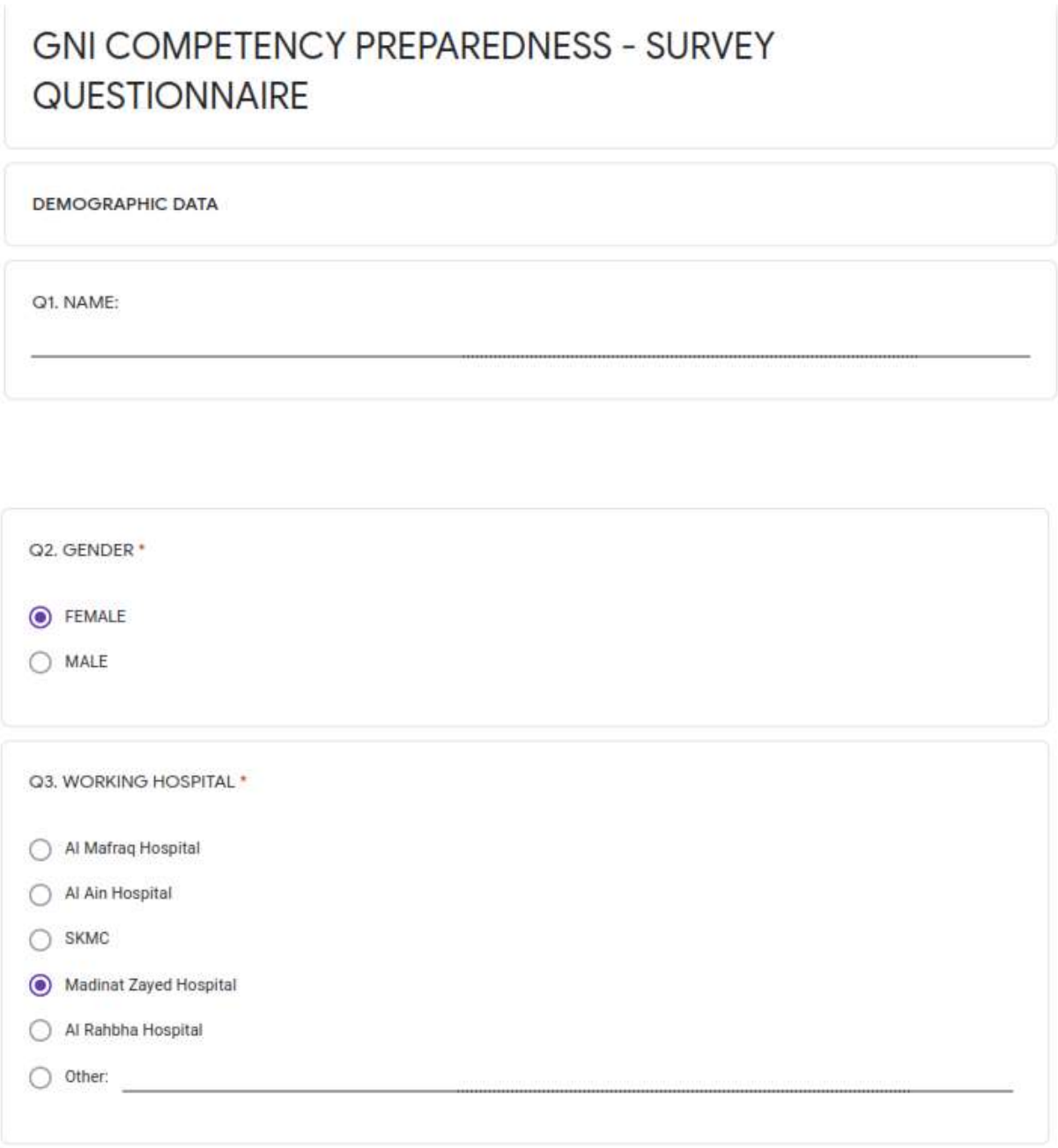
E5.1 Ability to work independently	3.55	3.50	3	.887
E5.2 Ability to work as part of a team.	3.65	4.00	4	.875
E5.3 Ability to accept constructive criticism	3.65	4.00	3	.933
E5.4 Customer service	3.85	4.00	3	.933
E5.5 Accountability for actions	3.70	4.00	4	.923
E5.6 Respect for diverse cultural perspectives	4.00	4.00	5	.973

Domain – E6. Management of Responsibilities:

Descriptive Statistics Measure 2: Expected Competency Category

	Mean	Median	Mode	Std. Deviation
E6.1 Ability to keep track of multiple responsibilities	3.50	3.00	3	.889
E6.2 Ability to prioritize	3.40	3.00	3	.681
E6.3 Delegation of tasks	3.40	3.00	3	.821
E6.4 Completion of individual tasks within EXPECTED time frame	3.45	3.00	3	.686
E6.5 Ability to take initiative	3.35	3.00	3	.671
E6.6 Conducting appropriate follow-up	3.45	3.00	3	.826

Appendix. D: Sample Quantitative Data – Survey Response



GNI COMPETENCY PREPAREDNESS - SURVEY QUESTIONNAIRE

DEMOGRAPHIC DATA

Q1. NAME:

Q2. GENDER *

- (●) FEMALE
- ( ) MALE

Q3. WORKING HOSPITAL *

- ( ) Al Mafraq Hospital
- ( ) Al Ain Hospital
- ( ) SKMC
- (●) Madinat Zayed Hospital
- ( ) Al Rahbha Hospital
- ( ) Other:

Q4. DESIGNATION

- ○ CNO
- ○ ADON
- ○ Unit Manager
- ○ Charge Nurse
- ○ Staff Nurse /Preceptor
- ◉ CRN
- ○ Other: _____

Q5. AGE *

- ○ 20 to 25 Years
- ○ 26 to 30 Years
- ○ 30 to 40 Years
- ○ 41 to 50 Years
- ◉ 51 to 60 Years
- ○ 60+ Years

Q6. QUALIFICATION *

- ◉ BSN
- ○ MSN
- ○ PhD
- ○ Other: _____

Q7. NATIONALITY

Filpino

Q8. YEARS OF EXPERIENCE *

- ○ 0 to 5 years
- ○ 5 to 10 Years
- ○ 15 to 20 Years
- ○ 30 to 25 Years
- ◉ 25+ Years

Q9. CLINICAL KNOWLEDGE - SURVEY QUESTIONS

Understanding of the principles of evidence-based practice. *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Knowledge of pathophysiology of patient Conditions. *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	○	○	◉	○	○

Knowledge of pharmacological implications of medications *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Interpretation of physician and inter-professional orders *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Compliance with legal / regulatory issues relevant to nursing practice *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Understanding of quality improvement methodologies *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Q10. TECHNICAL SKILLS - SURVEY QUESTIONS

Conducting patient assessments ,Clinical history collection,Physical assessment related to all systems *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Pain assessment *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Documentation of patient assessment data *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Performing clinical Procedures (e.g., sterile dressing IV therapy, etc.) *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Preparing the patients to diagnostic investigation *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Adherence to standard precautions including transmission –based precautions *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Nursing skills related to bowel elimination *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.) *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Safe administration of medications per oral Preparing and administering intramuscular, intracutaneous and subcutaneous injections *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Administration of IV infusions and medications *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Utilization of Information Technologies (e.g., computers, EMRs, etc. *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	○	◉	○	○

Q11. CRITICAL THINKING - SURVEY QUESTIONS

Recognition of changes in patient status. *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Lab report interpretation and reporting *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Oxygenation and respiration- Assessing changes and interpretation of breathing in acute problem situation and managing & Ability to anticipate risk *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Formulating Nursing care plan based on assessment findings. *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Interpretation of assessment data (e.g., history, exam, lab testing, etc) *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Decision making based on the nursing process. *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Recognition of when to ask for assistance. *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Recognition of unsafe practices by self and others *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Q12. COMMUNICATION - SURVEY QUESTIONS

Rapport with patients and families. *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Communication with inter-professional team *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Communication with physicians *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Patient education-Identifying learning needs and providing appropriate patient and family education *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Conflict resolution *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Patient advocacy *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Q13. PROFESSIONALISM

Ability to work independently *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Ability to work as part of a team *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Ability to accept constructive criticism *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Customer Service *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Accountability for actions *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	○	◉	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Respect for diverse cultural perspectives *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Q14. Management of Responsibilities

Ability to keep track of multiple responsibilities *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	○	◉	○	○	○

Ability to prioritize *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Delegation of tasks *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Completion of individual tasks within EXPECTED time frame *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Ability to take initiative *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

Conducting appropriate follow-up *

	NOT COMPETENT	LESS COMPETENT	MODERATELY COMPETENT	VERY COMPETENT	EXCELLENTLY COMPETENT
REQUIRED COMPETENCY LEVEL	○	○	◉	○	○
CURRENT COMPETENCY LEVEL	◉	○	○	○	○

THANKS FOR YOUR CONTRIBUTION! HIGHLY APPRECIATED.

Appendix. E: Sample Qualitative Data – Interview Transcript

Interview with Interviwee-1 on 03-03-2019

INTERVIEWER

Question number one is, what is your perception about the competency preparedness of these new graduates

In relation to patient care, direct patient care, in relation to teamwork in relation to general scope of nursing.

INTERVIEWEE-1

Okay, In general, just the deficiencies in lots of aspects because they're coming from university, I don't think their exposure overall is waste and they're not allowed to do so this is when they come in under GNI program you're asking just as soon as they come. And so, they've done their student placement in the hospital. So, I think from the time they do the student placements to when they come into the Organization they're provided with support, and they're provided with support from the hospital, and they're all assigned and preceptor ship. So that occurs as it does in any hospital. But there is a huge theory to practice gap in terms of their ability to turn what they've learnt theoretically, into actual practice. So, their ability to actually perform tasks is at a very low standard, because they need to start from scratch. And I think sometimes when the new nurses come in, they're extremely confident in what they think they can do. Because they don't actually know what they cannot do. So, when they come in, they are not really sure of their gaps. So that to me, would be major, is this confidential, all this conversation,

INTERVIEWER

yes, yes, yes.

INTERVIEWEE-1

And it doesn't go back saying who said Well,

INTERVIEWER

no, no, absolutely. No.

INTERVIEWEE-1

Yeah. So, it's the same for any Junior nurse. When we first start our practice, it's not like the theory. So, what you're taught in theory does not reflect in actual practice, do you understand what I'm saying, because you're taught the ideal, and we're taught that these are the ways that you will do things, this is the procedure, this is the process. But when you come into the actual hospital situation, either your patients reject what you want to do with them, or, you know, actual practice is different, for many reasons, cultural practice, and patients are not all was agreeable. And what you're taught in theory doesn't match the logistics or doesn't match the actual when they come in. And I think that's an issue because they're very confident I'd find students very confident nowadays. And as I said before, they don't know what they don't know.

Yeah, it is dangerous. And maybe we need more practical guidelines to take them through to read, demonstrate, and then they get a chance to practice and then they read demonstrate that they're competent to do. And again, it all depends on the area where you've been allocated to. Okay, yeah, so if you're allocated, and you know, on a good general Ward, and you have a good manager, and you have a good preceptor, your chances for learning are greater, I think some of the practice theory gap is that we're very busy. And we have a lot of our mixes of employees are not always geared with the correct and they're not good teachers, they are very task oriented, and they don't have critical thinking. A lot of people would have been employed in the past based on their skill, but they might have, you know, they might do continuous, upscaling to be able to, to demonstrate, or they might be have the confidence to teach these see that here, a lot of our nurses, very task oriented ages, and you don't have critical thinking skills, how can you feed it on to anybody else. And that's not necessarily their fault, either. Where they were told us where they were trained, it's how you were trained, it's the country you come from, it's the level of skills, the level of knowledge, it's the level of expertise, what's lacking in the UAE, in general, a clinical nurse specialist, so the clinical nurse specialist role as an educator and clinical a changes who have masters and maybe even PhDs and clinical education, it working in the organization. And I would see more of that happening in the West that I would happen in the Middle East, the courses aren't available, staff can avail of them that how can they learn and adapt and learn the skill to teach the juniors

INTERVIEWER

so, when they, when the new nurses once they finish the students ship, period, and they come in inside, which are the areas you think is our strikingly anything

to do with critical care. But obviously, we don't put new Yeah, the other thing about new graduates that is very positive is because they come in fresh, they sometimes pick up practices themselves that are not picked up by staff would be in the organization for a longer period, or, you know, you always hear it from training hospitals, training hospitals are more strict because they're teaching students. So, you've much more strict process protocols in relation to how you do things. And sometimes when the student nurses come in, because they've just been primed, they're fresh, and they go, Oh, she didn't wash your hands correctly, or she missed one of the steps, they might pick that up more than people who've worked in an organization for a long period of attempts, take shortcuts. And I even see that in western countries. And where I'm from, we were, you would, you know, always the training schools were more difficult and stricter with students. And sometimes that may be are failing that, although we try to exert and good practice and strict disciplines for, you know, how you should behave, your dress code, and you're strict dress codes, you know, for, especially for nurses hair tied up, yes, no wearing of loose earrings, and what watches, you should have your watch. Now, no use of mobile phones, they don't always abide by that when they come here, we're much more relaxed than you would be in, say, other countries of the world. In terms of, you know, maybe there's reason for that to, maybe there aren't, we don't, you know, you don't always see the same infections in maybe one nation to another. But, you know, sometimes we need to be a little bit stricter when we train. And we do try to do that we do kind of, you know, encourage them to, to adhere to the dress codes and everything and getting the obvious when they come to the units would be there. Basically, it's a huge transition coming from university to a ward for you, you've got to do 12 hour shifts, eight hour shifts, and whatever is dictated by the area that you work in. I find a lot of the new graduates when they come to the organization, they don't like the working hours, and they all want to work in the OPG setting.

Now, we have, we do try and give them the period when they first come out that they have to make, they have to go to a surgical, Medical ward. But I don't think you can learn everything in one to two years, I would say when I was a newly qualified nurse, took me much longer than one to two years to gain the experience I needed to, to go up the ranks, I think a lot of new staff and it's the same globally, they don't want to do the hard work, they all want to be managers immediately. I think that's a huge, that's a huge gap. So, when it comes to practice, practice, practice to become the best at what you're doing, I think that's scaring me of is that they're not able to do that. I think that's one of the biggest things as I said, the theory to the practice gap,

you know, when they go out there and actually have to do it for themselves. And then they decided I don't really want to do this, or I don't really like doing this. And then it's the level of exposure that they get. And I think you only get good level of exposure. If you spend a period of time maybe on a surgical ward, maybe a year. And then you go to medical Ward, you spend another year, and even that is only basic, it's usually after that, that you actually start to rationalize why things happen. And that everything starts like a building block, it starts to click into place, and that you have to be willing to give it time. So, if you're only 21, 22 years of age, you have to give yourself time and maturity and to understand the reasons why things happen like that. So, you know, it's not it's about continuous learning. It's not about continuous learning, in the sense that, Oh, yes, I have my degree. And next year I'm doing my masters and then find every day and I see a lot of Gosh, so you'd have Junior, and that sign of times, you'll have nurses coming out saying yes, I've got my degree, which if you're a diploma nurse, I'm automatically more senior to you. They forget about the experience and what you learn through experience, I suppose. And they need a good sound knowledge of basic general nursing from a medical and surgical perspective, how to handle your pre surgical to your medical cases, I see that as being the big gap. Okay, you know, that the, you have to consolidate what you learnt before to understand disease processes, be able to correlate why certain tests are done with the disease processes, be able to make assumptions, kind of a holistic, kind of, and then it's sad to say that, I think in many, one of the sad things in nursing today is that basic nursing care, you know, a lot of nurses want to be the other end of it, they want to be dealing with the medication management and dealing with statistics and then, but they don't actually want to go in deliver good oral hygiene to patient or good bowel care, or know how to change tracheotomy and do a simple thing like washing your patient, washing their hair, communicating with patients sitting down and saying, How are you today? And what are your problems today. So, we see a lot of gaps in take and output charts. And, you know, because they're not adding up the dots to save my with the patient be and then take it out, put it off and see or patient went to the toilet and that will be on the intake and output so their monitors and tape it they will monitor the output and then they won't say Oh, the reason why I've been asked to monitor output is because he's a surgical case or, you know,

it's because he's only six or something like that.

INTERVIEWER

I'm able to relate all this with my students. Yeah,

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where are you at?

INTERVIEWER

I'm recently working with Fatima college

INTERVIEWEE-1

or every other be all right. So, you see this in students when they're coming to us

INTERVIEWER

when we have this clinical person, which is a part of the requirement, okay, the patient was on

I mean, fluid volume deficit and all that. And no mention of what was the intake, what is the output and why should we look at it? How do we need to interpret the imbalance in putting out the intervention

INTERVIEWEE-1

One of the things I always stress to the nurse managers and to nurses in general is and I know it's very old fashioned would be the rope. I've even had a conversation what last week was a manager and an Emirati manager who seemed not to have heard about it before when I was a student nurse we always learned about real per lovin tyranny model of you know, the activities of daily living. Yes, yes, it was embedded into our training that when you went into patient, it was their name, their diagnosis, their age, their religion and their preliminary, their signs and symptoms. And then you went through all the activities of daily living, so you talked about their nutrition or Yes, they're on an adaptive die this is what the adaptive dieters for I see that missing in the documentation. On the time they hear the Cerner terminologies, adaptive diets, for somebody who's not, you know, on a regular no problem diets, but they never say what it is. So, they won't say they've seen a doctor files, but they'll be not exactly they're on a diabetic diet, or they're on a rainbow diet, or they're on a low sodium diet. And then if you say to them how many kilocalories then they won't understand anything.

And I know some will say, Oh, that's for the dietitian to do but one in my training. It was a holistic, holistic, you learned about everything. So you learned about not to be physiotherapist,

but about recognizing when patients needs to be sufficient when they needed physiotherapy, how to assess your patient how to help them with their coffee, flex, I think patient education is a massive deficit in in and a lot of it comes with experience and ability to communicate, wanting to communicate again, wanting to sit with your patient at the bedside, wanting to talk to them wanting to spend time with them, asking them about their family situation. Psychological assessment of patients, and I think that's, that's a big gap.

INTERVIEWER

Yes, exactly. Even the students whom we are dealing with when I when I teach them about just physiotherapy. Mrs. And that something to do with the physiotherapist. Yeah, yeah, that kind of,

yes, that's what they think. Okay. This particular work it is it is for that group of people here. Nutrition. Okay. This is for this group. Yeah.

INTERVIEWEE-1

And I think that's very segmented. And that's definitely a gap. Or the other thing I saw when I first came here. And in one area they were monitoring and, you know, until feeding by how many “ml” the patient was taking it. so, they'd say, oh, there, 60 “mls” an hour, and they will be calculating it like that. And one of the questions I kind of asked the most, why are you saying 60 “mls” and 70 “mls” surely is not based on the waves and the height of the patient and their BMI and what they require requirement. There is a call back or key low calorie environments as opposed to how many emails a day and I was kind of saying things like, if you went out and you go from a box of chocolates or a packet of biscuits, and you're trying to be healthy, and you know, you don't want to be do not look at the back of it, and say, how much value in it? Yeah, and you're looking for the fat and the fiber and protein and it's very high fat, you go, I'm not going to buy it. I go for a low fat option we do in our daily lives ourselves, when we choose what we want to eat, why are we not doing it for our patients?

INTERVIEWER

So, I'd see that that kind of integration is still not there. Yeah, not there. Yes, I know,

INTERVIEWEE-1

there's a community and communication barrier as well. And a lot of it is your mentor, your culture, your teacher, and not in university level, because that's straightforward. But actually, most stuff I think I learnt is what I qualified, I learnt the reasons behind I learnt my MP when I was a student, but how I put that into practice was actually on the units. And when I was muted and being patient and realizing that you don't know everything, so you know what, I had a condition I learned, I studied this, I practiced us, I learned all the medications that were related to us all the procedures that were related to a little bit like when you're a student nurse, and that's I put that into case man, you know, case and paid cases, many cases, what's the word? I looked at individual cases? case studies? Yeah, case studies. So, my, my, my chart, my staff nurse would say to me as new to qualified, she'd say, this patient is in with abdominal pain, I need you to look at this chart and tell me what you think is wrong? Or this patient is in there having an appendicectomy, tell me what bloods would be done, pre-appendicectomy, I know physicians order them, what would be the care what do you have to watch out for? What is the post up signs and symptoms and I having this discussion the other day, but patients for having direct to me how many nurses actually understands that you'd have to do you know, the post appendicectomy having your tracking of tequila chelation near the bedside and checking for, you know, deficits and calcium and you know, what, is it your truth twice sticks? I you know, how many do we actually do those things anymore? Or do people think they're not necessary? Yeah, how often would you check the blood levels nation for surgery? Like, what type of how would you tell them to how would you take a dream, you know, all these other things and

INTERVIEWEE-1

stuff and it's like another it's not there in the doctor's order sheet doctor did not tell me. So, I do not do that, that assessment part. And then in interpreting the assessment, and then going on with the intervention as well, just having the critical skills to kind of step from A to B. And I knew, I know, a lot of them come with experience. But people I think the new nurses coming out, they, they really need to, to understand that the process of learning is not over on the beginning. It's only beginning once you get your qualifications. And I think if they give themselves time and time is one of the greatest things that they can do and not be in such a rush and sort of middle consolidate their learning, they just keep moving on. And I think I see some of that as being an issue like we've lots of nurses here recently graduated and they're all working in the OPD session. Okay, so I think that has to come from a recommendation higher that you can't move to into an OPD until you've got a foundation of five, six years in clinical practice.

Yeah, where does exposure for them to learn and I suppose then postgraduate it's like a lot of the nurses I would see here would move into an area, but they might not take no postgraduate courses in that area like pediatric Okay, done. They do general training here majority ginger, yeah, they don't do pediatrics. Whereas in the West, you'd have a whole separate course pediatrics.

So here the curriculum is in the curriculum, there is a semester which is focusing on PDF, there is a semester which is focusing on maternity, but at the end of it, they are prepared for general nursing. Yes, and we have that at home as well. And that's always the best one to start with your general and you do the semester, you do a period of time and mental health and in in PDF do qualify to work in the area, we can walk into an area like that, but in for example, if you want to return to what we have to go off into the separate quality. Yes, yes. So, my general trainer so I'm a midwife as well. And even for pediatrics, you know, you as a general trainers, you can work with pediatrics, but you can't work as a specialist pediatric nurse, so you'd have to go out and do another postgraduate course in pediatrics, and I think that's very good, because you learn specific

INTERVIEWER

specific also about of JCIA standards and requirement

you know areas specific competencies, given more importance. How you tackle with those now, you have most of them as general

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courses we need the country needs to have post graduate specialized programmes. Also, another area where there seems to be a gap is in the role of clinical nurse specialist like in it, we should, in a general hospital, we should have caught on especially if there are higher diploma courses are masters level, so but you have to work in the area, get the experience and then study at the same time, so called a retina specialist, Breast Care Nurse, Nurse Specialist came of vigilance nurse specialist. And I think that that's an area that we could grow our education and so somebody goes into an area and they really like it. It's not just about your pediatric, your general and the sub specialties

know Yeah, like diabetic educators and providing really good courses about, you know, the diabetic educators and respiratory nurse education. So, you really taken that extra and I you

know, that extra level where you're getting staff geared up as a specialist level. Yeah, I think we're lacking that here. Generally, even a core group and there's no courses available. I mean, I think if you train in the majority countries in the Philippines, in Asia, they're not offered no, no West, they're offered their offers and in Ireland are offered in the UK and there's a lot of studying so you normally see a nurse come out work in an area then she likes the area that she works in and she wants to commit to it, she works in the area, then she's she their cell phones because it's her own interest, more so self-funding and or the organization fund search off and become a clinical expertise in a specific area. ICU, for example, even in and I know new grads can't go into ICU, but I mean to go to ICU, you need to be working in medical, interestingly enough, we have no we have like one Arabic speaker, I think, in our ICU, and we have very few local nurses. And there must be, you know, a qualified staff who commands from freshman college who are just brilliant. And then once they are clear pathway, do they get set, go to the surgical war for two years, go to the medical world for two years. And you're very clever, I want you to come and work and I see.

So how do we bridge our students and our new grads for working in ICU and CC and stroke and all the specialist areas and dialysis from what I would see having spent four years in this country would be the majority of those positions are filled by non-National Nurses. And I think that's a gap. I know, nobody should go in ICU immediately. But I think if you have an interest for us, why can't we develop up you need to have a good basis in med search. But if somebody sits down and career guides, do we career guide RG our new grads?

Yes, they have but not in detail. Like what you're mentioning. We need to clear them

sometimes it's not always but I mean, when I was a junior NASA came out and I ended up working in ophthalmology for a while. It's only when I went in depth Margie that I realized I really love like, so at 26 years of age, I became an ophthalmology Nurse Specialist wellness nurse, but I just Yeah, I did a diploma, a Post Graduate Diploma in nursing. And I had that done by the time I was 26. So, I think I mean, just because they're new graduates and they work for a year or two, I think we don't really fine tune them into areas, they kind of, they wander around and they go like, they don't like this. I don't like the hours and you know, so that's why they choose an easier option. And they kind of maybe get a little bit misguided correct. I like we sent a junior nurse to Turkey for you know, the organ transplantation that's a big thing now it's good the words that we're investing in our local nurses, but how did we prepare her to go to

the at that level to understand and bring because obviously for some transplants, okay, you have your life transplants, but it's experienced the teachers, you bet those cases patients. So, if you want to do even, you know, brain death transplants, majority of them come from ICU. So, I agree that we really need to be investing in in our Emirati nurses and developing them but to send somebody on a course and say, come back and tell us what you've learned. And this is a little bit unfair on her or him because they need to be they need to kind of have some understanding before they go

and especially in the broader respects what you're talking about developing staff we understand the psychological aspect aspects of care and emotional and spiritual all the holistic care of a patient rather than just coming in being task orientation right home and if we have task orientated people teaching our new grad the products will be similar to exactly is that I got that is maybe I'm talking around incentives.

INTERVIEWER

you're touching on almost all the areas which will really create an impact. Now, as of now, we cannot look at the competency as he able to do 123 know now, all these aspects will play a major role in terms of molding her into a professional are and who we think or whatever we are expecting her

INTERVIEWEE-1

and experiences were like, it's wonderful that a lot of physicians, you know, Junior physicians get in this country in large countries, but here other than go abroad and they come back and they're at the top of their game then or they go abroad, and they both come from here, and they might, but we don't offer that to our junior nurses.

Not that they need to go abroad. But, you know, for consolidation of like, even if they were to add more experience and go from here to other GCC countries that was sponsored by, you know, we do it for physicians, we send our physicians to America, we send our physicians Canada do we invest the same effort in sending our nurses places,

INTERVIEWER

there is something in the pipeline like they want to send the nurses to the United States, you have some training and it's just in the pipeline, I think around 10 of them have been selected now that is related to some research activity and then come and start up some research at something related but not just for non-related

INTERVIEWEE-1

it must be shared. Why don't we send our new course to the you to the UK? I know it depends some of its culturally related as well but I mean, out of every graduate there must be one or two that you could say would you be interested in going to the UK for year and would you be interested in going to America fear and I'm sure for this position they go with their families

INTERVIEWER

so, they sponsored by the hospital or from the academic

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academically, but, however, doctors going I don't know historically though, they always invest in physicians to do that maybe that's the gap that they're not have that if you don't have to send every nurse but you send one or two nurses and they go Wow, I've just come back with so much I can share and they can even make nice in their you know, their junior colleagues a passion for travel or passion for going away learning something and bringing it back to so going to America going to Canada going to the UK doing advanced study in diabetes management and then coming back and saying I've been here I've seen what it's like I think these are unhealthy or going and learning how to become a clinical nurse specialist taking that back and saying I'm going to do train the trainer now qualified to train the trainer because you know I've gone through the course I'm going to become a tutor Are there any Emirati she lecturers and tutors and but I know nobody Say that again you do need your experience but I mean we have nurses now who are qualified for many years who should be able to take back some of the maybe we do sell it to them to keep them in the profession

INTERVIEWER

I don't think me thinking as morning to that level to make sure what to say career pathway or anyway as of now there are accreditations being carried out and once that is done they are planning to previously there was diabetic education and renal nursing which was given to them as a master's program that I've known even that is kind of stopped

to answer said like we need to look at these specialty areas and yeah so whatever

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they will know their specialty and so the old and we're getting close to So then how many the year to working on the floor and then you need to bring them back in and say okay but it needs to be sure if you've been out in the floor now for two years or you're qualified for to eat they need two years qualification moving around and rotational basis and say what struck you in the last two? What's your interest, you know, do you want because, you know, people always think, you know, they always go and I give another example a second, they always say metal frame or matter free or am I want to work with pediatrics or I want to work in the general that we have of people don't ever consider geriatric care, you care of the elderly, which is a course in itself, they don't always consider the specialist areas such as your dynamics, and what else ophthalmology and ENT, these are the markers areas where your nurse working in those areas becomes an expert on the specific in that she's working in, which could be, you know, inpatient, outpatient, but we don't always think about those areas and psychiatry or like how many actually properly trained psychiatric nurses do we have not even one, there you go. So again, until we start looking at stuff like that. So, you send in our staff and she picks up some information on the ward and she continues working in the area, but she's actually not consolidating her learning because she's got no postgraduate course to be doing with it to be making her neck and I think that is a massive gap for our junior nurses. That's what I would see

INTERVIEWER

what is okay. What is your advice to the academic people in terms of preparing them? Well, let's talk about skills now preparing them well, okay. So that they will cater to your demands your unit managers

INTERVIEWEE-1

when they come to the us, they come in and observe history base is really when their students are that correct?

INTERVIEWER

they come they don't actually know basis during the second year, but to during the third and fourth year they are supposed to do hands on.

INTERVIEWEE-1

So maybe what are they doing the hands on Are they really when they do the hands on is there actual, you know, feedback to save what you've learned what you've done correctly, what you've done, maybe they need more practice, which is hard as well.

When I trained the old way, I trained on the job learning that was the way it was when I did my nurse training. And then afterwards, I went back for my academics. But actually, that's your best experience, you learn you practice you do you by doing is you learn how to do it, and you just repetitive lots of repetition. And I think that's that we need to do that, I think to you know, sometimes we've got a lot of monitors and machines in organizations now that people don't really understand the basics of doing a blood pressure, like what how many, you know, if you do a blood pressure to do it manually, to actually hear it, to actually hear a heartbeat actually know the difference between listening to an apex lead and a radio pulse to you know, I think that that, that he needs to be taught more to students and not that you just do it and but that you, you understand how you do it on a more basic level, and what it means if something is matching or you know, for radio pulse different today, they speak what measures interface and related to understand the repetition of work so that they get, they improve their skill and their knowledge. And also, in terms of case studies looking at specifics, like you have a big maybe when they're out on the wards practicing, or they go to their organization saying, okay, when you go to the, you're going to medical surgical medical ward because they have a device here separately, whereas to me, medical surgical is all one on one. But here and they're very much all your medical, your search, they get very tunnel focused, and the majority of new nurses that want to come out want to work and surgical, not medical. And you can understand why. Because search, it was easier your patients come in, and you send them for precision, they go home.

Yeah, medical case, they're much more complex, they have a lot more wrong with them. And they are chronic, you know, admissions and

Exactly. And nurses don't really want to work with that. So, I think that needs to be focused on that more and case studies. So, you have somebody who comes in with your big your top five, we have all the top five in every Ward, you know. So, I think what the universities could do is they could say, I'm sending you and you're going to work on the medical Ward, I want you in the course of your How long do they will they spend on the ward to make it feasible as they're spending two weeks that they get three diagnosis is 200 standard after spending two weeks is they're spending two weeks, maybe they are three, right? It puts a bit of pressure on them. But

I think it's not about coming to work and going home, put your feet up, march up. And I'm not saying that they do that. I don't know. But it's about like those two weeks that you're on the ward you need to go to work you need to do that a study with solid it what you've learned during the day do that is that measured?

INTERVIEWER

Yes. At the end of the day, we have a reflection session where they say, and during that time they mentioned about what they have learned about it, or is it not? Inflection is just my opinion.

Yeah, and I can see what was what was bad. And this is what I felt

INTERVIEWEE-1

is not really that's not really hitting the nail on the head because, you know, oh, yeah, and you can talk about a bit of reflection because it is good to offload, and Santa found this dress for them. I couldn't time management wasn't great and whatever. But I mean, actually, when you're at that level, when they come in and you say you're working with renal failure patients do Yes. Because the consolidated learning from that would be what medications with somebody and renal failure beyond How did you manage the nursing care? What are the aspects of nursing that are very important. So, each time they what you

INTERVIEWER

see this kind of teaching know, for example, if I'm a lecturer, I have around 12 students with me, even if I want to do I will be able to do only with maximum of two to three in that one maximum of two in that one hour period. Like as you said, Okay, this is my patient when she starts, Okay, tell me what happened to the patient when the patient came in? Okay, this is the primary chief complaints, let's say, Okay, what is going in your mind? Could it be this could be this could be this. Okay, if it is this, what other significant clinical features did your patient have that now how do you roll out these ones and then narrow it down to the specific diagnosis then specific? Okay, what are the medications that the patient is on? Good? Why do you think this particular medication as prescribed and why not that one? Yeah, even related to fluid, your first line medications, your second line medications, because they never change the drugs names change and the but the actual and you get better drugs as you go along. But there's

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also, management, you always have PPO, they're always going to be there. So, your nurse needs to know what a PPI is, and how it works, you know, for diuretics, Lasix is on the goal since I was a student nurse, and it's a really old drug, it's always been there. So, when you say if somebody I'm putting the Monday six, it should be what those which you put the month okay. I know doctors prescribe doses, but real estimation what doses reporter the indications what are the contract indications, and then what are the nursing elements and leadership it up? It's like when you patients go on steroids? And what are the five because I'm sure it's still the same lots of things can happen from on steroids, but there are five main things to look out for. What are they and Did you recognize any of them in your patient is Did you recognize any psychosis? Did you see anyone who's on long term steroids develop the buffalo home you know the these Did you you're watching the blood sugar every time you give them a dose are you are you relating it back to the doctor put them on insulin you know all those types of I think that's a huge gap and that our nurses don't really understand that would be I would say is she looking at yet the patient and say what was their urinary output when they were on this? If they were on a certain drove did it cause constipation does cause diarrhea like the cafe started cause diarrhea? If it did, what did you look at what might happen then someone gets profuse, you know GI issues what caught my depletion them you know stuff like that I think it will be good to have them be really focused in on certain conditions and when they come to their placement so that they have to do and even if it was protected time that they get a one hour two hours during the course of the day that they have to go look up look up at condition and come back a feedback to the nurse manager involved reception Yes, yes, manager would do little mini presentations Dude, you know, if they come for two weeks, and the word that their integration as part of the team that they can become part of the team. They don't just wander in and wander off and sit there and sometimes they look like loss of these awards and if they don't have very good if the nurses there and Judy with don't pay the very busy maybe, and they don't pay attention to them. The poor students gets shuffled the corner and suddenly know, Franco's will go for coffee. Yeah, and the 15 minute coffee break my turn into gospel and then they don't their junior, they're young, I'd be like, when I was a student, they don't really see the impact of that. But in the two weeks or could have been valuable. Two weeks of learning has become like, you know, maybe you say factored into your day, you'll spend six hours and clinical area but I expect you to spend two hours then when you leave the clinical area actually putting together the patient that you were with that day.

INTERVIEWEE-1

And then you come and you feedback. And maybe you even do it in Paris, or you forgot to do this, oh, we forgot this drug, you know, that might be kind of

INTERVIEWER

directing them to look at the patient as a whole is very, very

INTERVIEWEE-1

a lot about our, our job is task orientation. Oh, yeah, having to put in a urinary catheter having to learn how to do phlebotomy. And obviously as a student that can do that when the newly qualified and it's very scary, and they do need good supervision. And they do need a good preceptor. But somebody has patients a plan you have to start doing it sometime will be with you will help you along and I'll put in one path and you have to put one in because if you don't, you'll never learn

various other assets. You know, all their you know their basic nursing care and feeding patients giving medications, hanging. Ivy's giving drugs I know student and unlikely that what they can do with

INTERVIEWER

it is sitting with the person Yes, yes, they can do many times even the even the even the students when they are introducing themselves or they are introducing their requirements to the preceptor. They only say well, I'm here to observe Yeah, when the preceptor when we talked to the preceptor. That's when she says no, she told me that she's here only to observe no limits. No, no, she has to do

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yeah, and the other thing is, you know, when they're doing a drug round, remember, I still remember that for my student is doing the drug round with the staff as well as a student and they go Okay, Paula, etc. And I'd you know, whether it be blood pressure medication, so what is kept frozen angiotensin converting converter converts angiotensin one hand you're you know, I'd have to learn I physically have to go home and study a drug to come back and we had that will tell my manager what it was. And if I didn't know and then she'd met you know, another thing she's to make us do redo Porsche Do you nurses learn how to read a report, you

know, like the as we have the page. So, giving them, the confidence and we used to have to do that, as students to read it, as patient came in on such a date, these this is admitting diagnosis, these are the test they did, this is what was abnormal. And the tests then he was referred for this, he was referred for that. And you know, and then they had to do recommendation and he went for this and then he ended up having surgery and post-surgery, you got an infection and the curve on this antibiotic and it didn't work. And then they did cultures and they put them you know, stuff so they learn the processes, and then and then anyone help you know, and, and his daughter brought home and she's going to look after him and the we checked to make sure that he would get into his house and then he was living on the ground floor, you know, issues that that they don't often think that I think some experience in doing an actual a challenge to say you've got six nurses in front of you now you've just hand over

INTERVIEWER

wouldn't be so we did it. Yes. That is not that's not the practice you think that would be a good idea. Very good idea. Yeah, that'd be very good idea. Because that will again, train them to look at all the aspects in terms of like, as you said, when they go home, this is where they live. So, if they're going to go home, somebody with a knee replacement, okay, when they go home? What about the toileting how what is the Where is the toilet do they need to go up there is there a step for them to go and go up is a patient train for that mobility aspect the

INTERVIEWEE-1

nice things yes you're very good and health teaching about how to teach patient and you know how to prepare patients are discharged and to actually teach them at their level so that they understand and in order to do that you have to understand yourself so you can't have a patient about a drug that you don't understand you can tell a patient had to mind the rule if you actually don't know how to mind the world and you know do and when they come to they can do basic things that suture removal and do addressing the observed doing is having to do the septic technique that that's my suggestion

INTERVIEWER

thanks a lot wealth of information.

INTERVIEWEE-1

This is so when it when do you finish your PhD you writing this they're like

INTERVIEWER

no, I'm doing my data collection. I'm and I'm supposed to the data collected with all the say how facilities I finished two so far for there are two three remaining, even the ethical approval part of it is still kind of pending. So, once I finished that, maybe probably another year, it will take for me to complete it

INTERVIEWEE-1

make an impact on the future education.

INTERVIEWER

As of now, there are no there is no curriculum, which is kind of contextualize somebody teach somebody who was learned something which is taught in Abu Dhabi in Fatima college may not be the same curriculum, what is taught in Glasgow Coma, maybe that's okay, that's better than Fatima call it in certain aspects. Maybe shadow University is better than Fatima College in certain aspects, you should put together all of this and say, This is what the hospital requires our graduates to be. Yeah, so we need to gear up to make our products to be good enough to be Yeah, you need to manage

INTERVIEWEE-1

and then maybe if it was standardized, and one in standardized in one area, you'd send you nurses to that area. And then you could look at sub specialties and other areas. So rather than every single university to live in the general market, say, these are the hospitals that you do that are these are the areas you do the general training and then what we're doing is we're going to do pediatric internet, you know, in this area. Yes. So that's

INTERVIEWER

a trick in this area, this area, okay, that will also give a kind of carrier pathway in front of the students in front of the students. Yes,

INTERVIEWEE-1

I just don't think they know what their options are. And there's so many, like, even nursing informatics and everything, there's loads of jobs and that nurses can do nowadays. and public health, again, for public health, which is, you know, community care, we don't have community

Canada, we don't have this country. And I mean, that would be fantastic option. I know there's some cultural aspects, but that would be fantastic for local nurses to do because they're going into their own cultures and feel much more comfortable.

INTERVIEWER

That's right. But then, so now there is a course called Community nursing. It is not even 20% related to what we used to do in Asia, in India.

INTERVIEWEE-1

But you see what we call it as a community. And for that you have we have in Ireland, we have the public health masters and then we have community and the big differences community nurses who might not have their postgraduate and in public health, which they go on to do University now, but they can only do adult care, they can do dressings, they can do basic care for that, you know, as a registered nurse, but the public health nurse studies maternity. She could do the post and the baby checks and all the advance, so she does the medication she does more advanced and treatments the community The car has happened is the community nurses are really her assistant and they do the basic stuff. So, the interest and the skill are actually going once they do their public health because it's much broader and broader, yes to all the various aspects of care

INTERVIEWER

more kind of practitioner role where you need to really identify a reference needed care.

INTERVIEWEE-1

So rather than wasting their time, you know, doing these recurrent labels are going to be done every second day, the community nurses, their assistant will do that. And then they can be looking into organizing the care package of that page. And then the more gutsy kind of more high level care,

INTERVIEWER

that's a very good career pathway to

INTERVIEWEE-1

something. It offers a lot of flexibility. I laughs lots of flexibility and time, you and I may be okay, you might have to see so many patients, but you're not constrained. You're not within the hospital, you're out in the community, it might suit people better and help and it's also preventative medicine as well so that you're getting two people before they actually and you're getting to them in their own comfort of their exam rather than them having to come in come to the hospital

INTERVIEWER

prevent aspect is Yeah, can be dealt with in this way.

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Appendix. F: Comprehensive Nursing Entry Level Competency Preparedness Tool

COMPREHENSIVE
NURSING
ENTRY LEVEL COMPETENCY
PREPAREDESS ASESSMENT TOOL

COMPREHENSIVE ENTRY LEVEL COMPETENCY PREPAREDESS ASESSMENT TOOL

S.No	DOMAIN & COMPETENCIES	Novice (Knows)	Advanced Beginner (Knows how)	Competent (Shows how)	Proficient (Does)	Expert (Can Teach)
CLINICAL KNOWLEDGE						
1.	Compliance with legal / regulatory issues relevant to nursing practice.					
2.	Knowledge of pathophysiology of patient Conditions.					
3.	Knowledge of pharmacological implications of medications					
4.	Interpretation of physician and interprofessional orders					
5.	Understanding of the principles of evidence-based practice					
TECHNICAL SKILLS						
6.	Understanding of quality improvement methodologies					
7.	Conducting patient assessments, Clinical history collection, Physical assessment related to all systems and Documentation of patient assessment data					
8.	Performing clinical Procedures e.g., sterile dressing IV therapy, etc.)					

9.	Utilization of clinical technologies (e.g., IV Smart Pumps, medical monitors, etc.)					
10.	Identifying learning needs and providing appropriate patient and family education.					
11.	Utilization of Information Technologies (e.g., computers, EMRs, etc.					
12.	Formulating Nursing care plan based on assessment findings.					
13.	Safe administration of medications per oral medication					
14.	Preparing and administering intramuscular and subcutaneous injections					
15.	Administration of IV infusions and medications.					
16.	Blood and blood products transfusions					
17.	Phlebotomy- blood withdrawal					
18.	Lab report interpretation and reporting					
19.	Dressing					
20.	Oxygenation and respiration- Assessing changes and interpretation of breathing in acute					

	problem situation and managing.					
21.	Care of patient with drains					
22.	Pain assessment					
23.	Inserting the NG tube, feeding and care of patients.					
24.	Stoma care					
25.	Care of patient on PEG tubes.					
26.	Adherence to standard precautions including transmission –based precautions					
27.	Preparing the patients to diagnostic investigation					
28.	Medication calculation					
29.	Stopping the bleeding and bandaging					
30.	Assessing changes and interpretation of circulation in acute problem situation					
31.	Taking ECG					
32.	Performing cardiopulmonary resuscitation with defibrillator and medication					
33.	Nursing skills related to bowel elimination					
34.	Observation of fluid balance and recognizing problems in fluid balance					

35.	IV cannulation and care of the cannula					
36.	Preventing and taking care of circulatory shock					
37.	Observation of internal bleeding					
38.	Inserting a nasogastric tube					
	CRITICAL THINKING					
39.	Recognition of changes in patient status.					
40.	Interpretation of assessment data (e.g., history, exam, lab testing, etc.)					
41.	Decision making based on the nursing process.					
42.	Recognition of when to ask for assistance.					
43.	Recognition of unsafe practices by self and others					
	COMMUNICATION					
44.	Rapport with patients and families.					
45.	Communication with interprofessional team					
46.	Communication with physicians.					
46	Patient education					
47.	Conflict resolution					
48.	Patient advocacy					

PROFESSIONALISM						
49.	Ability to work independently					
50.	Ability to work as part of a team.					
51.	Ability to accept constructive criticism					
52.	Customer service					
53.	Accountability for actions.					
54.	Respect for diverse cultural perspectives					
MANAGEMENT OF RESPONSIBILITIES						
55.	Ability to keep track of multiple responsibilities					
56.	Ability to prioritize					
57.	Delegation of tasks					
58.	Completion of individual tasks within EXPECTED time frame					
59.	Ability to take initiative					
60.	Conducting appropriate follow-up					