

**UNDERSTANDING THE EXPERIENCE AND
PERCEPTIONS OF MANAGERS AND
PRECEPTORS INVOLVED IN COMPETENCY
ASSESSMENT AND PERFORMANCE
MANAGEMENT OF NURSING STAFF IDENTIFIED
AS PRACTICING UNSAFELY: AN EVALUATION OF
THE EFFECTIVENESS OF THE SIP/PIP
FRAMEWORK**

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ABSTRACT

BACKGROUND: The Health Practitioners Competence Assurance Act in 2003, lead to the introduction of Nursing Council Competencies to Practice for regulated nurses in New Zealand. Employers have operationalised the competency process to provide assessment, education and support of those nurses with competency concerns. A Supportive Improvement Plan (SIP)/Performance Improvement Plan (PIP) framework, has been developed for use within the District Health Board setting to provide a consistent and transparent approach for the management of competency concerns and ensure nurses undergoing the programme are competent to practice.

AIM: Evaluate the SIP/PIP process to illuminate the views of the nurse managers and preceptors on the effectiveness of the SIP/PIP programme in ensuring competent practice and to provide recommendations for improvement and strengthening of the framework.

METHOD: This study uses a qualitative approach with data collected through individual semi structured interviews with preceptors and nurse managers. A mixed method study was attempted, however it was not completed due to the lack of participation in the quantitative arm using an anonymous survey. Thematic data analysis was undertaken utilising NVIVO 10 software. Results were drawn solely from the qualitative arm. Ethics approval was granted from University of Otago, Human Ethics Committee.

RESULTS: Four major themes were drawn from the qualitative data. (1) Feedback-insight loop, (2) Process clarity, (3) Relationships, commitment & reflective response to participation in the SIP/PIP process, (4) Barriers and enablers to the SIP/PIP process.

CONCLUSION: The SIP/PIP process is a useful framework for the nurse manager and peer preceptor group offering a clear pathway to assess, support and performance manage nurses with competency to practice concerns. However it can be further improved by ensuring a) all participants understand their roles within the SIP/PIP framework b) time for reflection during practice is built into the framework, c) consideration of the introduction of preceptee self-assessment into the framework, d) strengthening the education of nurse managers in employment relations principles. Ongoing engagement with and feedback from those involved in the process will keep the framework relevant and effective.

PREFACE

Undertaking this thesis has been the most wonderful learning experience and I am no doubt a better nurse for it, certainly more knowledgeable regarding the mechanisms of research. I wish to acknowledge a number of people who have been integral to this journey.

Firstly, the support from others within the Senior Nursing Leadership team in terms of encouragement and sharing of their own thesis journeys which was very inspiring. To my ever patient supervisors Jenny Conder and Bev Burrell who allowed me to craft my own way through this process but with lots of guidance, tolerance and faith that I was going to end up completing this work. To Kelly Tikao, who generously acted as my independent interviewer, thank you for fitting this in amongst your busy work and family life. To Pamela Tippet who helped me with the huge task of transcription and putting this thesis all together. Thank you to Amanda Clifford for all your unsung work such as organising the loan of a digital recorder from the department of Post Graduate Nursing Studies to assist with recording of the interviews. I want to acknowledge the generous support with Health Workforce New Zealand funding to undertake this study.

Finally, it is the people closest to you that ultimately keep you going through the difficult times. Firstly, my three children Nic, Kate and Sam who have had an absent mother most weekends as I hid myself away to continue to write. I hope my role modelling of tenacity motivates and encourages you to continue to study throughout your adult lives. To my mother, a nurse for over 50 years who taught me the importance of compassion and providing a high standard of nursing care. Finally to Heather, who has been so gracious, supportive and accommodating throughout this meandering path, offering encouragement and permission to take the time ... which is the greatest gift you could have given me.

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LIST OF ABBREVIATIONS

Annual Practicing Certificate	APC
Competency Assessment Programme	CAP
Continuing Competency Frameworks	CCF
District Health Board	DHB
Employment Relations Act (2000)	ERA
Enrolled Nurse	EN
Health Care Assistant	HCA
Health Practitioners Competency Assurance Act (2003)	HPCA
Health Research South	HRS
Human Resource	HR
International Council of Nurses	ICN
New Entry to Practice	NETP
Nursing Council of New Zealand	NCNZ
Performance Improvement Plan	PIP
Professional Development and Recognition Programme	PDRP
Registered Nurse	RN
Regulatory Authority	RA
Southern District Health Board	SDHB
Supportive Improvement Plan	SIP

DEFINITIONS

Supportive Improvement Plan (SIP)

First phase of framework designed to assess preceptee clinical practice against the identified competencies not being met. Based on the provision of preceptor support, knowledge and education to the preceptee along with real time feedback on practice including completing an assessment score against each competency being evaluated.

Performance Improvement Plan (PIP)

Follows the same process as the SIP but has possible disciplinary outcomes following Employment Relations guidelines in line with the Employment Relations Act (2000), that could lead to preceptee termination of employment and reporting to the regulatory body being the Nursing Council of New Zealand.

Preceptee

A nurse identified as having competency to practice issues requiring SIP/PIP intervention.

Peer Preceptor

A nurse trained to provide peer mentoring, support and assessment following completion of a preceptor induction two day workshop.

Nurse Manager

The senior nurse who is the line manager for the preceptee.

Nurse Director

The senior nurse leader responsible for the professional advice for a cluster of nursing services.

Supernumerary

The preceptor works with the preceptee directly supervising their work performance with no other allocated work load.

1. CHAPTER ONE: Introduction

1.1. Introduction

The competent safe practice of nurses as health professionals is central to every health consumer worldwide. It is internationally accepted that practicing nurses should maintain an ongoing high standard of nursing care by demonstrating continuing competence in nursing practice (Crotty, 1998; Decker, Sportsman, Puetz, & Billings, 2008; Haggerty, Holloway, & Wilson, 2012; Jordan & Thomas, 2008; Pijl-Zieber, Barton, Konkin, Awosoga, & Caine, 2014; Polit & Beck, 2004; Tilley, 2008) In the New Zealand context, the Nursing Council of New Zealand (NCNZ) is the regulatory authority that oversees nursing practice. The nursing regulator's main function is to ensure public safety through administering processes ensuring nurses meet ongoing continued competency requirements throughout their practice lives. Although the New Zealand Nursing Council competencies define how a nurse should practice, there is no guidance on how to operationalise the evaluation of competencies within the employment setting.

In 2009 the concept of competency based practicing certificates¹ was relatively new and the operationalisation of the Nursing Council competencies by employers and nurse leaders was in its infancy. An observed cluster of nurses with potential competency to practice issues at the author's District Health Board (DHB) highlighted that there was no consistent identifiable process for nurse managers to follow. Each manager developed ad hoc processes to deal with nurses with competency issues, and these varied widely across the DHB (Nurse Director Group, personal communication, 2009).

The DHB senior nursing leadership team, led by the researcher, developed a framework based on their professional practice knowledge and understanding of the Nursing Council competencies. The principles of the framework included clinical assessment of the nurse with identified competence to practice concerns known as the

¹ Nurse required to meet the Nursing Council standards for continuing competence through annual declaration or demonstration at recertification audit.

preceptee² by a dedicated peer preceptor³ who was tasked with giving feedback, in real time, to encourage positive practice change by the preceptee. This process is managed by the nurse manager who is supported by a senior nursing leader, most often a nursing director.

The Supportive Improvement Plan (SIP) and Performance Improvement Plan (PIP) framework was developed by working in collaboration with DHB Human Resource Department Advisors, whose expertise and experience of employment law was sought to help inform, develop and enrich the framework. From the literature, a best practice article from The Advisory Board™ on Employee Based Ranking, (International Council of Hospitals 2002) and was chosen as the initial basis for the SIP/PIP framework.

The framework evolved into two components or definitive phases but can be thought of as a continuum. In phase one, the Supportive Improvement plan (SIP) is based on gathering evidence about the nurse's level of competence and defining the areas of practice where the nurse was not competent within their individual scope of practice and employment setting, measured against the NCNZ competencies. Ongoing assessment takes place with the foundations of the SIP requiring the preceptor to support and mentor using a peer preceptorship model. During the SIP, there are no formal consequences regarding the preceptees lack of competence as this part of the processes focuses on support with ongoing assessment. If no improvement to a competent level of practice is noted then following the SIP/PIP continuum the preceptee enters Phase two, known as the Performance Improvement Plan (PIP), this contains similar principles to the SIP, with ongoing preceptor support, mentoring and assessment. However, in this phase the nurse manager is required to inform the nurse that they are now entering a formal employer/employee disciplinary process whereby continuing lack of competence could result in formal disciplinary actions being taken by the employer that could include even termination of employment and being reported to NCNZ as required by Health Practitioners' Competence Assurance Act (2003).

Since its inception in 2009, no evaluation of the SIP/PIP process has occurred and there is interest in the use of the SIP/PIP process from other DHBs and Non-Government

² A nurse identified as having competency to practice issues requiring SIP/PIP intervention.

³ A nurse trained to provide peer mentoring, support and assessment following completion of a preceptor induction two day workshop.

Organisations (NGO) who employ nurses. It is therefore appropriate to evaluate the process before it is disseminated externally.

1.2. Aim of the Study

Primary aim: To examine the experiences of the preceptee, peer preceptors, and nurse managers who have participated in the SIP/PIP framework using evaluation research.

Secondary aim: To identify modifications and improvements that could be made to the SIP/PIP framework to improve the process.

1.3. Structure of the Thesis

1.3.1. Chapter Two : Background

Explains the SIP/PIP process to situate it in the New Zealand regulatory context.

1.3.2. Chapter Three : Literature Review

A review of the literature outlines nursing regulation from an international perspective. It examines the historical evolution of the concept of continuing competence for nurses including a commentary on the New Zealand context. Finally, a review of continuing competency frameworks is provided.

1.3.3. Chapter Four : Method

Outlines the researcher's theoretical epistemological journey and the justification for the final chosen research methodology. The chapter explains the method of data collection, analysis and ethical considerations particular to this research. Finally, it concludes how findings can form an evaluation of the SIP/PIP process.

1.3.4. Chapter Five: Findings and Analysis

Presents a thematic analysis of the 14 semi structured interviews undertaken with the research participants. Four major themes identified are supported by narrative to provide context and assist in the interpretation of their meaning.

1.3.5. Chapter Six : Discussion, Recommendations, and Conclusion

Chapter six consists of a discussion relating to how the research results can be used to inform further development of the SIP/PIP framework. It concludes by providing recommendations as to how the findings could be implemented. Study limitations are discussed as well as areas where further research is necessary.

2. CHAPTER TWO : Background

2.1. Introduction

This chapter outlines the context of nursing regulation in the New Zealand setting including supporting literature and provides a brief outline summary of the SIP/PIP process used within one DHB.

The International Council of Nurses (ICN) has advocated for regulation of the nursing profession over its one hundred and ten year history (Jordan & Thomas, 2008). The International Council of Nurses (2009) state, “The primary aim of regulation is protection of the public. It is therefore important at this time to identify the contacts, shared experience and provide a comparative analysis of the fundamental working of the legislation that governs the regulatory framework internationally” (p. 6). The World Health Organisation (WHO) previously developed a similar view which highlights the valuable role that regulation plays in the safe delivery of health care internationally (World Health Organisation, 2006). Although ICN is working towards international standards of regulation it acknowledges at this time it is only able to gain a partial worldview as no systematic archive of legislation or best practice is currently available (International Council of Nurses, 2009).

2.2. Nursing Regulation in New Zealand

The Health Practitioners Competency Assurance Act (HPCA) 2003 was enacted in September 2004 bringing together the regulation of 16 registered health professional groups within New Zealand under one regulatory framework. (Vernon, Chiarella, Papps, & Dignam, 2013).

The Act is operationalised by each of the professions’ Responsible Authorities (RA) often referred to as regulators who maintain public safety by ensuring that practitioners are competent to practice in their designated professions. The New Zealand Ministry of Health (2010) defines RAs as those that “regulate their professions through registration, issuing practicing certificates, carrying out competence reviews,

recertification processes, investigating complaints about practitioners and considering concerns about their health” (p.1). Each RA must outline the scope of practice in which the health professional is registered. If the health professional belongs to more than one profession she/he must maintain their registration through the Annual Practicing Certificate (APC) process to practice in both professional scopes of practice.

Prior to regulation health professionals opted for self-regulation outlined by voluntary codes of practice or voluntary accreditation systems (Pearson, Fitzgerald, Walsh, & Borbasi, 2002). Some of these voluntary codes are still evident today for example, the Royal College of Surgeons affiliates have to pass education and practice standards set by a professional board to become members (Royal Australasian College of Surgeons 2010).

Statutory regulation provides a legally defined set of practice standards although a regulated workforce is noted to be the most costly system to maintain. It is funded through the payment for registration on the statutory roll and fees paid for annual renewal of practicing certificates. These fees fund investigations into competency to practice and disciplinary tribunals held to determine if any health professional does not meet the statutory requirements of its membership. The HPCA is perceived to be a public endorsement of a health group’s professional status (Ministry of Health, 2010).

In New Zealand, nurses are required to demonstrate their competency to practice annually to the Nursing Council of New Zealand (NCNZ) through a statutory declaration that they have:

- Completed 60 days (or 450 hours) of practice in the last 3 years
- Completed 60 hours of professional development in the last 3 years
- Meet the NCNZ competencies for their scope of practice.

Five per cent of nurses who apply for APCs are randomly audited, which requires the nurse to provide evidence to support their APC application. If the RA selects a nurse for audit, she/he are required to produce his/her evidence of meeting the competency requirement. This evidence can be undertaken in any two of the following three ways:

- Evaluation and assessment by a senior nurse most commonly their line manager through the annual appraisal process aligned with the competencies in their scope of practice.

- Peer assessment by a registered nurse against each of the competencies being validated and signed.
- Self-assessment against each of the competencies.

(Nursing Council of New Zealand, www.nursingcouncil.org.nz).

Nurses are exempt if they hold an endorsed professional portfolio on the Professional Development Recognition Programme⁴ (PDRP) (www.nursingcouncil.org.nz/Employers/Continuing-competence) the criteria of which ensures the nurse meets competence requirements. Anecdotally, it appears many nurses maintain a professional portfolio as a means of avoiding audit, although in effect all criteria of the PDRP process meets competence requirements.

Self-declaration of competence can be seen as a poor means of ensuring competence. Gallagher, Smith, & Ousey (2012) comment that in the New Zealand setting the application for an annual practicing certificate that requires a declaration of competency against the competencies is at best a passive process and that nurses are only motivated to actively demonstrate competence if required to produce evidence at audit.

There are three regulated scopes of practice in New Zealand:

- Nurse Practitioner
- Registered Nurse
- Enrolled Nurse

For each scope there are separate associated defined competencies that the nurse must meet. Within each scope, the competencies differ according to defined levels of clinical practice. The largest number of nurses in one scope is the Registered Nurse (RN) scope of practice. The Nursing Council of New Zealand (2014) annual report states there were a total of 51,406 nurses practicing, including 129 nurse practitioners, 48,406 Registered Nurses and 2,871 Enrolled nurses.

This analysis is concerned with Registered nurses and describes the regulatory process for this group of health professionals. NCNZ broadly defines the scope of a RN

⁴ PDRP – Professional Development and Recognition Programmes (PDRP) enable nurses and midwives practice to be rewarded and recognised. These programmes support innovation, reflect contemporary practice and are competency based.

as “Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care, and to advise and support people to manage their health.” The three full scopes of practice can be found at (www.nursingcouncil.org.nz/Nurses/Scopes-of-practice). Any nurse holding a current APC is assumed to be competent to practice within their scope of practice through this process.

2.3. Competency Assessment within the SIP / PIP Process

Despite the Nursing Council’s continuing competency framework, there are still a small number of nurses who are identified as having potential competent to practice concerns in some areas. The NCNZ outlines clear processes as to how employers or members of the public can bring such nurses to its attention. If a nurse is reported to the council, any management plans and reports used to investigate or remediate practice can be submitted. However although the council provides guidelines on how these issues should be managed, it leaves implementation to the discretion of the employers. There is a gap in a standardised approach nationally and at DHB level on how to manage this group of nurses. Because there is no national framework the DHB has developed the following SIP/PIP process outlined in Fig. 1- Flow chart of SIP/PIP process.

It is often nursing peers who raise the question of competence of a fellow practitioner (International Council of Hospitals, 2002). Frequently after a long period of perceived lack of competence, as nursing peers tend, in the first instance, to try and use informal methods of support to assist colleagues with poor performance. These include decreasing patient workloads in volume or through allocated patient acuity (personal observation). Commonly a critical incident or catalyst, such as a major drug error, alerts the nurse manager to a potential competence issue. Once the nurse manager has this knowledge, an investigation process begins. The nurse manager must ensure a sound fair investigation as stipulated in employment policies, procedures and industrial awards. Unlike planned undergraduate competency assessments or those for Competency Assessment Programme (CAP) nurses, where nurses are expecting a competency assessment as part of the process for registration, nurses undergoing SIP/PIP processes often enter into the competency assessment process unexpectedly.

The SIP/PIP process follows the principles set out in the Employment Relations Act (2000). The SIP/PIP has been used successfully in the improvement of a nurse's performance working through the framework identifying where the Nursing Council competencies were not being met, providing targeted support and education and an ongoing competency assessment to measure outcomes more consistently. It quantifies competency issues and identifies exactly which competencies are not being met, the process identifies what strategies have been put in place including education supplementation and support.

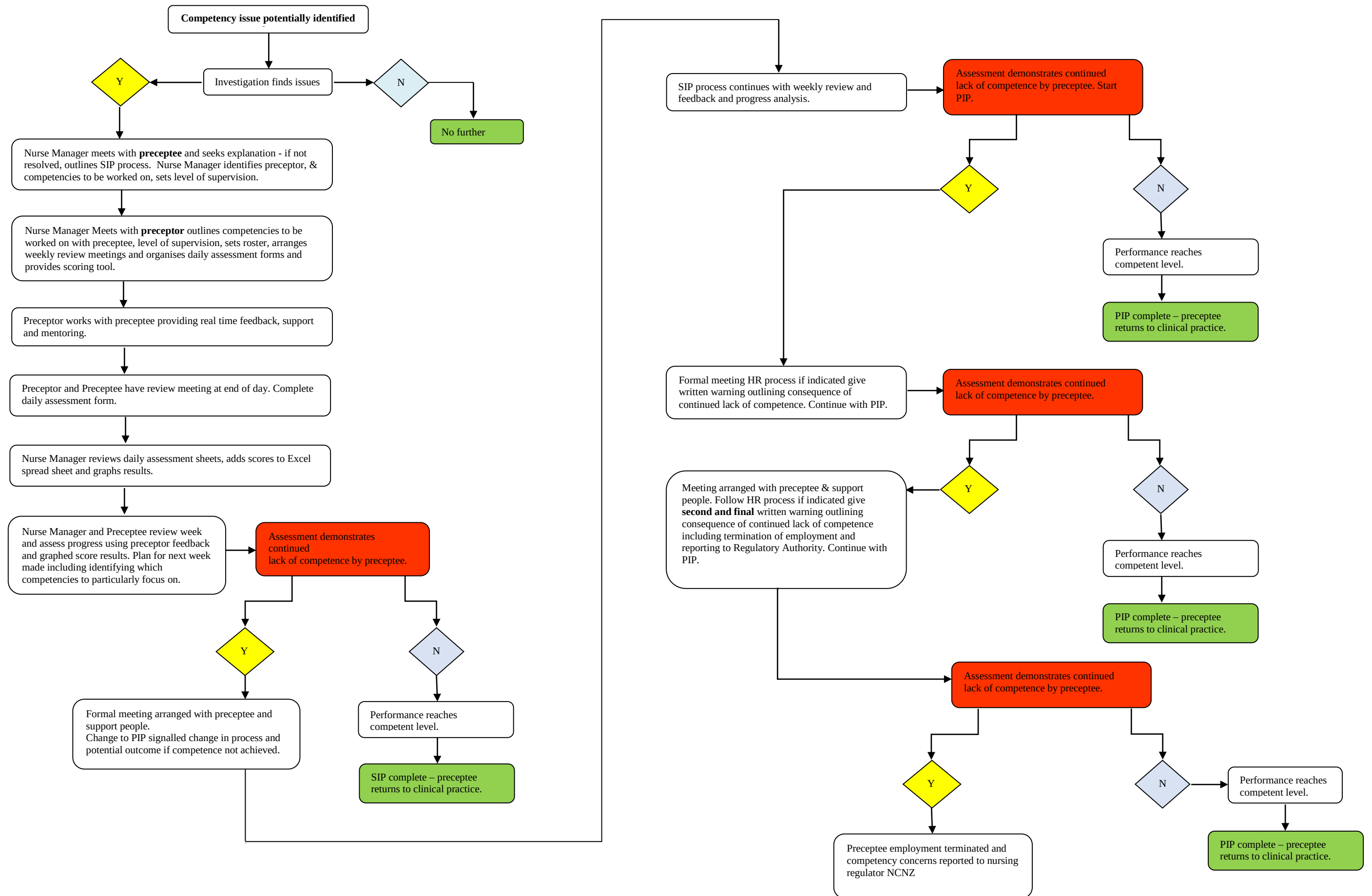
The introduction of the SIP/PIP has helped have a clear, transparent and replicable process for all nurses with competence to practice issues. Nurse Managers representing the employer along with nurse leaders such as Nurse Directors are obliged to set aside time to plan and oversee the SIP/PIP and set up an effective employment setting that gives the preceptee the best opportunity to improve and return to competence. SIP/PIP processes are undertaken in a timely manner, clearly outlining the identified deficits and offering extra training or education if needed.

The preceptee as the employee, also has obligations to participate fully in the SIP/PIP and also attend or complete education sessions as indicated. Information and assessments are shared so the employee can see what has been gathered and how this was interpreted. In some SIP/PIP situations, preceptees have requested changes to preceptors and/or work areas to allow opportunities to demonstrate competence without perceived prejudice.

If the preceptee fails to show competent practice in the SIP then a meeting must be held to talk about transitioning to the formal PIP process. The time period that the SIP/PIP will continue is very much a matter for each individual preceptee process.

A brief narrative outline of the SIP/PIP framework is provided in Appendix A.

Figure 1 – Flow chart of SIP/PIP Outline



The following chapter explores, through a review of the relevant literature, the international historical journey behind continuing competency assessment within nursing. In addition it outlines competency assessment frameworks, including new assessment tools such as simulation. The role of the preceptor in competency assessment is examined and the way formal disciplinary employment termination processes are integrated should this be necessary. Finally, an overview from the literature on the impact of feedback in the development of insight and how this affects movement towards regaining competency will be presented.

3. CHAPTER THREE : Literature Review

3.1. Introduction

This chapter describes the literature review process which focuses on the identified issues of defining competence and competency separately. Key points from the literature identified that there is no agreement on specific ongoing competency assessment internationally. The preceptorship model is used widely in undergraduate training but also may have value in ongoing continuing competency assessment to support the nurse with competence issues. Finally a more refined examination of the recent research around the use of feedback and its effectiveness in improving insight of people with competence to practice issues is examined.

3.2. Research Strategy

The first stage of literature searching used key words or phrases to search CINAHL, Medline, Ovid, ProQuest, Web of Science and Google Scholar databases. The following terms and key words combined with Boolean logic AND nurs* to link the key words within the nursing context.

- Competence, competency, continuing competence
- Performance management
- Regulation
- Feedback, insight
- Preceptorship

Table 1 – Abstracts and Articles

Search Terms	Abstracts Reviewed	Articles Retrieved
Competency	118	37
Regulation	8	6
Preceptorship	24	13
Performance management	6	2
Feedback, insight	30	3
Adult learning styles	8	4
Total Articles : 204		

A manual review of the abstracts indicated whether the article added was relevant or led the researcher in a new direction. For example when reviewing articles related to competency, the same articles discussed competency frameworks then highlighted the use of feedback as a mechanism for competency improvement.

The second search strategy used an evolving strategy known as ‘berry picking’ (Bates, 1989). This approach uses results of a query as a starting point with further relevant information gathered from articles that lead the researcher to refine the search. Included in this technique is ‘backward chaining’ defined as where reference lists may provide further direction on where to search for relevant information. Other techniques used included citation searching or ‘forward chaining’, where you begin with a citation and then work forwards to find out who cited it, author searching, and subject scanning. These approaches allowed ongoing and varying new information on the topic to be collated as more articles were reviewed. The knowledge gained from each interaction led to new thinking and possibly new queries that needed to be answered. This berry picking approach broadened the review to include website information from government

departments and nursing councils in other countries. After a comprehensive search, 52 articles were included in the literature review.

3.3. Historical Evolution of Competency Assessment

New Zealand was the first place to regulate nurses by passing the Nurses Registration Act 1901. Following completion of a three year training programme and passing of a state final examination, she/he was able to register as a nurse on a state database with the nurses details added to a registration register (Maclean, 1932). Subsequently many other countries introduced formal education and examination to endorse nurses as able to practice (Allsop & Saks, 2003).

Over the next sixty years, it became internationally accepted that the attainment of an initial nursing registration provided a lifelong entitlement to practice. (Jordan & Thomas, 2008; McGuire & Weisenbeck, 2001). In the late 1970's and 80's the introduction of the concept of continuing education through professional development placed emphasis on nurses as having to demonstrate a commitment to and evidence of, ensuring their practice was based on current knowledge. However at this time there was no ongoing requirement that nurses obtain an annual practicing certificate based on showing evidence of competence.

The evolution of the concept of continued competence to practice began in America where pivotal changes occurred with the landmark Pew Commission reports in 1995 that launched regulatory reform within healthcare (Decker et al., 2008; Jordan & Thomas, 2008; Tilley, 2008). A parallel rise in the consumerism movement followed, signalling a public who wanted health professionals to be held accountable for their professional practice. The Commission validated the public's perception that health professionals, including practicing nurses, have a responsibility to remain current with evolving health practice leading to them being accountable for their own practice. The commission pressured regulatory boards to assure that they monitored and assessed health professionals on an ongoing basis and when triggered follow up on key practices indicating unsafe or incompetent nursing care.

The taskforce outlined the following principles:

- Promoting effective health outcomes and protecting the public from harm.

- Holding regulatory bodies accountable to the public.
- Respecting the consumers' rights to choose their health care providers from a range of safe options.
- Encouraging a flexible rational and cost effective health care system that allows effective working relationships among health care providers.
- Facilitating professional and geographical mobility of competent providers.

(Pew Health Professions Commission, 1995)

3.4. Competency Frameworks

By the mid 1980's a worldwide transformation of undergraduate nursing training began, leading to the evolution of competency assessment processes. Supported by the Pew Health Professions Commission in the USA, Project 2000 in the UK and similar reviews in Canada, Australia and New Zealand, led nursing training to transition from the apprenticeship model of hospital-based training into the higher education facilities of university and technical institutes (Cowan, Norman, & Coopamah, 2005; Watkins, 2000). With this transition, educational programmes became accountable for ensuring the nurses they graduated were fit for practice. The education based training model emphasised nurses as needing a more critical and analytical approach when providing health care (Cowan et al., 2005; Watkins, 2000).

Tension arose between the existing workforce and the degree trained graduates as employers had expectations of the newly registered educationally prepared nurses to be 'work ready' at the completion of their training. However in some cases they lacked experience and needed time to build up clinical skills to practice confidently. Conversely, the objective of the educational based degree model was to equip the graduate to have a collection of skills that allowed them to practice in clinical settings other than hospitals and to understand the value of continuing learning, reflection and be able to demonstrate these on an ongoing basis. Competency assessments were seen as a way for the educationally prepared nurse to show that they had the skills and knowledge to practice in the workplace.

Determining who should be deemed a competent practitioner proved difficult. Frameworks, models and processes that demonstrated supposed tangible evidence of the capabilities of nursing students emerged (Gallagher et al., 2012). Watson, Stimpson,

Topping, and Porock (2002) comment that competence has currency and could not be avoided within nurse education sparking a new debate around the ability of diploma based versus bachelor degree training programmes as the graduates from these programmes were measured against each other often using elaborate evaluation tools. With the addition of more academically prepared nurses into the work force, questions regarding competence emerged from their more clinically experienced but often academically limited colleagues (While, 1994).

Ongoing evaluation of the newly graduated nurse in clinical practice continued and review processes revealed that the number of nurses who failed to transition from undergraduate student to newly registered nurse grew. Pirie and Green (2010) describe the evaluation of Project 2000 in Britain, which identified performance issues in newly graduated degree programme nurses, including that although they were well endowed with theory, their practice was not always competent at the outset of employment. The concept of the theory practice gap emerged with examples of newly graduated nurses who were deemed to have completed educational requirements and passed as competent, when they entered the workforce were found not to be work fit. (Tilley, 2008). It was found that these nurses entering practice benefited from a supported year in practice. This initiated the evolution of New Entry to Practice⁵ (NETP) programmes to assist new registered nurses into practice, often with a peer preceptor providing support.

Haggerty et al. (2012) found that the introduction of supported transition to practice programmes such as NETP that utilises preceptor mentoring and support, reduced turnover rates of new graduates and showed improvements in competence. The preceptor role became formally recognised and was initially used to transition new graduates into workplace clinical practice.

As the public wanted increased assurance of a safe health care workforce, further moved expectations that all nurses should be required to demonstrate continued clinical competence throughout their careers. Nursing regulatory bodies embarked on the development of quality assurance mechanisms to ensure ongoing competence. In New Zealand, these evolved into a set of competencies standards for each of the three defined

⁵ New Zealand's Nursing Entry to Practice Programme (NETP) enables nursing graduates to begin their careers well-supported, safe, skilled and confident in their clinical practice, equipped for further learning and professional development, meeting the needs of health and disability support service users and employers.

practice scopes; these were for the Nurse Practitioner, the Registered Nurse, and Enrolled Nurse.

The standardisation of nursing practice competencies had its critics, with some feeling that the competencies became too broad to be able to accommodate the flexible nature of differing practice environments and nursing specialties. Debate as to whether a different level of competence should be set for nurses with more post registration experience than entry level practitioners ensued (Gallagher et al., 2012; Pearson et al., 2002).

Benner's (1984) landmark work 'From novice to expert' assumed that the nurse in clinical practice progressed through clearly defined phases of practice confidence, as she/he gained experience in a particular clinical setting. This cycle repeated when the nurse moved to a new area of specialty practice, where the nurse would return to the novice phase. This was seen as a normal part of a nursing career pathway, and supported the notion that only a baseline level of competence needed to be demonstrated. Levels of competence remain contentious and can cause confusion for those attempting to measure competence (Vernon, Chiarella, Papps, & Dignan, 2010).

The NCNZ continuing competence framework review suggests that context of practice is as important to consider as the scope and area of practice.

As each one of the competencies is considered independently, there is a point reached whereby a global view of competence needs to be formed. Decker et al. (2008) and Gallagher et al. (2012) believe the importance of a global overall rating or assessing the nurse's global capacity requires personal judgment, which evaluates the nurse's performance as a whole. Levett-Jones and Lathlean (2009), raise the issue of where does the cut off lie between competence and not being competent. For example if the nurse is 90% competent as judged by a series of tasks or observations, are they competent to practice? Messick (1994) questions whether it is the individual task or total sum of the tasks that is important, and whether the interaction and co-dependence of competencies as a whole is material? These questions open a potential Pandora's Box of interpretation of what competent practice is and how it is measured.

Further debate continues over who is accountable for ensuring nurses maintain a competent level of practice (Decker et al., 2008). Jordan and Thomas (2008) point out that there are differing viewpoints from each of the constituents in the process being the employers, regulators/licensees, educators and individual nurses (Pijl-Zieber et al., 2014).

Most agree that the onus is on the individual to demonstrate competence by undertaking continued education and updates, providing evidence of competent practice through mechanisms such as professional portfolios that are peer reviewed against agreed practice standards. The role of the regulators is to set the standards of competence, monitor compliance and act when competency issues arise (Vernon et al., 2013). Finally the employer has an obligation to both providing safe health care to their consumers and acting as a 'good employer' supporting and providing pathways for the nurse to maintain their competence (Decker et al., 2008).

3.5. Competence and Competency

There is no international consensus or one accepted definition of competence or competency (Butler et al., 2011; FitzGerald, Walsh, & McCutcheon, 2001; Girot, 1993; Levett-Jones, Gersbach, Arthur, & Roche, 2011; McCarthy & Murphy, 2008; Watson et al., 2002). Both competence and competency are described as complex (Butler et al., 2011; Pirie & Green, 2010) and even nebulous (Watson et al., 2002). Although there is no definitional consensus, there are many commonalities within the definitions used. The ICN believes the lack of an internationally accepted definition is a challenge for nursing and it is working towards a global language to ensure both consistency in of competency is defined and standards used for competency assessment (Jordan & Thomas, 2008).

The terms 'competency' and 'competence' are often used interchangeably; nevertheless authors have begun to differentiate between them (McConnell, 2001; McMullan et al., 2003; Pijl-Zieber et al., 2014; Woodruffe, 1993). McConnell (2001) defines competence as "an individual's capacity to perform a job's responsibilities". This differs from competency that "focuses on an individual's actual performance in a particular situation" (p.14).

Knowing is not the same as doing, with the demonstration of competency in the real world setting being seen as most important (McGuire & Weisenbeck, 2001; McMullan et al., 2003; Pijl-Zieber et al., 2014). Many researchers support the separation of competence, (capacity) from competency, (actual performance), (Cowan et al., 2005; Decker et al., 2008; McMullan et al., 2003; Nolan, 1998; Pirie & Green, 2010; Tilley, 2008; Whelan, 2006). Vernon et al. (2010) states, "There is general agreement in the literature that competence assessments in nursing cannot solely be based on

demonstration of theoretical knowledge or technical skill but should also involve some inference about a candidate's attitudes and professional practice" (p 19).

McAllister (1998) believes that trying to continually refine what is understood as competence can more often result in the description of what is absent in an incompetent practitioner. Philosophical debate still remains as to whether competency based standards are totally appropriate for nursing. There is a fear that they could be interpreted in a concrete and reductionist way with pass/fail criteria.

McAllister (1998) also believes this could be a danger as highlighted by the tick box competency task lists that originally dominated the assessment process. Others believe that humanistic aspects become lost and devalued as skill and knowledge components of competency that can be more easily measured take priority. Competence is seen as more than the achievement of individual competencies but a view of the whole within the clinical setting (Pijl-Zieber et al., 2014). Competence can be viewed as a baseline achievement that can lead to the loss and impetus to strive for excellence in practice (Chapman, 1999; Cowan et al., 2005; Watson et al., 2002).

Common comments of definition of competence include a combination of knowledge, skills, attitudes and behaviours (Butler et al., 2011; Pirie & Green, 2010; Whelan, 2006; Wilkinson, 2013). The Nursing Council of New Zealand defines competence as: "the combination of skills, knowledge, attitudes, values and abilities that underpin effective performance as a nurse" (Vernon et al., 2010, p.18). This definition aligns comfortably with the ICN (Bryant, 2005), and some regulators including the Australian Nursing and Midwifery Council, the American National Council of State Boards of Nursing (NCSBN), British Nursing and Midwifery Council (NMC) and the Canadian Nurses Association (CNA).

3.6. Continuing Competence

In New Zealand the wider encompassing HPCA Act was initially reviewed in 2009 by the Director General of Health and again in 2012. The 2012 review concentrated on improving the function of the HPCA Act given that the health needs of the population were changing. This included the shift away from the majority of health care being performed in the hospital setting to being provided in the community based settings rather than in hospitals and the driver for more inter-professional collaboration. It also signalled

that more inter-professional collaboration is needed across professions and that teamwork is key to providing contemporary health care (Ministry of Health, 2010).

The review of continuing competence framework undertaken by the New Zealand Nursing Council in 2010, outlined the different ways competence can be assessed. Table 3 summarises the common assessments undertaken in Australia, UK, USA and Canada all of which have comparable health systems to New Zealand (Vernon et al., 2010). The purpose of the review was to ensure that the competency assessment process was contemporary and continued to be supported in evidence against the international regulatory setting.

Table 3 – Commonly Used Competency Assessment Pathways

Accepted ways of demonstrating competence	Comment
Continuing Professional Development	Is considered to be a valid indicator potentially improving currency of knowledge and skills using reflective activity gaining insight into practice, but used independently is not a reliable indicator of competence.
Self-assessment and self-declaration of competence	This is reliant on the individual using self-reflection against the competencies.
Minimal levels of practice hours	Within a defined period – providing verified evidence of a minimum set of practice hours also implies that skills and knowledge would be regularly used. Again in isolation this is not a valid assessment tool.
Peer review assessment	Using peer review offers some triangulation about a nurse's practice. A level of professional maturity is required to participate in peer review with inter-rater reliability remaining a subjective factor, particularly where close relationships between peers or small workplace peer groups may make it harder to provide objective peer reflection.
Professional portfolio	Evidence of fitness to practice can be demonstrated through meeting criteria outlined to pass a professional portfolio. This is in line with adult learning and active learning frameworks rather than passive learning as portfolios reflect how knowledge is used in clinical practice through clinical examples outlined in the portfolio.
Self-declaration	Relies on the nurse's insight into their clinical practice to make a valid declaration.
Audit	Provides checks to ensure nurses are able to provide evidence of demonstration of competency.

Vernon et al.'s (2010) evaluation study of continuing competency frameworks found that, of the numerous competency assessment tools available the literature, "no one indicator used independently can measure competence. Valid measurement of indicators can be subjective in nature and is 'difficult' with inter-rater reliability a critical component of the assessment process" (p.21) supporting using a combination of indicators. Furthermore, Vernon et al. (2010) also noted that there is evidence that the current continuing competency framework is acceptable to the nursing profession in the New Zealand setting. Vernon et al.'s (2010) evaluation on behalf of the NCNZ used a mixed method evaluation approach with survey and semi structured interviews. Using purposeful sampling, participants were drawn from key stakeholder group in the continuing competency process, which included Nursing Council employees, nurse leaders, and directors of nursing in public and private sector, nursing educators and nurses who had been audited in the preceding 4 year period. Their findings found that 76 % of the survey respondents believed that the Continuing Competence Framework (CCF) for renewing practicing certificates in New Zealand is a valid mechanism for ensuring nurses are competent to practice.

The NZ audit process was also reviewed against continuing competence frameworks in UK, America, Canada, New Zealand and Australia. New Zealand audits five per cent of the regulated workforce who make a declaration of competence when applying for an APC in contrast to Australia, which audits two percent of nurses applying for an APC to ensure ongoing compliance. Statutory declarations are made in UK, America and Canada and have no audit follow up (Vernon et al., 2010, p. 20).

The continuing competence framework acts as a baseline measure to ensure nurses remain safe to practice. Regulators relying on the employer, other health professionals or the public to report cases where nurses have been identified as having potential competency issues.

3.7. Preceptor Model Supporting Competency Assessment

A definition of a 'peer preceptor' used by one District Health Board (DHB) 'is a registered nurse or enrolled nurse who has completed the DHB education on the preceptor role through attendance at two consecutive study days' (Mitchell & Earl, 2010). Preceptors are also required to update their preceptor knowledge bi-annually, attending a

further study day, which provides updated preceptor information and ensures preceptors maintain their peer preceptor status. This is consistent with other peer preceptorship models internationally (Butler et al., 2011; Girot, 1993; Haggerty et al., 2012; McCarthy & Murphy, 2008).

Preceptorship can take place in a number of situations, such as providing preceptorship support to undergraduate nursing students, new entry to practice (NETP) orientating registered nurses to the workplace or as part of a Competency Assessment Programme (CAP) process to meet Nursing Council requirements. It is now also being utilised in SIP/PIP processes.

3.8. History of Preceptorship Model

The preceptor model evolved as a result of issues identified with the transition of newly registered nurses from educationally prepared nursing programmes. In 2011, 86% of USA undergraduate programmes used a preceptor model to support students learning in a clinical environment. Evidence suggests that where industry and academia work together to promote the best outcome for students the preceptorship model is strengthened (Haitana, 2011).

Training organisations are also reducing tutor numbers often due to financial constraints within the educational institution or a lack of experienced tutors (McClure & Black, 2013). This reduction in tutor numbers has resulted in some hospital clinical placement models using registered nurse preceptors for support, to provide guidance and teaching at the clinical work face for undergraduates (Myrick, 1988). This role with undergraduates has led to an expectation that all nurses support those in training, through orientation, and perform assessments either through direct preceptorship or through supporting colleagues who undertake the preceptor role and by supporting preceptors by decreased their clinical workloads allowing time for the preceptor to undertake their role.

3.9. Preceptor Education

The Butler et al. (2011) study found only 57% of preceptors were happy with their preparation for the role, which highlighted the importance of preceptor education to include practical assessment workshops and refreshers for preceptors. The most frequent source of support came from other preceptors.

The literature suggests that when competency assessment initially emerged, preceptors had trouble with the language used in competency assessment documentation (Butler et al., 2011; DeWolfe, Laschinger, & Perkin, 2010; McClure & Black, 2013). McClure and Black (2013) found that the more times preceptors performed the preceptor role the more confident they became, as well they developed a greater understanding of the process and language. The language used in the regulators competencies acknowledges that the competency processes had to be broad and flexible to be used across many nursing settings. It is also acknowledged that the language is complex but warns that any simplification risks leading to a reductionist perspective and interpretation (McClure & Black, 2013).

3.10. Challenges for the Preceptor Model

The majority of research on the preceptorship model comes from studies involving undergraduate students. Some researchers identified that all preceptors need to have a sound nursing knowledge base and a high level of observable nursing practice being considered expert nurses in their field of practice (Butler et al., 2011; Pirie & Green, 2010). Criticisms of the model include student complaints of subjectivity and a lack of consistency in the student assessments processes.

Haitana (2011) has commented that nurses can be reluctant to sign off on another person's competence because they felt that they would be held accountable in some way if the nurse they had assessed was not competent in the future. Conversely, anxiety arose from the sense of responsibility for failing a nurse in a competency assessment and being responsible for another nurse's potential professional demise (Hrobsky & Kersbergen, 2002). It has been suggested that there needs to be manager and professional support for preceptors who are dealing with peers or students who do not meet competency standards (Cassie, 2014; Duffy, 2003). Promotion of the importance of the role of the preceptor to ensure patient safety should be emphasised. Saunders, Huynh, and Goodman-Delahunty (2007) identified the importance of acknowledging the position of power that a preceptor has in the assessment process and that emotional intelligence should be used to navigate through the situation.

3.11. Rewards for Preceptors

The literature notes a range of intrinsic rewards for preceptors including increased personal learning, peer respect, recognition, personal satisfaction and knowing they were contributing to the education of other students and nurses (Bradshaw, 1997; Butler et al., 2011; DeWolfe et al., 2010; Haitana, 2011; Hyrkäs & Shoemaker, 2007; Kalischuk, Vandenberg, & Awosoga, 2013; McCarthy & Murphy, 2008). Haggerty et al. (2012) described the use of a preceptor badge as a visual marker, that acknowledges the specialised knowledge and up to date learning that preceptors have. DeWolfe et al., (2010) explored the preceptor's perspective on support and retention of preceptors, and found that the most tangible reward was feedback from the preceptee and personalised feedback from those managing the precepting process.

3.12. Relationship Between the Preceptor and Preceptee

Developing a sound professional relationship between preceptee and preceptor is crucial for learning if opportunities are to be optimised and be meaningful (Butler et al., 2011; Haggerty et al., 2012; Haitana, 2011). Myrick (1988) and Myrick & Barrett (1994) describe this as professional nurturance whereby the relationship between the preceptor and preceptee starts with the preceptor providing a sense of assisting and supporting the preceptee during their precepting experience thereby decreasing some of the anxiety associated with the process. Preceptors who exhibit behaviours such as friendliness, understanding the learner's needs, skills in adult teaching methods and who create a positive learning environment were all found to strengthen the relationship between preceptor and preceptee (McClure & Black, 2013).

Communication and trust was found to be critically important if feedback about performance was to be accepted by the preceptee. Building trust takes time, the more closely the pair work together the more assessment, observation, and discussion opportunities occur (Haggerty et al., 2012). The period of initial assessment cues the preceptor to the level of autonomy of patient care that the preceptee should have. The complexity of patient assessment and care planning mean that the preceptor not only has to observe the nursing process in action by the preceptee, but also elicit the use of nursing knowledge that are behind their actions. This can be determined with questioning by the preceptor about observed practice and why things were done in a certain way. The

preceptor has to trust the preceptee with aspects of patient care to move into the “letting go” phase where the preceptee can practice more autonomously. This process builds on itself as the preceptee gains confidence, which also allows for feedback to be accepted (Haitana, 2011).

3.13. The Nurse Manager Role in SIP/PIP

Whelan (2006) describes the “competency process as a team effort and a collaborative one in which the nurse educator, the manager, the preceptor and the staff members participate to ensure competent staff members” (p. 199). Butler et al. (2011) supports the role of the nurse manager as being essential to guiding the process, ensuring that preceptors are prepared for the role and supported throughout the process (DeWolfe et al., 2010).

The nurse manager role is also seen as pivotal to the success of the competency assessment process. Managing supernumerary time for preceptorship in rosters, ensuring documentation is completed and maintaining patient safety, while carrying out their obligations as a good employer can be challenging. Managing decreased clinical workloads acknowledging the value that the preceptor is providing to the preceptee, is pivotal.

The nurse manager oversees the process of competency assessment, including ensuring that preceptor selection match both the preceptee’s needs and that of the organisation. Preceptor availability can be challenging including managing a change in preceptors due to booked annual leave understanding that supporting the preceptor is crucial. There are rostering constraints including occasional personality conflicts between preceptor and preceptee, which the nurse manager has to manage. Keeping preceptor turnover for preceptees to a minimum helps to keep consistent assessments, ensuring the number of preceptors the preceptee works with is minimised. If the preceptor changes, it is essential that sound documentation processes are used so information and assessments remain objective and informative ongoing (McClure & Black, 2013).

3.14. Employment Relations Support for Nurse Managers using the SIP/PIP Process

Performance management using frameworks such as the SIP/PIP process is an employer driven process and requires the employer to comply with employment law. Under New Zealand law, the Employment Relation Act (2000) outlines expectations for both employers and employees. The health sector has specifically noted sections within the Act that clearly prescribe how employers/employees are to work together regarding employment issues. Principles include acting in ‘good faith’, with ‘good reason’ and having ‘good process’ to help create an environment that is fair, constructive and maintains patient safety. Waldegrave, Anderson, and Wong (2003) describe characteristics of a positive employee/employer relationship as having ‘give and take’ qualities between the parties, approachable employers and inclusive decision making, which leads to a sense of trust between the parties. Boxall (2001) holds the view that the Employment Relations Act (2000) signalled a re-balancing of the rights of the employer and worker creating a stable platform for employment relations in New Zealand.

The employer has an obligation to ensure that any process used is fair and reasonable. Harcourt, Wood, and Roper (2007) make the point:

Employers would adhere to procedures more readily and refrain more often from firing people they did not have substantive grounds to dismiss bolstering the “commitment effect” through increased perceptions of job security, at least among so-called “good” employees. More employees would work harder to meet minimum performance standards and avoid engaging in misconduct, knowing that not doing so would result, at least eventually, in dismissal (p 962).

More simply, this means if sound and fair processes are in place then the employee and employer both stand to benefit as the expectations around performance management are clear.

3.15. Feedback to the Preceptee

Pirie and Green’s (2010) study on preceptorship identified that assessors need to be able to provide constructive feedback that is be seen to be supportive. The assessor

also needs to be a knowledgeable teacher and excellent role model (Myrick & Barrett, 1994). Learning to provide constructive feedback is an essential part of preceptor training and education. This includes skills on how to give feedback on strengths or areas of practice to be worked on. It is also recognised that preceptors have an obligation to report issues of competence or behaviour which could negatively impact on a health consumer (Code of Conduct 6.9, 8.5. Nursing Council of New Zealand, 2012).

Specific feedback with detail as to where the standard is not met along with explanation of how to provide evidence of the activity positively in the future, should be provided to the preceptee. Linking the feedback to patient care including quality practices using objective and descriptive terms is also helpful. Pirie and Green (2010) argues that the “Assessor can help the nurse develop a wide range of qualities such as knowledge and skill development with a critical understanding and a professional attitude” and “Educational research has established that assessment can greatly influence the way practitioners learn and with direct observation and feedback, has been demonstrated to raise levels of achievement and promote best practice which would ultimately result in reduced risk to the patients.” (p. 224). Preceptors are tasked with the role of showing how to put theory into practice in a practical way that was meaningful for patient care (Butler et al., 2011).

3.16. Insight

Linked closely to feedback is the concept of insight by the preceptee. Insight is defined by Brown, McAvoy, and Joffe (2014) as the culmination of a set of actions which goes further than simply being self-aware and describes “a readiness to explore intellectually and emotionally how and why I, and those I interact with, behave, think, and feel as we do, and for me to adapt my behaviour accordingly” (p 171). Brown et al. (2014) describe three components which contribute to the development of insight. These are self-awareness involving reflection, possessing emotional intelligence and finally mindfulness explained as a ‘process of noticing’.

The performance of individuals who do not demonstrate insight has been described as static, poor or labile and not consistently reaching or sustaining competency. Research by Kruger and Dunning (1999) suggests that those who perform poorly are often unaware that this is the case. Ehrlinger, Johnson, Banner, Dunning, and Kruger (2008)

confirmed that poor performers consistently overestimate their ability and often do not respond to repeated feedback. However improvements in insight did occur if the individual skill being worked on improved, suggesting that the more learning opportunities led to optimised skill competence and improved insight.

3.17. Approaches to Assessing Continued Competency

A number of ways to undertake competency assessment have been developed with most recent methods using advanced simulation techniques that evolved within undergraduate health education. Randolph et al. (2012) describe high-fidelity simulation “as the use of technology to mimic the clinical environment, where participants can provide comprehensive, realistic patient care, including communication, assessment, clinical reasoning, decision making, procedures, and documentation” (p.542). The move away from preceptee supervision of direct patient care to the simulation laboratory is seen as a way of ensuring patients are not put at risk during competency assessments. Simulation as a teaching and learning skill has been used for a number of years in undergraduate nursing programmes by creating experiential styled learning experiences which are developed to stimulate what happens in a real clinical work environment (Decker et al., 2008; Hagler & Wilson, 2013; Nehring & Lashley, 2009).

Validity of competency assessments through the use of simulation however is in its infancy. Decker et al. (2008) believe additional research is needed to assess the predictive validity of simulation to measure competence. As a tool in competency assessment, simulation must have content validity. This occurs using “scenarios [which] were authentic and subjected to peer review, the simulated experience was designed by experts and evaluations were conducted by professionals trained to use predefined reliable scoring criteria” (p. 122).

Challenges to using simulation include high set up costs including the use of sophisticated electronic mannequins or paid trained actors as patients. Props and equipment are needed to emulate the real practice environment and make the experience as authentic as possible. Due to these high set up costs, simulation assessments of competence may only be viable if organisations centralised simulation centres which then increases the associated costs of travel to a simulation venue. Ongoing costs may also be

high, as new scenario banks need to continually updated, adding enough variation to test across a number of practice specialties.

Once established, the simulation scenario may be used repeatedly and this in itself creates increased validity of this as an assessment tool, and as more nurses are taken through simulation and more evidence the tool measuring their performance is gathered. As the simulation session can be videoed, it provides both an opportunity for ongoing analysis, assessment and feedback. The simulation can assess both preceptee competence and also their performance as a team member within a clinical scenario. Hinton et al. (2012) reports development of a reliable competency testing process using simulation that has been adopted recently by the Arizona State Board of Nursing as a legally defensible process for assessing performance of nurses reported for practice breakdowns. The question still remains: can simulations predict performance in real life clinical situations?

3.18. Summary

The need to ensure ongoing competence within the nursing workforce is undisputed. The task of defining exactly what competent practice means remains murky as the multitude of definitions within the literature indicates. Nursing internationally is still some way off an agreed definition, although this is seen as becoming more necessary as the nursing workforce continues to be more mobile. As global nursing workforce shortages impact there is likely to be pressure to align nursing competencies to allow a freer flowing workforce to meet health care needs worldwide.

Employers need to have a clear way of managing nurses with competency concerns that follow sound employment practices and comply with employment law and regulations. The peer preceptor model provides a way of supporting the preceptee within clinical practice, assessing their competence and providing feedback in real time to enable them to modify their practice. Finally there are new models of competency assessment using simulation emerging that allow practice to be assessed and can be used to prompt reflection and facilitate modification of practice.

The following chapter presents the methodological approach used to evaluate the SIP/PIP framework including the epistemology underpinning the choice of research design.

4. CHAPTER FOUR : Method

4.1. Introduction

"Research is the systematic inquiry that uses disciplined methods to answer questions and solve problems. The ultimate goal of research is to develop, refine, and expand a body of knowledge" (Polit & Beck, 2004, p. 4). This chapter outlines the methodology used for this research project. It describes the epistemological context and explores how the methodology was chosen to answer the research aim which is:

"To use the experiences of preceptee, peer preceptors and nurse managers who have participated in the SIP and PIP framework using evaluation research to identify the modifications and improvements that could be made."

This chapter explores the epistemological approach taken for this evaluation research project. It includes a historical outline of evaluation research, shows the paradigm shift from a primarily quantitative approach to an acceptance of more qualitative methods. This steered the researcher's initial decision to use mixed method methodology with a quantitative approach that attempted to survey preceptees, and enriching this data with qualitative, semi structured interviews with the nurse manager and peer preceptor group. Although a mixed method was attempted it was not completed due to the lack of data produced from the anonymous survey. This will be discussed in the findings and limitations section.

Numerous authors suggest that the researcher needs to understand what underpins the research method to ensure that it is aligned with the researcher's own beliefs and philosophies, understanding the theoretical paradigms from which the methodology is drawn (Crotty, 1998; Denzin & Lincoln, 2005; Gerrish, 2010; Koch & Harrington, 1998; Ritchie, Lewis, Nicholls, & Ormston, 2013). Perhaps more importantly, is deciding which method will best assist them to answer their posed research question.

Denzin & Lincoln (2005), describe this quest for understanding by saying "The gendered, multiculturally situated researcher approaches the work with a set of ideas, a framework (theory, ontology) that he or she then examines in specific ways

(methodology, analysis).” (p.21). Cronbach (cited in Patton, 2002) describes “It is an exercise of the dramatic imagination”, observing that “designing a study is as much art as science” (p. 12).

Patton (2002) provides the following guiding questions for the novice researcher to consider when determining which methods to use. These questions were utilised to help the researcher plan the research project:

- What is the purpose of the inquiry?
- Who are the primary audiences for the findings?
- What data will answer or illuminate the inquiry questions?
- What resources are available to support the inquiry?
- What criteria will be used to judge the quality of the findings?

4.2. What is the Purpose of the Inquiry?

The Supportive Improvement Plan (SIP), Performance Improvement Plan (PIP) framework developed by the researcher has been utilised within a specific District Health Board (DHB) since late 2009. As discussed in the introductory chapters, the framework is being increasingly used to provide an objective consistent process for assessing nurses who may have competence issues and secondly facilitating the development of their practice so she/he can practice competently. Alternatively the process provides evidence that the nurse cannot practice competently despite education and training and should have their employment terminated. That is, there can only be two outcomes from the SIP/PIP process from the employer’s perspective. The first is that the preceptee returns to a competent level of clinical practice. The second is that the SIP/PIP process having provided assessment, targeted education with the view to increasing supplementary knowledge along with peer preceptor support, has delivered objective evidence that the preceptee is not competent to practice. This would lead to reporting to the regulatory body and in some cases the preceptee will have their employment terminated.

The impact the SIP/PIP process has on the participants, being the preceptee, nurse manager and peer preceptor involved in the process. The purpose of this inquiry is to evaluate the framework particularly focusing on those participating in the SIP/PIP framework seeking to discover from their perspective what was effective and acceptable

and what aspects needs strengthening. If the purpose of the inquiry is evaluation, what is known about evaluation research?

4.2.1. Evaluation Research in relation to the SIP/PIP process

Stufflebeam and Shinkfield (2007), describe evaluation research “as a relatively new science that is continually evolving, paralleling the international debates on epistemology and exploring what is valid or credible in the quest for new knowledge” (p. 63). They invite research novices to participate in evaluation research, as it is a young methodology and one that improves with more participants to help inform ongoing evaluation research knowledge.

Evaluation is based on a series of judgements about a process and thus it is noted that evaluations cannot be value free (Stufflebeam & Shinkfield, 2007). Stufflebeam and Shinkfield (2007) go further and emphasise that evaluation of any practice or process needs to ensure that it is achieving what it was set up to achieve. Polit and Beck (2004) expand on this noting that the strengths and weaknesses of the process being evaluated need to be identified, including any barriers that prevent expected outcomes from being met. Salkind (2011) augments this with the view that evaluation using many participant experiences adds richness to the data as each participant’s experience is unique and valid. Patton describes evaluation research as applied research or action science as it differs from other research standpoints in that it does not seek to create theory but rather evaluates to enable, action that leads to an improve and enhance process.

Stufflebeam & Shinkfield (2007) suggest that those managing any process being evaluated are accountable to ensure any evaluation outcomes are presented to decision makers for consideration for implementation. The researcher is in the position to follow up on the findings from this evaluation research project and implement changes leading to improvements in the SIP/PIP process. The final part of the evaluation will include developing recommendations on the evaluation findings for key stakeholders and make available the results to those who have been previous participants to conclude the evaluation process. The researcher can accept positive evaluation feedback that leads to increased confidence in the process, but also must be committed to modify and improve identified weaknesses. Evaluation is valuable as it illuminates new findings or points of view not previously evident. It achieves this through data collection followed by analysis of the data to reveal new knowledge and information (Stufflebeam & Shinkfield, 2007).

Polit and Beck (2004) also note that the researcher needs to be aware and decide the strength of individual feedback versus the overall collective feedback, and ensuring that not one perspective is valued over the other.

Even though evaluation research is recognised as a relatively new method with its emergent theory of evaluation, the researcher must decide what underpins evaluation research's body of knowledge. There have been epistemological challenges related to the merits of qualitative versus quantitative research methods. Evaluators need to have a firm understanding of both paradigms in order to make sound methodological decisions. This understanding of two divergent paradigms helps the researcher to be aware of all methodologies and opens them to using components from both (Clarke 1999).

4.2.2. Historical Perspective of Evaluation Research

An understanding of the history behind the evolution of evaluation research is useful as this method effectively illustrates a paradigm shift in philosophy over its short existence. Stufflebeam and Shinkfield (2007) describe distinct periods in the history of evaluation research.

Suchman (1967) comments that early evaluation research “came to be dominated by the natural science paradigm which extolled the virtues of objective quantitative measurement, experimental research design and hypothesis testing. These procedures constitute what is known as hypothetico – deductive approach to research” (p. 1). At this stage of development, evaluation was undertaken mostly by survey which was interpreted identifying deficits.

In the early part of the twentieth century, the manufacturing sector started to evaluate system design using the concepts of standardisation and efficiency. The education sector followed and adopted the same model to standardise testing to show the effectiveness of education strategies. However, early evaluations were criticised for being dominated by the quantitative paradigm and for using surveys and measurements to evaluate process or programmes, which was seen as being one dimensional. Patton (1987) described using this approach as ‘habit’ and he emphasised the need for greater creativity in the use of methods and a willingness by practitioners to give more consideration to the specific context in which an evaluation is conducted (Clarke & Dawson, 1999).

There were opponents to this method of evaluation, as it did not look towards identifying improvement or endorsing changes to the education curriculum. Tyler's influence on education evaluation from 1930 to 1945 saw the introduction of measuring learning outcomes against objectives (Stufflebeam and Shinkfield 2007). This meant planning for evaluation at the outset when introducing a new curriculum.

By the early 1970's, however, there was recognition that evaluation needed to be conceptualised including a systematic broad approach to consolidate all facets of an evaluation process. Stufflebeam and Shinkfield (2007) point out "these conceptualisations recognised the need to evaluate goals, look at inputs, examine implementation and delivery of services, as well as measure intended and unintended outcomes of the programme" (p.40). This demonstrated a change in paradigm, as more components of qualitative research such as mixed methods, were included within evaluation research to broaden the approach so it could be used in any evaluation.

4.2.3. Quantitative Approach

Traditional evaluation research sits within the positivist era, whereby scientific truths are seen to exist and able to be proven through experimentation, and controlling variables to demonstrate an outcome thereby providing empirical evidence. Quantitative evaluation research is based on what can be measured or observed.

Guba (1981) explains that quantitative methods hold to a number of principles. They sit within a science-dominated field that seeks to find out what is happening or establishing the truth. This positivist approach exalts that there is only one version of the truth. Clarke and Dawson (1999) suggest that "by following rational methods of empirical inquiry the social researcher can find regularities and relationships and discover the causes of social phenomena. This is how truth is established, by the application of rigorous and systematic scientific investigation" (p. 7). Secondly the quantitative approach also believed that to ensure the validity of the research, the researcher must be separated from what is being researched, thus removing bias. Scriven (1991), describes this as a summative evaluation where the goal is to find out if the programme being evaluated meets its objectives, through endorsement of the programme if the evaluation is positive or ceasing the programme if it is negative.

If the researcher applied a solely positivist style approach to the SIP/PIP evaluation this would only consider evaluating the outcomes of the SIP/PIP framework (Table 4). This illustrates how a one dimensional view could be formed and would miss the impacts and views of the participants working within the framework which are equally important to evaluate.

Table 4 – Does the SIP/PIP Framework Meet Its Objectives Using A Quantitative Approach?

Organisation

Meets organisation's needs including transparent measurable process with outcome:

a) Preceptee returning to competence

or

b) Preceptee objectively measured as incompetent with well documented evidence and employment terminated and reported to regulatory body. (Problem solved).

Nurse Manager

Proactively manages preceptee, evidence of competence/incompetence documented, and dovetails in with HR process to progress to restoration of competence or removal from workforce.

Peer Preceptor

Framework provides guidance to peer preceptor on how to carry out the preceptor role and is reliable and replicable.

Preceptee

Identifies issues, is transparent, and based on a supportive approach.

Using a primarily quantitative approach, there are limitations as a solely quantitative approach is focused on outcomes not the experiences of participants to meet those outcomes. It was important to the researcher to look at possible side effects either (intentional or unintentional) for the participants. For example, what is the emotional impact on the participants? Are there any long lasting effects from the process on any of the participant groups? If the peer preceptors and nurse managers are involved with future SIP/PIP processes, how does this influence or impact on the experience provided to future preceptees?

4.2.4. Qualitative Approach

The second major research paradigm is described as qualitative or naturalistic research. At a simplistic level it seeks to understand human relationships, human behaviour and interactions between people. This paradigm acknowledges more than one truth. “The qualitative paradigm sees reality as constructed by the complex set of meanings people attribute to their experiences acknowledging there can be multiple truths whereas the quantitative paradigm holds that reality is known at a fixed point and that can be objectively measured”(Gerrish, 2010, p. 333).

The task of the qualitative researcher is to develop insight and understanding. It supports the evaluator getting close to the data in order to understand and describe the participant’s point of view (Clarke & Dawson, 1999). Stufflebeam & Shinkfield (2007), acknowledge that a summative evaluation process would provide descriptive information, which would enable an evaluation of the SIP/PIP’s effectiveness by assessing goals, outcome objectives, operational effectiveness and costs. But more significantly they believe in the importance of the judgements made by the evaluator as part of the evaluation. Taking a qualitative approach outlined in Table 5 demonstrates that there is no evaluation to date considering the impact on those who participate in the SIP/PIP process.

Table 5 – Does the SIP/PIP Framework Meet Its Objectives Using A Qualitative Approach?

Organisation

Not formally evaluated.

Nurse Manager

No complaints logged regarding the SIP/PIP framework to date.

Peer Preceptor

No input to SIP/PIP development except for participation, no issues raised through Nurse Manager.

Preceptee

Variable oral informal feedback.

4.3. Who are the Primary Audiences for Findings?

4.3.1. Utilisation Focused Evaluation

Patton (1987) values evaluations that are useful, practical, ethical and accurate. The primary criterion for judging such evaluations is the extent to which intended users actually use the findings for decision making and programme improvement. Evaluations should lead to change and improvement rather than just the completion of reports and analysis where “focus must be placed on identified potential users of the program being investigated so that user orientated evaluation will give the opportunity for practical effective outcomes” (p. 10). The primary audience for the evaluation research findings are nursing leaders that use the SIP/PIP as part of employment procedures both in the DHB setting and the private sector who may benefit from the evaluation of this framework. It is likely that the regulatory body may also have an interest in the findings as they have recently reviewed NCNZ competency processes which, although independent to the SIP/PIP process, may potentially interact with some of the participants of SIP/PIP processes.

It is possible that the framework could be adapted for use by other health professions such as Allied Health or Medical professionals who work under the HPCA, using their individual regulatory standards to guide the process, or non-professionals where a job description would substitute for the regulatory guidelines. Other groups likely to have interest in the framework are the participants in the process such as the preceptee, preceptors and nursing managers and any professional advisors to nurses including union organisations.

4.4. What Data will Answer or Illuminate the Inquiry Questions?

Choosing a method that will best answer the research question is key. Following a review of both major paradigms it became apparent that both methods have merit, but choosing one over the other could lead to vital data that would more fully answer the research question being missed. A mixture of both methods provides a more comprehensive approach attempting to gather the experience of all participants including those most directly impacted by the SIP/PIP framework being the preceptees.

4.4.1. Mixed Methods

Acceptance is growing for researchers to not have to conform to just one paradigm either qualitative or quantitative, but to consider what is becoming known as the third paradigm of mixed method research (Johnson & Onwuegbuzie, 2004).

Mixed methods offer a broader set of tools to unmask themes and for this evaluation to provide a better understanding of context and process of the SIP/PIP and the influence these might have on whether or not the framework is effective. As Gerrish (2010) comments “The simplistic characterisation of disciplines is becoming less relevant as more researchers recognise the legitimacy and value of different forms of knowledge and methods required to generate new understandings” (p. 333). Thus the mixed method approach is seen as less restrictive and more open to understanding the complex interactions of processes that such as the SIP/PIP employ.

Indeed, mixed methods is considered to take a pragmatist approach to research as (Johnson & Onwuegbuzie, 2004) explain:

“that consideration and discussion of pragmatism by research methodologists and empirical researchers will be productive because it offers an immediate and useful middle position philosophically and methodologically it offers a practical and outcome orientated method of inquiry that is based on action and leads iteratively to further action and the elimination of doubt and it offers a method for selecting methodological mixes that can help researchers better answer many of their research questions (p. 17).”

Sandelowski (2000) observed that “mixed method studies are not mixtures of paradigms of inquiry per se, but rather paradigms are reflected in what techniques researchers chose to combine and how and why they desire to combine them” (p. 247). She considers that the researcher should declare which is the dominant paradigm and then state how each approach is going to be timed in the study, either sequentially or consecutively.

There are pros and cons when considering using the mixed method approach. Firstly the researcher needs expertise or knowledge on both methods to understand how to carry out each component of the study. Results and findings when using mixed methods may mean those purists who firmly sit within either of the other two dominating

paradigms may not accept the research method as being valid, thus making the findings not acceptable. This could also be further compounded if both methods are executed poorly, therefore not maintaining research quality within each method (Gerrish, 2010; Polit & Beck, 2004). As Sandelowski (2000) noted previously, there is agreement that mixed methods can be acceptable to people holding to one particular paradigm or not supported by either. Gerrish (2010) suggests “mixed methods may be the way of transcending the paradigm wars” (p. 334). Integration of methods adds value, bringing together insights gained from both methods.

The researcher initially chose mixed method methodology, as it offered flexibility to evaluate the two groups in differing ways. A mixed model approach appealed due to the difference in the perspectives of those using the framework. Salkind (2011) reported that a researcher must use all of the tools available to them to optimise answering the research question as broadly as possible.

4.4.2. Anonymous Survey

The choice of anonymous survey using the online tool survey monkey to gather data from the preceptee group was made with consideration of the above ethical points. In order not to harm this group, the researcher believed that the preceptee needed a different more sensitive method to attempt to gain understanding of their views of the framework. The choice of an anonymous survey would have allowed them to participate without fear of recognition. In choosing the survey approach with pre-selected questions and rating scales, the researcher was drawing on the benefits of quantitative methodologies that put some distance between the researcher and the researched. In addition, the survey method meant that participants were less likely to inadvertently expose their identity.

4.4.3. Semi-Structured Interviews

Whilst the anonymous survey was to provide some distance for the preceptees, this was not seen as the most effective method to explore the perceptions of the nurse managers and peer preceptors. For these two groups the topic was considered to be less personally sensitive and therefore qualitative methods could safely be used to obtain richer data. Power relationships were able to be managed through the use of third party recruitment and interviewing.

4.5. Ethical Considerations

Ethical approval for this research was granted by Otago University Ethics committee in August 2013, ref number 13/211. Approval to undertake the study was also gained from Health Research South (HRS), a collaborative body which manages the research partnership between Otago University and the DHB. Broadly, ethics pertains to doing ‘good’ and avoiding ‘harm’, (Orb, Eisenhauer, & Wynaden, 2001). It is about awareness of consequences, both intended and non-intended. The research proposal and formulation of the project and methodical approach chosen by the researcher were specifically designed to protect participants, whilst allowing them maximum opportunity to express their views of the SIP/PIP framework.

Qualitative research uses relationships between the researcher and the participants to capture the thoughts and feelings and experiences of these participants. The researcher must be aware of the power invoked by the researcher as the relationship is formed to extract data and the relationship goes on to analyse the participants’ experiences to form knowledge or in this case an evaluation of the SIP/PIP process.

The interview as a technique to obtain data can be a place where power of the researcher dominates. The interviewer sets the scene and in semi structured interviews, they dictate the flow and direction of the interview. Due to this recognised power, the researcher acknowledged the potential for this power to influence those participants that she professionally leads. The HRS peer review recommended that interviews with those participants who work within the researcher’s practice area were undertaken by an independent interviewer, thus separating the researcher from the process to avoid any perceived risk of coercion. To mitigate this, the introduction of the independent interviewer was thought to offer protection to participants in the researcher’s practice setting. It was estimated that the researcher would undertake approximately fifty percent of the interviews, on participants who worked in all other areas apart from the researcher’s own practice locality.

In addition, a third party was asked to undertake the management of recruitment into the study on behalf of the researcher. The third party was a Human Resource (HR) advisor from the DHB who managed the initial participant database and sent out email

invitations to all potential participants. This provided another layer of separation between the researcher and participants.

4.5.1. Beneficence and Power Relationships

The concept of beneficence: ‘Do no harm’, is a pivotal consideration in the evaluation of the SIP/PIP process. The current SIP/PIP framework is being utilised on a regular basis at the DHB and would continue in the absence of any issues being raised by participants or staff administering the process. The researcher was acutely aware that the SIP/PIP process benefited the organisation. She wished to provide an opportunity for the preceptee, nurse manager and preceptor to reflect and contribute to any evaluation of the process by raising concerns or identifying strengths of the process.

The researcher was aware that interviewing the preceptee group could be distressing, particularly for some preceptees if the process had been career changing. Yet she wanted to provide them with an opportunity for their views to be heard, gaining their perspective. The intention was to hear their view through an anonymous survey creating a distance from the researcher capitalising on the strength of quantitative research methods with the researcher being separate from the data collection. A solely positivist supports the researcher to remove themselves from the research and be a non-active participant. Karnieli-Miller, Strier, and Pessach (2009) endorse that this traditional research focus between the researcher and participants should maintain a “dichotomous, unequivocal constant uniform and predetermined interaction” (p. 280).

With the second arm of the study using semi structured interviews, this would be impossible to achieve as the researcher has a vested interest in the SIP/PIP process and is unable to remove the knowledge of the frameworks underpinnings from influencing data gathering by the qualitative method. It is recognised that the relationship between the researcher and the participant is different in every individual interaction and is dependent on the researcher’s worldview, professional standpoint, their epistemological approach and methodology (Karnieli-Miller et al., 2009).

The motivation to undertake the research is an important stance for the researcher. In a highly professional role, the responsibility for protecting public safety is paramount, ensuring nurses provide a quantifiable standard of work practice. However, nurses are both professionals and individuals and any system that grades or evaluates them is likely

to have an emotive factor in application influencing how this is carried out. It is important to the researcher that the SIP/PIP process not only benefits the health organisation, but does no harm to those that participate in it, either as a preceptee undergoing the framework, or nurse manager and peer preceptors administering the framework. Being overt about this motivation is important in providing insight into the researcher's approach and methodological choice.

The researcher holds a Director of Nursing position in the DHB and acknowledges that she developed the SIP/PIP framework for use in the DHB. She has administered, overseen and supported nurse managers and preceptors in the SIP/PIP process. She is not the line manager for any of the nurse managers or preceptors. She has worked with nurses who have competence to practice issues who have both been supported back to competent levels of practice and those that have been unable to demonstrate competence and have been through a disciplinary process, with some having their employment terminated and reported to the regulatory body. Insight into the position the researcher has and the potential for power imbalance is recognised and acknowledged, with steps taken to recalibrate and lessen the risk of abuse of this power as stated in the ethical consideration section.

Karnieli-Miller et al. (2009) acknowledge that those that participate in research are capable of free will and choice, having varied reasons for participation. Some will contribute from an altruistic approach, wanting to help make the SIP/PIP process as best as it can be. Some may want to make their views known about what can be added, altered or removed to improve the process. Some will have no formed view and will just tell their story, leaving the researcher to interpret their view and combine it collectively with others to provide insight and evaluation and some may exercise their right to not participate in the study. The data collection phase is dependent on the participant's willingness to share and contribute to any degree they wish. The researcher at this point has to accept what is presented to them by the participants. The researcher can ensure that the participants feel as comfortable to share their views or experiences as possible.

Finally data analysis is where the researcher has the power of interpretation and can decide what to include or not in their findings. A researcher must honour their commitment to tell the participant stories and in the case of evaluation research, giving strong consideration to changes to improve the process or accept endorsement for what is working well. "Overall the primary moral research obligation is to the participants and

their welfare which can be achieved only through nonjudgmental analysis and writing” (Karnieli-Miller et al., 2009 p. 286). Kvale (2006) on qualitative research concurs:

With the close personal interaction of qualitative interview and the potentially powerful knowledge produced, ethics becomes as important as methodology in the interview research. Interviews are a sensitive and powerful method they are in themselves neither ethical nor unethical neither emancipating nor oppressing. Critically, social science interviews may contribute to the empowerment of the oppressed (p.497).

Interpretation bias can be lessened by getting the data independently coded to check that themes drawn align with those identified from the researcher.

4.5.2. Informed Consent and Confidentiality

Informed consent is a cornerstone principle in health provision and health research. Ensuring that all participants were fully aware of what the research entailed, including how it would be undertaken and by who, was pivotal to the participants being able to make an informed choice to participate. A full outline of the study was provided in an information sheet (Appendix D). This was sent out via email invitations seeking participation. The invitation included a declaration of who the researcher was and her role in the organisation. Participants were able to exert their rights as an autonomous person to voluntarily consent to participate or refuse without fear of any consequence.

In addition further steps to maintaining confidentiality included the researcher being blinded to the participants who were interviewed by the independent interviewer, including not having access to the taped interview recordings where voices may have been recognisable. Transcripts for that group were only accessed when they had been de-identified and had pseudonyms applied.

Group One - Preceptee Survey Group

As the survey was anonymous and delivered online, implied consent was considered given if the preceptee returned the completed survey. The researcher ensured that the information sheet for this group clearly outlined the purpose, the information about how the study data was being gathered and the requirements of the participants and

information on independent supports to help preceptees make an informed decision on consenting to participate in the study.

Group Two - Peer Preceptor and Nurse Manager Semi Structure Interviews

This group received an invitation email requesting them to read an attached study information sheet. (Appendix D). A written consent form (Appendix C) was provided with the initial invitation, which was reviewed again with the participant prior to the interview.

The transcribed interviews were returned to the participants for checking to ensure they were happy with what they had disclosed. Prior to returning the transcripts, participants were informed that this was their last opportunity to withdraw from the study. Providing an opportunity to check the data collected allowed the participants to review what they had said had been accurately reflected in transcripts and confirm that they were satisfied for the information to be included in the analysis. There were minimal adjustments made to the transcripts and no participants withdrew from the study.

One unintended response occurred whereby another Nurse Director was asked when the researcher was going to return the interview transcripts for checking. There had been a delay of over two weeks when the transcriber was most busy, with both interviewers carrying out interviews within a three week period. This request provided confirmation to the researcher that the participant felt comfortable with self-identifying their participation in the research. It also reminded the researcher that participants might expect a quick turnaround of the interview into a transcribed form, alerting the researcher ensuring in future that the participants are kept up to date with any delays in timelines outlined.

4.6. Methods of Collection and Analysis

4.6.1. Data Protection

Data in the form of taped interviews and transcriptions of the interviews were kept in a locked filing cabinet, in a secure room, which had security level swipe card access. The transcriber was a professional who was aware of the confidential nature of the

information she was transcribing and signed a confidentiality agreement. The raw data is kept for ten years by the university as is outlined in their research policy and guidelines.

4.6.2. Venue

Participants could choose where they would be interviewed. Both the researcher and the independent interviewer were prepared to go outside of the workplace to the participant's home or alternatively use a private office in the DHB. Providing a choice of venue was an opportunity for the participant to exert control over part of the process. Most participants preferred to be interviewed within the workplace. The use of a meeting room in the workplace was acceptable as most nurse manager and preceptor participants viewed it as neutral ground and a non-threatening environment.

4.6.3. Interview Technique

Interviews were recorded on a digital recorder and downloaded following each interview. A selection of prepared baseline interview questions was used for each group and provided guidance to ensure that the novice researcher covered specific questions with each participant. However every interview was unique as the flow and questioning was guided by the answers provided by the participant. Brief field notes for future reference were made by the researcher following each interview.

Light refreshments were offered at each interview to assist with making sure that the participant was comfortable. Developing rapport with each participant was relatively simple as the researcher outlined the reason for the study. The interviewer checked that the participant was still happy to consent and that this documentation was in order. The first question was "Tell me about how you would describe the SIP/PIP process to a new nurse manager or preceptor?" This allowed the interviewer to explore if the participant had a good understanding of the SIP/PIP process.

4.6.4. Sampling

Nurse Manager and peer preceptor groups were chosen using a purposeful sampling technique. A total of 12 participants were initially sought to take part in the

semi-structured interviews. A mixture of nurse manager (6) and peer preceptors (6) was seen as giving a spread of perspectives.

The DHB Nurse Director group identified those preceptees that had participated in SIP/PIP processes over the last three years and developed a database of potential preceptee interviewees. A total of 18 preceptors and 16 nurse managers were identified as potential participants.

The third party HR advisor used the purposeful sampling process, selecting participants from a wide range of work areas and managing the spread of the participants providing an equal mix of nurse managers and preceptors.

Following the initial interviews, a further preceptor and a nurse manager who had been on annual leave self-identified as wanting to participate in the research. Due to the small sample size and the willingness of the participants to be interviewed, and following consultation with the researcher's supervisors, it was agreed that the extra interviews would add value to the data set. The final total was 7 nurse managers and 7 peer preceptors totalling 14 interviews where undertaken by the researcher and independent interviewer.

4.7. Data Analysis

4.7.1. Thematic Analysis

Qualitative data gathered from the semi structure interviews produced a large raw data set and the researcher chose thematic analysis as a way of extracting evaluation themes and ideas. Braun and Clarke (2006) state the purpose of thematic analysis is to identify patterns of meaning across a dataset that provides answers to the research question. They state patterns are identified through a rigorous process of data familiarisation, data coding, and theme development and revision.

This general inductive approach is noted for condensing raw data, establishing links between the research question and the summary of findings, and enables interpretation, in this case evaluation of the process (Thomas, 2006).

Thomas (2003) discusses the appeal of a general inductive approach, as it is pragmatic and simple to follow, and provides an excellent foundation of basic research analysis skills for the novice. Another advantage is the flexibility of the process as it is not associated with any one 'branded' qualitative methodology (Braun & Clarke, 2006). They go on to suggest that clarity of the process, and practice of the method is vital and

outline a distinct six steps process which can be used to guide the researcher, see Table 6.

Table 6 – Phases of Thematic Analysis (Braun and Clarke, 2006)

1. Familiarisation with the data

This phase involves reading and re-reading the data, to become immersed and intimately familiar with its content.

2. Coding

This phase involves generating succinct labels (codes!) that identify important features of the data that might be relevant to answering the research question. It involves coding the entire dataset, and after that, collating all the codes and all relevant data extracts, together for later stages of analysis.

3. Searching for Themes

This phase involves examining the codes and collated data to identify significant broader patterns of meaning (potential themes). It then involves collating data relevant to each candidate theme, so that you can work with the data and review the viability of each candidate theme.

4. Reviewing Themes

This phase involves checking the candidate themes against the dataset, to determine that they tell a convincing story of the data, and one that answers the research question. In this phase, themes are typically refined, which sometimes involves them being split, combined, or discarded.

5. Defining and Naming Themes

This phase involves developing a detailed analysis of each theme, working out the scope and focus of each theme, determining the ‘story’ of each. It also involves deciding on an informative name for each theme.

6. Writing Up

This final phase involves weaving together the analytic narrative and data extracts, and contextualising the analysis in relation to existing literature.

Reproduced with permission from publisher: (Braun and Clarke, 2006, p.87)

Although these phases are sequential, and each builds on the previous phase analysis is typically a recursive process, with movement back and forth between different phases. It is not rigid, and with more experience (and smaller datasets), the analytic process can blur some of these phases together.

To help manage the dataset the researcher used NVIVO 10 for Mac Beta (www.qrs.international.com) a computer software tool used by qualitative researchers to help organise data collected from interviews. Data can then be extracted from transcripts and arranged into nodes that are containers for coding ideas and which in turn help to more easily identify themes from the data.

4.7.2. Coding and Themes

Initial coding led to a total of seventy four individual nodes being identified, which were then further refined into twenty seven sub codes. This first cut of nodes was primarily descriptive in nature capturing each differing idea as a node category. At this level of analysis, the data is still cumbersome and does not allow any level of interpretation of the data beyond description. As suggested by Braun & Clarke (Table 6, point three), re-reading the codes allows for greater familiarity with the data set leading to further fine-tuning with nine definitive themes identified in Appendix A. A thematic tree was formed to illustrate how each primary node was reviewed into secondary sub codes, which is outlined in Appendix A. An example of how initial nodes were refined further until themes were evident is provided in Table 7.

To check that coding was interpreted validly, all nodes with descriptors were printed off, cut up and re-sorted back into themes to ensure that consistent categorisation of the nodes into themes had occurred. The thematic tree (Appendix A) shows how the thematic analysis process was undertaken.

Being a novice researcher, peer scrutiny and regularly meeting with experienced supervisors added further validation of the analysis process. This included an independent check by an experienced nurse researcher who was familiar with thematic analysis of coding of a set of transcripts to make sure that nodes were identified in a similar way.

Following supervisor input and with a final refinement process, four major consistent themes were developed for inclusion. The final themes were feedback -insight loop, process clarity, relationships, commitment & reflective responses to participation in the SIP/PIP and rewards, barriers and enablers to implementing SIP/PIP.

Table 7 – Example of Coding Development

Theme	Secondary node	Primary node
Barriers & Enablers to implementing SIP/PIP	Difficulty in operationalising supernumerary time	Nurse manager barrier to creating supernumerary time due to rostering constraints

4.8. What Resources are Available to Support the Inquiry?

Employer support and approval for the research project was sought from the Executive Director of Nursing of the DHB to provide endorsement for the research to be undertaken within our nursing workforce. She also supported the Health Research South application within the DHB setting. The Human Resource department allocated an HR resource person to act as third party contact for participants in the interview process. The independent interviewer was sourced from within the nursing resource of the DHB and the transcriber was part of nursing clerical resource pool.

4.9. What Criteria will be used to Judge the Quality of the Findings?

The goal of any researcher is to “create a research strategy capable of producing meaningful findings” (Clarke & Dawson, 1999, p.36).

Key concerns of the quantitative paradigm are reliability and validity. Whittemore, Chase, and Mandle (2001) state “Reliability refers to the stability of the findings, whereas validity represents the truthfulness of the findings” (p. 523). Lincoln and Guba (1985) responded to the need to convince the dominant and somewhat hostile scientific community about the merits of qualitative research by linking validity to credibility external validity to transferability, and reliability to dependability. However Koch & Harrington (1998) question whether the rules of judgement of one epistemology applicable to another?

Whittemore et al. (2001) states “Validity cannot be assumed and presentation of research findings must invite the opportunity for critical reflection by consumers” and goes on to say “Validity is not an inherent property of a particular method but pertains to the data accounts or conclusions reached by using that method in a particular way for a particular purpose” (p. 526). So the debate for researchers using mixed methodologies is that with both paradigm’s criteria need to be met and outlined carefully, but identified a single set of criteria does not necessarily justify each portion of knowledge gained.

It was hoped that by using a mixed method approach with both the anonymous survey data gathered from the preceptees and the interview data from the nurse managers and preceptors would enable a broader analysis. Both these arms of the research were undertaken simultaneously. It was envisaged that this would provide an opportunity for triangulation of all data. Triangulation is carried out by examining the research question from more than one perspective, utilising selected parts of each methodology to enrich the data and in the analysis, and produce a new perspective that may not have been revealed through a single methodology. Alternatively it may produce similar findings, which increases their validity across the two paradigms (Foss & Ellefsen, 2002). As will be discussed in the upcoming results section, there was no meaningful data collected from the quantitative survey. Although it is not possible to triangulate the data by this means, it is possible to review the quality of the findings from the qualitative interviews.

Guba (1981) outlined four criteria for measuring the worth of qualitative research findings. These are creditability, transferability, dependability and confirmability. Firstly the credibility of findings is demonstrated in a number of ways. The structure of the interview questions meant that all participants were asked similar opening questions to allow standardisation of the initial phases of the interview. However, each interview was unique. Through the use of open ended questioning, and following up on threads of information provided by the participant, the data was further enriched. Each interview built on the last, where interesting points raised in one interview could be added to the next, checking on any resonance with the later participants.

The use of an experienced independent interviewer helped to improve the ethical acceptance of the research, but also strengthened the credibility of themes that came from both interviewer sources of data collected. Shenton (2004) believes “individual viewpoints and experience can be verified against others and ultimately a rich picture of the attitudes needs or behaviour of those under scrutiny may be constructed based on the

contributions of a range of people” (p.66). This was achieved by obtaining the views of both participant groups directly involved with the delivery of the SIP/PIP process and through the transcription validation process.

Transferability describes how well the research findings can be applied to other situations. Shenton (2004) goes on to say that “findings of qualitative project are specific to a small and particular environments and the individuals” (p.69), making it impossible to transfer findings onto other discreet populations or situations. Guba (1981) outlines that although the researcher has an obligation to provide as much contextual information regarding the situation the research is undertaken, including a description of the participants, ultimately it becomes the report reader’s responsibility to make any decisions about transferability. Shenton (2004) supports this saying “Ultimately the results of a qualitative study must be understood within the context of the particular characteristics of the organisation or organisations and perhaps the geographical location in which the fieldwork is carried out” (p.70).

Dependability is increased through clearly outlining in detail how the research was undertaken. Researchers wanting to replicate this study are able to use similar methods. Notwithstanding that, the results will be individual to the context, situation, time and participants. In this report the method is soundly outlined and provides the reader with the information needed to undertake a similar design. The researcher’s contact details are provided for those wishing to have further detailed information.

The final point is confirmability of the findings of the overall evaluation have been have been accurately extracted and interpreted from the raw data set.

4.10. Chapter Summary

This chapter has outlined the epistemological and theoretical perspectives considered by the researcher. The value of both the quantitative and qualitative methods were evaluated to decide which method was best suited to answering the research question and provide the richest data for interpretation and thematic analysis to allow an evaluation of the SIP/PIP process to occur.

A mixed method was chosen as it was felt this would capitalise on the strengths of both methods, and because each method was more logically suited to one of the participant groups.

Ethical considerations led to changes in the approach used for data collection to ensure particularly the group of participants from areas that the researcher interacted directly, were undertaken by an independent interviewer. Utilisation of Patton's (2002) guiding questions helped the researcher plan the research project. The results and findings of the study are presented in the next chapter.

5. CHAPTER FIVE : Findings and Analysis

5.1. Introduction

This chapter presents the results of the quantitative preceptee survey and analysed findings of the qualitative research arm using information drawn from interviews with nurse managers and preceptors to evaluate the SIP/PIP process. The four major themes drawn from the thematic analysis are outlined in preparation for discussion and recommendations in the final chapter.

5.2. Results of the Anonymous Survey for Preceptees

The results of the Survey Monkey were disappointing, with no responses recorded in the Survey Monkey repository, other than the researcher's test response to ensure that the electronic link was viable. At two weeks with no responses, a second email was sent out reminding people of the study invitation and resending the Survey Monkey link. The Survey Monkey was kept open for a total of three months to ensure every opportunity for preceptees to participate. At the end of the three months the Survey Monkey was disabled as no responses were recorded. Potential reasons for this poor response are examined in the discussion chapter along with limitations that this brought to the overall study.

5.3. Results of Semi-Structured Interviews

A thematic analysis was undertaken from the interview pooled data collected from both participant groups; nurse managers and preceptors four major themes were identified which form the basis of the evaluation and recommendations. Interview excerpts are used to support explanation of the major themes and sub themes. The four major themes are:

- Feedback - insight loop.
- Process clarity.
- Relationships, commitment & reflective responses to participation in the SIP/PIP.
- Barriers and enablers to implementing SIP/PIP.

5.4. Theme One : Feedback and Insight Loop

Feedback-insight loop refers to the process of the preceptee developing insight into his or her practice through regular feedback received as part of the SIP/PIP. The concept of the feedback insight loop was identified from the data as being an essential component of the SIP/PIP process by both groups of participants.

Three subthemes were identified. The first subtheme was the timing of feedback given, with feedback in real time seen as the most valuable form of feedback, leading to the development of insight by the preceptee. However, the feedback provided at the daily meeting between the preceptor and preceptee that gave more time for reflection on the day's practice and as a whole, was also seen as important.

The second subtheme revealed both nurse manager and preceptor reactions about giving feedback to the preceptee. Both groups felt some initial discomfort if they were not experienced in providing direct feedback around performance. Both groups expressed a growing confidence in their ability to give feedback using the SIP/PIP framework, which gave validity of usefulness to the SIP/PIP process.

The final subtheme identified how feedback helped develop preceptee 'insight' in the preceptee and acted as an indicator for predicting the preceptee's successful improvement in performance during the SIP/PIP process.

5.4.1. Feedback to the Preceptee

The first component of the feedback - insight loop, was the importance of feedback to the preceptee through assessment about their clinical performance. The way in which feedback was provided to the preceptee and the timing of the feedback were commented on by both interview participant groups.

Both groups interviewed felt that the SIP/PIP process provided an opportunity for have meaningful discussions about the preceptee's practice. It gave a sense of permission for the preceptor to be honest in what they were seeing in clinical assessments. This endorsement of the preceptor role in the SIP/PIP process empowered preceptors who felt they had implied support with the SIP/PIP process and the notion of carrying this out in

the preceptee's best interests offered a true and genuine desire to help assist them back to a competent level of practice.

"I mean they [preceptee] are probably going to feel for a start taken aback that there's issues maybe if they're not aware of them... but hopefully it is sort of explained to them in a way that these are the bottom line things that need to change and what we need to do to change those in a more supportive way than might have been done 20 years ago." (Nurse K, nurse manager)

"It certainly gave them [preceptor] more...not just responsibility but more authority ...not only the individual but with the process, actually gave them more ability to say what was acceptable and what was not. So I certainly felt that with the one preceptor that their confidence with stepping forward and saying what was acceptable and what wasn't certainly grew through the process." (Nurse G, nurse manager)

"Mostly I have had a good rationale for everything that I've had to say and people have taken it in the intent that it was made. Actually one nurse said to me that I'm glad you said that to me because I never realised that was how I was presenting myself." (Nurse E, preceptor)

5.4.2. Feedback in Real Time

Timing of feedback was suggested as significant by both interview groups. Feedback in real time was seen as the most beneficial way for the preceptee to benefit from the content of the feedback, and had the most positive effect if the preceptee needed to adapt their practice or behaviour. Real time feedback given while practice was being observed help the preceptee to connect their practice to the effect or impact on the patient.

"Oh vital. It has to be right there and right then, because then it gives them a chance to do something about it. ...if you've only got a couple of weeks, you can't wait a few days in because you've wasted a few days then." (Nurse E, preceptor)

“You should give your feedback immediately because it’s a bit like disciplining a child - if you do it at the time you’re going to remember it. ...if I am corrected at the time I will remember it and it gives you time to improve there and then or you can ask for more help. And if you leave it then you know you’ll think why you didn’t tell me that before.” (Nurse C, preceptor)

Preceptors observed that giving feedback in real time helped to minimise the arguments or the validating some preceptees did if feedback was not given until the end of the day or at weekly meetings. Preceptors reported that they felt delay in giving feedback led some preceptees to over reflect, which was seen as burdensome and not productive to gaining insight.

“If you give the feedback in real time, people can take that on board and they haven’t got the time to sort of reflect and perhaps generate the ifs and buts and excuses for not. What they tend to do is to sort of accept the feedback and have that as their reflection. If you wait until the next day what I’ve seen is that people have thought about it for themselves and they have come up with their own reasons why things didn’t happen, so they’re reflection is almost a negative opportunity as opposed to a positive opportunity.” (Nurse J, nurse manager)

“I think it’s very useful... if you address it a week or even a day later some of the other contextual things get lost... like the ward was busy or that’s right the phone was ringing at the time when I had to go do that so therefore the drugs were later, or things like that will get lost and forgotten about and then the story just becomes a bit more distorted. Or there’s more chance for the participant to sabotage perhaps the feedback. So I think the real time feedback is really good.” (Nurse K, nurse manager)

Interview participants believed that none of the preceptees wanted their deficit in clinical practice to harm a patient or delay effective treatment and this was a powerful motivator for reflection and improvement. When giving feedback in real time maintaining patient safety was the overarching principle with all preceptors commenting that this had

to be guaranteed, ensuring the preceptee's care would be monitored and there would be certainty that the patient remained safe at all times.

“There was a nurse for instance who was doing a PICC line dressing with my educator and she said her sterility was absolutely atrocious and the educator, because of safety of the patient thought she needed to just say “look you need to change your glove don’t you?”, which she did, she gave the feedback straight away because she, [preceptee] could have gone and done another one, working on that sterility straight away because that is very important. So if you’d left it until the end of the week to catch up with her, it wouldn’t be fair on the nurse at all, and she wouldn’t probably have even remembered it, and why she did and how she did it.” (Nurse A, nurse manager)

Preceptors felt that where it did not compromise the nurse/patient relationship, or embarrass the preceptee, that feedback in real time was the easiest and the most effective way to help the preceptee gain insight. Most thought it only fair to give any feedback as the care was being provided, thus allowing the preceptee to work on the feedback throughout the rest of the shift. Positive feedback was seen as a strong motivator, enriching the preceptor/preceptee relationship. Preceptors believed this meant that many opportunities for giving feedback given were utilised. It was acknowledged that the busy workloads could lead to some lost opportunities for feedback, if feedback was only given at the end of the day.

5.4.3. Feedback at the End of the Day

Although feedback in real time was preferable, there was still value seen in the short feedback meeting at the end of the shift. This meeting provided a more relaxed, dedicated time to undertake an overview or summary of the whole shift and helped the preceptor and the preceptee create goals or identify things to work on for the following shifts. Some preceptors felt that the preceptee had more opportunity to raise things from their perspective at this meeting, helping to keep a balance within the relationship. The meeting at the end of the day provided a chance to recalibrate the process, balancing what

was working well with what needed to be improved and settled the relationship so that the next day was viewed as a clean slate.

“It just gives that nurse an opportunity to have a voice every day so that I know they are getting from me what they want and I can hear their opinion on how they think I am precepting them and anything I’m doing that’s not fair and it’s also a chance to tell them what they have done well and to tell them if there are any issues and it can be tricky but I have found that it works well and it sets you up well for the next day as well because you’re all on the same page and it’s totally important to have that honesty”. (Nurse E, preceptor)

Creating time at the end of the day to meet was an issue for some SIP/PIP teams. Some teams had modified the framework, opting not to meet at the end of the shift. Reasons for this included delays in getting off shift on time and/or preceptee unwillingness to attend the meeting. This also appeared to coincide with the scoring system not being used. Preceptors commented they wanted more clarity about the end of shift meeting time including whether they would get paid overtime if the meetings went on longer than the regular shift end time.

Interviewer B: “Did you meet with her at the end of the everyday and give her the feedback?”

Nurse L: Not every day. No. It’s not practical to do it every day.

Interviewer B: ... So tell me about why it’s not practical?

Nurse L: Well with this girl, she was always keen to get off at half past three, so she did need to get home to her small children. Often I was waiting until four or half past four for her to finish writing which, because that was part of the issue was the documentation, before you could then talk to her about it. Often I would actually just sign it and come back the next day and actually look at it and go over it with her. So actually she did get feedback but often it wasn’t at the very end of the day.” (Nurse L, preceptor)

Some preceptors commented that if the SIP/PIP was not progressing positively then the meeting at the end of the day was more fraught, with conflict situations arising

that were seen as having created more negative feelings. Some preceptors felt this added to their stress levels.

“I think it was more about giving feedback. I found that quite hard because most of it was negative, because normally you try and do the ‘shit sandwich’ with the positive and when it’s all negative it’s kind of a challenge.” (Nurse M, preceptor)

5.4.4. Nurse Manager and Preceptor View of Giving Feedback

Nurse Managers and preceptors both struggled with giving feedback if they had not undertaken a SIP/PIP process before. With more SIP/PIP experience, both groups became more confident with providing feedback. They also realised that not dealing with a preceptee’s competency issues through avoidance or a sense of not wanting to upset the nurse, did not help the situation and if the preceptee had true competency issues then they would not be resolved without intervention.

“I think it is nerve racking ... it used to be a lot worse than what I find it now because I look at it now as you trying to help that nurse because it’s worse if you don’t give them feedback, you know? It just accelerates really and the problems just become worse and not better.” (Nurse D, nurse manager)

Participants with SIP/PIP experience found it easier to give feedback, even when the person had little insight or did not want to hear the feedback. Both groups felt that education on giving feedback prior to commencing a SIP/PIP process was valuable in building confidence.

“I don’t think the person wanted to hear what I needed to say..., this is where I think preceptor education is really important. And I had enough ability from my vast experience of doing this sort of thing to manage that situation, but I’m not sure that would be an easy situation for somebody who didn’t have that experience to manage, when they’re confronted with the preceptee saying actually that’s not so.” (Nurse D, preceptor)

A number of nurse managers commented on how experience gained through the SIP/PIP framework gave them more confidence about giving feedback to all staff generally such as when dealing with complaints from patients or other staff. Their experience with the SIP/PIP framework meant they found it easier to have meaningful conversations with all nurses about not only their practice, but about professional behaviour. They commented it allowed them to deal with performance issues by ‘nipping them in the bud’ and helping with their own professional development in the nurse manager role.

“I think it’s empowered me. It’s actually strengthened my ability to meet these things now in this role.” (Nurse A, nurse manager)

Most participants realised that the more confrontational and serious the nature of the competency issue, the more likely that the preceptee would be less insightful and to have a negative reaction to feedback and the SIP/PIP process. The nurse manager group found the data generated by the framework validated their approach making them more confident in the assessing of the competence of the preceptee.

“It does depend on how they respond because if they listen really well and if they agree, then it’s easy. But if straight away it’s like ‘aw I don’t think that’s right, I don’t think this is so’, then you have to be really firm. But you have to give them examples you can’t just say this is what I’ve heard, you have to say, this is what’s been documented, this is what your preceptor has written down, this is what I’m hearing from other nurses?” (Nurse D, nurse manager)

“Certainly there were situations that appeared to move towards being confrontational, but actually having the data there meant that we could always return to that, having the 1, 2 and 3 [scoring] and what actually fits into those categories within that department meant that that the individual couldn’t claim that their preceptor was just bringing their personality into it ...having that actual graph data showed a pattern of behaviours for the individual that meant that the subjectivity was completely taken out of it.” (Nurse G, nurse manager)

“I just think that it was really stringent and a very robust method of actually dealing with things which made things easier for me because even though I had empathy for the individual that was going through it, actually good competent practice is what patients expect. And at the end of the day I just kept saying to myself, well if it was my mother or my father or my child that was being cared for what would be my expectations. And my expectations would be that they had competent practice relative to that area of speciality.” (Nurse G, nurse manager)

5.4.5. Levels of Insight of Preceptee as Perceived by Nurse Managers and Peer Preceptors

Both participant groups strongly believed that insight being the preceptees’ ability to have self-awareness and be reflective of their clinical practice and professional behaviour as assessed during evaluation of their practice was vital.

Three levels of preceptee insight were identified. One group of preceptees displayed a degree of insight into their practice when the issue of competence was initially raised with them. The second group displayed no insight or reflective ability to review their practice initially, but went on to develop insight during the SIP/PIP process. The final group, although small, remained static, failing to show any insight into their lack of competent practice despite participating in the SIP/PIP.

“We could probably go into what you put [into] those three categories really. You’ve got the ones who identify it straight away and are very grateful and really appreciate what you’re doing, going that extra mile to try and assist them. You’ve got the ones who do see some insight after a wee while after a few meetings and evidence based stuff. Then you’ve got the third category that is never going to see it. They are the difficult one” (Nurse D, nurse manager)

“Most definitely and the one I am working on at the moment is a reasonably junior person yet has just improved fantastically and she had good insight. She knew that she was struggling and that she wasn’t making the grade and so she’s embraced the process and found it very useful.” (Nurse B, nurse manager)

5.4.6. Importance of Insight to Modify Preceptee Behaviour

The importance of insight was fundamental for reaching achievement of competence was a significant subtheme. Both the nurse manager and preceptor groups identified that key to the success of the SIP/PIP process was the preceptee's insight or ability to develop insight into their level of practice during the SIP/PIP process. Daily collection of assessment data which was documented helped provide the preceptee with understanding what they had achieved and what needed to be developed and improved. Combined with feedback, it provided opportunities for the preceptee to gain insight into their practice deficits.

"I certainly feel that even now... that they are actually a better nurse and possibly even a better person for it, for the insight that that brought to them. I think at the time the [preceptee], in those situations, it can feel a little overwhelming and it can feel like you're being picked on somewhat. But the great thing about having that static data means that you know that it's really clear. There's absolutely no subjectivity in it." (Nurse G, nurse manager)

Once a degree of insight was achieved, the preceptor was able to provide support, targeted education and ongoing assessment. This, in turn, led to more preceptee engagement in the SIP/PIP process. The SIP/PIP process itself provided a framework that identified the clinical competencies to be assessed. This allowed a real opportunity for tangible clinical examples to be used to reveal a failing or incongruence in preceptee nursing knowledge and practice.

"I had a nurse who was consistently scoring patients' pains at 10/10, call up the house surgeon on call, off his busy duty, then he comes and scores the patient's pain as 3 or 4/10. She was giving pain medication [in response to] the high level score. When we discussed it with her, she had no insight into what she was doing. She was absolutely adamant that this patient was scoring that high pain score, and had no insight into the fact that nobody else scored it at that when they had scored the patient immediately afterwards. (Nurse A, nurse manager)

The interview data showed the majority of preceptees eventually gain a level of insight that allowed them to develop competencies they were deficient in. The interviews confirmed that the SIP/PIP provided a mechanism to observe, assess, measure and define the actual issues.

“Because in my experience those people that require a performance improvement plan don’t generally have a lot of insight into the way that they are acting and what they’re doing. And so if you can actually pin it down to situations it just makes it so much easier because you can say what’s right and what’s wrong as opposed to a general... maybe you could’ve done this or maybe you could’ve done that.” (Nurse G, nurse manager)

In the beginning I don’t think she did have insight ...but then when we went through it with her and she had it explained to her then yes. But in the beginning no. (Nurse F, nurse manager)

“The real understanding around an individual’s insight for me is absolutely paramount. If you can sort of talk to someone and they constantly blaming other people and have no ability to see what part they have to play, that’s really important.” (Nurse J, nurse manager)

“Look at the whole clinical record on this is particular day...there was a whole lot of stuff that was not done and then I looked further and there was more stuff not being done so it wasn’t just this one particular thing. When I first started talking to her about it, it was like no it wasn’t me,... well actually yes it was you and here’s the notes to show and here’s the documentation that you haven’t done. But then when I laid it out in front of her and showed it to her then she became quite...” (Nurse F, nurse manager)

Experienced preceptors looked for innovative strategies on how best to give feedback to help the preceptee gain insight. They grappled with how to get their assessment findings across to a preceptee who may not want to hear the information. The preceptor’s realisation that they are being tasked with providing an assessment and

through the SIP/PIP process they were entitled to make an assessment was seen as important by the preceptor group.

“I can remember thinking... how else can I say this, how else can I relay my message, ... I think that’s also the way in which you give feedback...you sandwich it with some positive and some not so positive, and that’s quite important as well. But after a point, you need to say well actually, this is how it is.” (Nurse M, preceptor)

Completing a SIP process, even if the preceptee did not return to a competent level, was seen as a positive experience by both nurse managers and peer preceptors in that competency and performance issues with the preceptee were being dealt with, and had a natural conclusion.

“But by the time they went through the process, then they started having those debriefings every day, by the end of it, she realised that it wasn’t for her and she went on to other fields. I don’t know where she went but she left the department in goodwill. We gave her a lovely afternoon tea and said good-bye as you would...properly.” (Nurse C, preceptor)

Nurse Managers and preceptors appeared to have good ability to reflect on their own practice, gaining insight into their individual performance by actively seeking feedback. They held positive views on what feedback could offer to help continually improve practice.

“I have insight in my [practice] you know where I need to improve or grow a wee bit ...if you have insight... it can only be to your advantage. You have got to recognise what you are weaker at and then you can improve on it. It’s not a failure.” (Nurse C, preceptor)

“Equally I think that when you’re a preceptor you do concern yourself with your own personal integrity and especially when you’re assessing someone, and I think that this is another tension when you’re assessing somebody who is a peer to the

other people on the floor, you know, and that was tricky. This potentially could be me.” (Nurse N, preceptor)

5.4.7. Concept of Self-Assessment

The importance of self-assessment in relation to the preceptee gaining and maintaining insight of their ongoing clinical performance was raised. Preceptors expressed that preceptees often failed to undertake any form of self-assessment or personal reflections of their practice. Currently the SIP/PIP process does not have any requirement for self-assessment by the preceptee although they have an opportunity to informally do this in the meeting at the end of shift.

“What was important to the person that I was precepting for me in terms of looking at this person’s performance, was insight. And I think that that is hugely important when you’re talking about a person’s ability to self-assess their competence.” (Nurse M, preceptor)

Preceptors commented that the preceptee self-assessment could potentially help to offset the perceived power imbalance in the SIP/PIP process. It was suggested that preceptee self-assessment may help the preceptee feel they had more control, and could influence the assessment components of the process. Arriving at the same conclusions as the preceptor could act as positive reinforcement and help the preceptee develop insight.

“I think that the only way you can address the power imbalance to a point is through self-assessments, I don’t think we focus enough on helping people practice the skills of self-assessment, or develop the skills of self-assessment.” (Nurse N, preceptor)

5.4.8. Ongoing Competency

Both preceptors and nurse managers pondered whether the maintenance of competency would endure or if relapses in incompetence would occur in the future.

Most participants realised that ongoing measurement with individualised timeframes was needed to ensure that each competency being measured was consistently practiced. One preceptor summarised this as the 3 C's: competency, consistency, constantly; which the researcher interpreted as meaning ensuring that the level of competent practice needed to be seen in ongoing practice.

"I think you'd need to have, to have a good amount of evidence. Because to me the other important thing about competence and measuring competence, is not only that the person can do it once but they can do it twice, three times, four times, five times....so consistency and consistently is important. Because someone might demonstrate to you that they can do something in this context, but then they might not do it again, or, especially with the person that I was working with who had potential memory problems, and cognition problems. Sure I've seen them do that competently there, but will they do it competently tomorrow, especially if I'm not there?" (Nurse N, preceptor)

There was recognition that for some preceptee's, a baseline level of competency was all that was going to be achieved, and that this level of practice was an acceptable safe standard of practice.

"He's never going to be a Ferrari he was always going to be a Morris Minor but he'll get there. He'll be a plodder, he'll be safe, he'll get there, he'll turn up every day, he'll just work at his level 3 and that will be him. (Nurse I, preceptor)

5.4.9. Preceptees that Never Gained Insight

Some nurse managers and preceptors believed that a small number of preceptees were never going to gain insight into their poor performance and felt frustrated at their own personal continuing effort with a preceptee unable or unwilling to see their own incompetency.

“So you know I think insight is significant, if you don’t have it then you’ve got lots of battling all the way.” (Nurse J, nurse manager)

“Some of them don’t, and they never will, but.... If you don’t have insight you just can’t go there.” (Nurse A, nurse manager).

“I think that... [Insight] I actually think that that person wasn’t capable of that.” (Nurse N, preceptor)

For those that never gained insight, both the nurse manager and peer preceptor groups felt the SIP/PIP documentation framework helped capture individual incidents to create a full clinical practice performance picture. Preceptees who never gained insight into their performance, could then be presented with a final collective assessment of their practice which showed a lack of competence. For nursing management this also formed the basis for data that could be submitted to the Nursing Council for the preceptee when reported to it regarding a competency concern.

“So that’s what one of the things in this process is trying to have very specific things, so you can say, I’m not failing you [name omitted] because I don’t like you or your useless, because that’s what we used to say ..., I’m failing you because you put out two metoprolol and you thought they were panadol and that could have injured the patient. I’m failing you because, you didn’t follow infection control processes ...that specific nature means that you have got something very concrete to give back to them and so thus it takes a bit more of it away from you because these are clear things that are theirs to own.” (Nurse L, preceptor)

5.4.10. SIP/PIP Benefits when the Preceptee did not Return to a Level of Competence

Preceptees who lack insight appear to be reported to Nursing Council more often and thus more likely to be dismissed than those who demonstrate insight. Insight into performance issues limited the likelihood that the SIP/PIP would be effective in

supporting the preceptee back to a competent level of practice. Nurse managers considered it was important to continue the SIP/PIP process for a realistic time period to fulfil the ‘good employer’ obligations under employment law, giving the preceptee every opportunity to improve and understand the performance issues raised even if preceptee performance did not improve.

“One of the nurses I would say didn’t have insight and that continued on to performance management and to Nursing Council...so it was clear in all the documentation what was happening and that she wasn’t meeting competency but she wasn’t taking that responsibility or didn’t think that she had a problem but it still ended up being the problem” (Nurse K, nurse manager)

“There was always an excuse or a reason why, you know, that’s what becomes problematic.” (Nurse N, preceptor)

“In just about all areas she wasn’t meeting it but the issue wasn’t so much that we didn’t know where she was at, the issue was that she wouldn’t own where she was at. It was always my problem or there was always some reason that she was at that level, that we weren’t giving her a chance or she didn’t have enough experience... this was where she had to get too, and we weren’t able to get there even after 9 weeks.” (Nurse L, preceptor).

The significance of the feedback insight loop will be explored more fully in the discussion chapter.

5.5. Theme Two : Process Clarity

The second major theme that emerged from the interview data related to process clarity for both nurse managers and preceptors. They reported in their experience it was also an issue for the preceptees. Nurse Managers and preceptors interviewed described aspects of the framework that showed lack of clarity of the SIP/PIP process and how this impacted on the operationalisation of the SIP/PIP.

Nurse Managers stated that a number of preceptees did not have a clear understanding of the SIP/PIP process before it was implemented and thus did not fully

understand its purpose or what was involved. Some nurse managers believed the time taken for the preceptee to become familiar with the SIP/PIP process could delay positive progress in improving competence. They commented that more standardised information for all participants about the SIP/PIP framework be made available. They believed that having information available would be useful for all nurses even if not directly involved as a preceptor or preceptee.

“They [preceptee] don’t have any idea. Usually they don’t understand the gravity of it until they meet with an NZNO representative who might inform them. No I don’t think a lot of people understand the gravity of what this might mean for their job and their registration.” (Nurse B, nurse manager)

5.5.1. Scoring System in the SIP/PIP

Preceptors particularly identified that they wanted clarity in regard to the range and application of scores offered in the scoring tool used to assess preceptee progress against each competency. They commented that the scores did not take into account the level of experience of the preceptee. They were unsure if the benchmark for a competent level of practice for preceptees was at the new graduate level, or should be higher for those nurses with more years of clinical experience. This was also an issue for preceptors precepting experienced preceptees.

“It depends on the level of nurse that we’re also doing the assessment on. Because I have just recently had one who is quite a new grad and then the year before that I had someone who is 25 years in service who was a very experienced nurse and I would expect someone who has been a nurse for 25 years at a very acute level and quite senior would have a different level of basic standards to a new grad. So I mean the basic underlying rule is, are they safe and competent according to Nursing Council but subjectively I’m harder on the nurse who has more experience because you expect a better standard from that person.” (Nurse E, preceptor)

“But I suppose if you say that you’re a registered nurse, then you’re meeting the competencies for registered nurse practice. I mean you know, and you’ve got your practising certificate then the employer should expect that you produce those competencies. And I suppose that’s where the sort of novice to expert comes in. Like you’re producing those competencies but it might be on a novice level, and so maybe if we’re talking about a registered nurse with 20 years’ experience, maybe they’re producing those competencies but it’s only proficient, you know, their performance drops back and then they need to up their game again.” (Nurse N, preceptor)

One preceptor reflected on her time as an educator in an undergraduate nursing programme. She felt that her experience of student assessments had influenced her thinking about using a grading score. She reflected that moderation of scoring between assessors had proved difficult and this had led the education provider to move to a pass/fail system. She questioned whether this should be the same in the SIP/PIP process as a way of removing variability in scoring.

“We used to have big discussions about this in the nursing school grading practice experience because of the subjective nature of assessment... because it’s all very well having competencies, but if people don’t interpret them the same then what are you assessing? People’s different interpretations of the same thing? And so you know, and they have moved to pass fail because it is easier in a way. (Nurse N, preceptor)

5.5.2. Level of Supervision of Preceptee

The level of supervision that the preceptee would have was not always made by the nurse director as required in the SIP/PIP framework even though this is paramount in ensuring patient safety while the nurse gains necessary competency skills. There appears to be confusion and lack of clarity by some nurse managers as to whether levels of supervision were set to provide supernumerary cover for the preceptee. The interview data suggests that this lack of clarity has led to some informal adaptations of the SIP/PIP process. A number of reasons were identified in the data for not being able to provide a

preceptor to work supernumerary with the preceptee. Nurse Managers stated this was due to operational reasons, citing difficulty making a preceptor available to undertake the SIP/PIP often at short notice as this impacted on the workload of other staff and potentially it had an unexpected knock on financial impact on the ward budget.

“Because of the environment that we provide and finding a preceptor for this person in the first place is really, really, hard because it took resources away and it took an extra nurse away, because like we can’t afford this, more in the resource rather than the money wise, but just taking a whole person off the roster and making them supernumerary is a huge drain on the resources.” (Nurse M, preceptor)

“So sometimes we have had the preceptor working one-on-one with the person, sometimes they have just been working alongside them with each of their own workloads. So the first one we did, the nurse was buddied up with someone but still had a workload. We have had other ones since then where we’ve actually recognised that when we’ve done that things are quite severe and we are really now worried about this person working on their own and so we have then buddied them up so that they are supernumerary. (Nurse A, nurse manager)

“Ensure that you get that time. That supernumerary time.” (Nurse I, preceptor)

Preceptors felt it important that they were to be supernumerary at least in the initial phase of the SIP/PIP, so they can truly have the time to assess how the preceptee is practicing.

“When its things like task based things, you actually have to be there watching them do it. Like I’ve seen some people preceptor and they’re happy to see the person go away and do things but the problem with that process is that they want to know what are they doing and unless you are actually watching, you can’t know exactly what they’re doing or what’s been said, so you have to shadow (Nurse E, preceptor)

5.5.3. SIP Length

Nurse Managers and preceptors understood that each SIP/PIP process had to run on its own timeframe as it was specific to the individual preceptee however all participants raised the length of time that the SIP/PIP could take as an issue. For some preceptors the extended length of time that the SIP/PIP process continued caused them the most concern, stress and fatigue.

“Let’s hone it down to what the problems are and then look for strategies for change and help the person with those strategies for change. But then how long is a piece of string. How long do you let that go for? And you see this became problematic” (Nurse N, preceptor)

“I think the very long one I was getting very tired by the end of it and I think that it was too long it could’ve been shorter. I think we knew what was going on but they just needed the numbers [evaluation scores] really. (Nurse E, preceptor)

Nurse Managers reported that the financial impact of the SIP/PIP on their budgets could influence the length of a SIP/PIP. The nurse manager is accountable for the ward/unit budget and within the DHB the SIP/PIP processes are currently not budgeted for due to the inability to predict where they would occur. This meant that the SIP/PIP had to be coded as a negative variance against the budget for its duration with some nurse managers feeling pressured to complete the SIP/PIP process early or not provide the supernumerary time for the preceptor, which in turn could jeopardise the SIP/PIP’s effectiveness in order to meet budget performance measures.

“Financially it’s getting harder and harder to do it because the wards are getting busier and busier and at the moment we are all just struggling to get the work done that we have to do, let alone trying to support somebody as well. I can see one of the biggest problems that is going to crop up, is that we are just not going to have the time to do it properly.” (Nurse E, preceptor)

5.5.4. Pragmatics of Managing a SIP/PIP

Nurse Managers took a pragmatic approach, confident that the SIP/PIP framework was flexible enough to cover the variable nature of the competency issues within different practice settings. They recognised the importance of sound documentation to record assessments and progress.

“I think it’s been quite different each time. Very different Nursing Council competencies, different staff and need to do it in a very different way. It’s been quite individualised. I haven’t necessarily used the same format. I think the last one I have been through, the senior staff on the ward have been extremely supportive. The educator, the associate that I worked with were all very pleased to have it as a formal process and have it clear. I had lots of feedback about how good it was to have a process and to have everything documented.” (Nurse B, nurse manager)

Some preceptors wanted more input into the management components of the SIP/PIP process and that they felt they had something to offer, having worked most closely with the preceptee. They wanted to understand the scope of the preceptor role suggesting it was more than was just assessment and support.

“The other things that came up in this particular process was, was it the right environment, why have we made the choices that we’ve made around how this is going to be done, and are they the right choices? And maybe even as a preceptor having a stake in that.” (Nurse N, preceptor)

5.6. Theme Three : Relationships and Reflections of Participation in the SIP/PIP

5.6.1. Peer Preceptor and Preceptee Relationship

Both groups commented that the relationship between the peer preceptor and the preceptee was felt to be a pivotal component within ensuring SIP/PIP success. The preceptor needed to quickly develop the relationship, and establish a functioning line of

communication with the preceptee. This relationship was likely to be harder to establish, if it was imposed on the preceptee.

Participants reported that the relationship between the preceptor and preceptee naturally grows over time. In some instances, a change of preceptor was considered if the preceptee felt strongly that a personality clash was responsible for the poor assessment scores of their practice. However, if a change of preceptor occurred and the behaviour continued to be observed by the new preceptor, this strengthened the evidence within the assessments. Preceptors were aware that although they were supporting the preceptee, They were also there to make an assessment of competence which could create tension in the relationship.

“I probably learnt in terms of providing supervision and assessing, I think that’s the tension in the relationship of preceptor. You’re providing supervision, you’re being supportive, but at the end of the day you’ve got to make an assessment decision. Because the person can be as supportive ... but at the end of the day you’re going to tell them if they’re good enough or not. (Nurse N, preceptor)

A positive preceptor/preceptee relationship helped make the SIP/PIP process less stressful improved their chances of the preceptee listening to feedback and modifying practice.

“The support I suspect. Maybe she [preceptee] got more comfortable and relaxed. I think she felt a little bit bullied where she had come from, but she’s Indian and she was in a vulnerable situation and she probably didn’t feel like saying anything before. I know that she didn’t really find it very easy.” (Nurse B, nurse manager)

5.6.2. Personal Integrity and Confidentiality

Some preceptors felt worried that their direct relationship with the patient was compromised as they had to allow the preceptee to work as they would normally and then assess the practice and give feedback to the preceptee. This led to some preceptors feeling responsible when preceptee’s practice did not meet the required standard.

“That’s what I found the hardest because I felt the relationships that I was building with the patients was severely affected because I was having this nurse that I was working with and she was doing things and saying things I just wasn’t happy with and I was there and I felt it was reflecting on me but I had to let that happen so I had something to document. I actually found myself going around seeing the patients afterwards almost damage control, you know, explaining if you’re not happy with anything let me know, you know, just smoothing everything over ...that was very difficult.” (Nurse E, preceptor)

It was obvious in the data that all preceptors and nurse managers understood the need to maintain confidentiality of the SIP/PIP process, from a professional perspective and for the integrity of performance management process should it move into a more formal process. They also maintained a high level of professional behaviour as participating in this process also reflected on their own integrity.

“I think that when you’re a preceptor you do concern yourself with your own personal integrity and especially when you’re assessing someone, and I think that this is another tension when you’re assessing somebody who is a peer to the other people on the floor, you know, and that was tricky. Actually I was in the process and people wanted to know what I was doing, and I was very tight lipped about what I was doing, because that wasn’t my place to say, and only to the people that I needed to talk to. But you feel watched and you feel this person could potentially be my colleague. This potentially could be me. (Nurse N, preceptor)

Preceptors recognised that sometimes it was important that they signalled that the relationship with the preceptee was not working. Preceptors said they felt they were able to raise this with their nurse managers and received support to resolve the situation which could include being removed from the preceptor role.

“You know a nurse doing this program, is a stressful situation and they have to have someone that they feel they can trust to do a good job and if I felt that they were not trusting of me then sure I would go to (name omitted) or the charge nurse and say, yip okay I haven’t got the relationship with this nurse but I need to do

this process fairly so I'm not the person to do it. I wouldn't have a problem to say that." (Nurse E, preceptor)

5.7. Theme Four : Barriers and Enablers to Implementing a SIP/PIP

Some nurse managers and preceptors acted as positive enablers of the SIP/PIP process, which enhanced the function and flow of the framework. Conversely a number of barriers to the process occurring smoothly were identified.

5.7.1. Usefulness of Nursing Council Competencies in the SIP Process

Both nurse managers and preceptors commented on the value of performance based practicing certificates and the Nursing Council competencies and how these worked positively within the SIP/PIP process. It was clear from the data that nurse managers and preceptors had become familiar with the Nursing Council competencies and how to assess and interpret them. Nurses commonly use them in multiple situations including their own self assessments, peer assessments, appraisals, and competency assessments for CAP nurses, undergraduate nursing assessment and the Professional Development Recognition Programmes (PDRP).

"I think the most useful thing is to have the Nursing Council competencies broken down into indicators. I keep in my top draw one of the Nursing Council booklets that has got it broken down into indicators and because they're the definitions that you can talk to. The Nursing Council competencies themselves are a bit vague but if you actually pluck out indicators that are appropriate to your environment then that's much more helpful." (Nurse B, nurse manager)

"All the appraisals are due on every staff member against the [nursing council] competencies, I've become really comfortable with them and familiar with them. So for me now it's easy, initially it was very difficult, and I just couldn't even relate the things to the competencies, whereas now because I have done so many

appraisals, I've been through so many of these things, I can generally relate it to the competency.” (Nurse A, nurse manager)

It was evident that nurse managers had observed that the new graduates seem most comfortable with the concept of demonstrating competence and interpretation of the specific language used in the nursing council competencies.

“I think that now it is getting easier because we all as nurses are understanding the competencies better. Whereas initially it was all new to all of us. For instance, like some of our new grads they're just brilliant with competence, they do them the whole of the way through their training, they can talk to any of the competencies. I think they are going to be probably in a better position to do this sort of thing, as us from the old school who have never done it, would actually really quite struggle. (Nurse A, nurse manager)

The preceptee was more likely to make practice changes if they understood the Nursing Council competencies and why they have been formulated was an important feature identified for helping them understand the need to make practice changes if competency was not being met. Preceptors often had to assist preceptees to understand the interpretation of how to demonstrate the competencies.

“You know, what are Nursing Council asking for? In your own words, what do you think they're asking for? And why do you think they are asking for that? What's the importance of that competency? And then if you get people to understand it, then it becomes more, I understand that, I can evidence that... But it is about insight, when I came back, I thought to myself, right I have got to think about what I know, what I don't know, and I need to find out.”(Nurse M, preceptor)

“That's the only way that you can try and get them to see. You can point out the competencies and say Look, you're just not meeting this because a, b, c or d, you know? And they do look at that and it does help them a lot. If it wasn't for the

competencies it would be really hard to try and push home exactly what you are wanting them to meet.” (Nurse D, nurse manager)

There was agreement that the competencies helped identify practice issues in a structured way. Even though there was individual interpretation, the essence of what needed to be demonstrated was clear.

“I think that’s where they find the competencies in the framework really useful. I know competencies are not the be all and end all of nursing, but they do almost produce a bottom line and everyone’s got general competencies but in your area you interpret them in your practice, this is how I meet them, so when you’re working with other nurses you expect the same of them to be able to do things in a similar way. So I think they do help nurses and they certainly...the workshops that we’ve run, there’s been a lot ah-ha moments and really use this as a useful tool especially for identifying where there’s issues.” (Nurse K, nurse manager)

They also agreed that there was a need for the SIP/PIP process which uses preceptor oversight to ensure public safety by maintaining and monitoring levels of nursing practice.

“Do you think that’s a good process?

Of course it is. Because it’s a change to our job. Things a lot different now than 20 years even 10 years ago even 5 years ago. And you must develop with your job otherwise you don’t function. I’d be just like [name omitted]. Trying to dodge the bullet and you can’t do that, you can’t be effective in your job. I don’t think you’d be safe in your job if you didn’t do your homework and some extra learning.” (Nurse I, preceptor)

“This is why we do these appraisals and why we do these portfolios because they are all based on the competencies and every question that you’re asked and you’ve got to show evidence of that. So therefore keeping that up to date is going to keep you safe... and so doing that appraisal is one way of knowing if you are meeting your own competencies.” (Nurse C, preceptor)

5.7.2. SIP/PIP Documents more Readily Available

Nurse Managers stated that preparation and having a clear outline of the SIP/PIP framework was vital before starting a SIP process. Currently there are no formal documents available on MIDAS⁶. They suggested that a suite of templates was formulated to aid accessibility and for reference would be an improvement.

“It’s not on our MIDAS and I had to go searching for the information and so more prepared than the first one but we’ve I suppose you never know when you are actually going to have to do it and so as prepared as I probably could be. (Nurse B, nurse manager)

“Probably having access knowing, having this information ...because I had to sort of go a long way around, so it would be quite good if it was on or available a bit more freely I think.” (Nurse F, nurse manager)

“I think probably for me, what I think is really important is knowing what you’re doing. Being really clear about what it is you’re there to do so that you can do it well, and I think that that’s really important for any sort of process like this where there are high stakes for the person that you are doing it for or doing it with. You know, there are high stakes and that’s hard.” (Nurse N, preceptor)

Preceptors and nurse managers stated that they needed less support after taking part in two or more SIP/PIPs as they were familiar with the framework. It was important ongoing to have the time to undertake the process and all the relevant resources available.

“For me I was trying to seek that information out for myself. It wasn’t at my fingertips and I didn’t know who to ask, who’d been involved in it before. So I had to find that and seek that myself. So if that information is somewhere when you’re going through a process like this and it’s easily accessible I think that would be

⁶ DHB internal electronic information portal

really important... I guess the time to allow it to happen or to make it happen.”(Nurse F, nurse manager)

5.7.3. Support when taking part in a disciplinary process for Nurse Manager And Peer Preceptor

Expert human resource support for disciplinary processes

The importance of sound expert support, guidance and education for nurse managers, particularly with regard to employer/employee relationship processes was the next recognised sub theme. Nurse Managers commented strongly that for many, managing someone when there are issues with performance is daunting, with some having little practical experience in employee performance management. The nurse manager new to performance management or who had only ever undertaken one SIP/PIP was often unsure of the concepts of sound employment relations practice, including what being a ‘good employer’ or acting in ‘good faith’ meant. The nurse manager group commented that education and timely employ relations support was imperative to completing SIP/PIP processes regardless of having either positive or negative SIP/PIP outcomes for the preceptee.

“From a HR perspective, because ultimately at the end of this if things don’t improve then you end up in HR process, and just sort of having the knowledge of where that was going to lead because those are the questions that the individual was asking me as well, and ultimately at the time I didn’t really have that knowledge of exactly where this could end up and what that process would actually look like because I hadn’t been through it before. So maybe just tying it with the expectations of HR in the process because obviously the documentation that you make in the process is very relevant to an HR process that then happens after that.” (Nurse G, nurse manager)

“I think I was a little bit out of my depth really. HR advisors have so much knowledge and I think I personally... actually knowing from an HR perspective how one process works into the other and what that looks like and what HR

expectations were right at the start, would have made me a lot more comfortable as the process went on” (Nurse G, nurse manager)

Nurse Managers recognised that the SIP/PIP process provided the framework for capturing assessment evidence of lack of competence but once the process was moved from on to the formal PIP process then a clear understanding of employment relations procedures made the difference in how this progressed. It was also important for the nurse manager to feel supported in what they often perceived as a torturous route through an employment process particularly if this was likely to lead to dismissal.

“The first time I went through the process I was very much led through it by a nurse director and I felt that really supportive and she helped with some of the language both times it helped having HR check the letters is useful although it’s very much the timing is difficult... so you’ve met with them and then you want to following on from that meeting, type up another letter to say this is what we discussed today and this who was all present and this is the plan. Because you know if they’re rostered on to be on the next day or the next shift, you want the plan to start then. But obviously you’ve got problems with the time lag and so I find that to be quite frustrating. I guess if once everyone got really good at it in the process perhaps you wouldn’t have to be going to get things checked by HR quite as quickly but I mean it’s still really important.” (Nurse B, nurse manager)

“I think it’s really good to have structure and define the process and it’s something that is lacking in a lot of the HR processes and we don’t really have the same tool kit that I was used to working with in other organisations overseas...I find that the process here tends to be a bit more vague. It’s not prescriptive. You need to go back to your HR advisor for what to do and the staff don’t necessarily know the processes as it’s not well published.” (Nurse B, nurse manager)

Some nurse managers felt they needed expert support to ensure they followed the correct processes given that it would be scrutinised by external parties. At times it was difficult to get Human Resource support in a timely manner particularly when it came to the practical components of support such as help with writing formal letters, which may

be highly scrutinised by union advisors or legal representatives supporting the preceptee. Nurse Managers suggested that HR advisors could develop a suite of template letters which would help guide the nurse managers and made them more available in a timely way.

Nurse Managers felt vulnerable if the SIP/PIP process stalled or was delayed while waiting for HR support as they had to keep managing the clinical situation and any potential risk to patient safety, as well as needing to provide rostering preceptor support and account for unbudgeted financial impact.

“So I think the more people doing SIP/PIP’s then the workload obviously increases for HR so then it might be less timely, I think if you’re going to have it as a process that that needs to be met. In saying that if you’ve got letter templates they’re written by HR, if you’ve got a very structured prescriptive process then perhaps that can all go a bit faster.” (Nurse B, nurse manager)

Nurse managers wanted more education around basic employment processes. They were afraid of making errors which may be picked up by the preceptee’s support person or union advisor. Most had developed their skills over time and through experience. Some nurse managers had experienced situations where the preceptee was being reported to the Nursing Council and then later being called to participate in a disciplinary hearing with the regulator which they found to be a daunting experience.

“I think with employment you’ve got employment law in there as well – so I think that the person whether if it’s the preceptor whose doing the comments, they need or they should have HR advice right from the start. Because if they don’t document it in a certain way it can get unpicked later and , so I think there just probably needs to be more HR sort of fully in there but they need some HR advice around how to do these things correctly.” (Nurse K, nurse manager)

5.7.4. Professional Support for the Nurse Manager and Preceptor

The researcher was interested in the perception of support for both participant groups using the SIP/PIP process. Support was identified as being significant, particularly

for those new to the process. Both groups felt well supported by their professional advisors, line managers, including nursing directors, service managers and other senior nurse managers and could articulate where to access support if needed. Although feeling overall supported, some did not feel they were well prepared for their first SIP/PIP experience.

Nurse Managers commented positively about the input from their nurse directors or professional advisors who gave them help to navigate through the performance process.

“I didn’t feel at all prepared, but I had tremendous support from [name omitted] who really, really, really, supported me through everything. She came to a lot of the meetings with me, so even though I didn’t feel that prepared I never felt like I was floundering or couldn’t manage it because I always felt support” (Nurse A, nurse manager)

“So whereas the nurse has their support person who needs someone else to mentor you and I found having a nurse director was really useful to do that. The second time round I have done the process with an associate nurse manager but however the letters and things have come from me and yeah I think you need someone to talk things over with. You can’t do it on your own. So you need HR, nurse director, someone else to be involved. (Nurse B, nurse manager)

“Although our nurse director is fairly visible but there are times when she’s not available and it’s not because she doesn’t want to be available it’s just she can’t be.” (Nurse F, nurse manager)

Knowing how to access basic training in performance management and employment relation processes was identified as being important by new nurse managers. This was seen as providing a platform for the more advanced level of performance management required by the SIP/PIP framework. One nurse manager commented that even with preparation, the reality of undertaking and operationalising the SIP/PIP was more complex than she had anticipated and thought that hands on support from a mentor, especially for the nurse manager new to conducting the SIP/PIP process, was important.

“I think the key thing is that support that goes particularly to the nurse manager and the preceptor, the whole process is geared at supporting the person undergoing the process. The support needs to be for the nurse manager and the preceptor and that can be like I said before the practical support and so putting it together, the support for the continuing because the moment you drop the ball you have to start again. You know, and yet it’s tiring, it’s quite difficult to focus, just to keep that energy up. So the support to the nurse manager and the preceptor is absolutely vital.” (Nurse J, nurse manager)

Generally preceptors reported feeling supported in the SIP process by their nurse managers. They were comfortable operating under its mandate of a specified SIP/PIP process. They felt that they were able to ask for support from their nurse managers if this was needed. They cited examples of being able to access support, particularly if an increase in their stress levels has occurred such as when the length of time the process was taking became onerous. It appears the preceptors felt empowered to ask for support or to opt out of the process if it was impacting on them as individuals.

“I would not like to have another student in the next six months or year. That’s how I felt. And [name omitted] and [name omitted] felt the same. They felt like, “give us break”. Yeah, we had done enough.” (Nurse L, preceptor)

“Definitely. Supported in a way of I feel that I have their backing and I know if I say something about the nurse I have total trust that what I am saying is how it is....” (Nurse E, preceptor)

“Well...the long one which went on for about five weeks, I said by the end of it I said, right-oh that’s it. You know. Is there any way we can stop this now because it’s stressful, the same issues are coming up and I have to think are we actually getting anywhere anymore, and you know, [name removed] sorted it. But I’ve never said no I’ve had enough and I’m not doing it.” (Nurse E, preceptor)

5.7.5. Debriefing

Both groups identified the need to debrief at the conclusion of each SIP/PIP process, especially if the SIP/PIP processes ended with a formal employment relation process and dismissal which was often very stressful for the nurse manager. The need for reflection with either the nurse director or an independent person was thought to be supportive and helped bring the process to a natural end. Preceptors also wanted an opportunity to be able to debrief and resolve stress and in some cases have an opportunity to not participate in peer precepting for an agreed period of time to allow them to revitalise after the experience.

“I certainly did that with the person who had that event that major medical issue, and went back and we debriefed with the manager and that was really good and that was to get feedback on our processes essentially...it was to get feedback on our process and whether we could have done things differently.” (Nurse J, nurse manager)

Clinical supervision was also suggested as a way of helping preceptors come to terms with the outcome and move on fresh. Mentorship was seen as another way of offering a pressure release from the emotional impact working with a preceptee through a SIP/PIP process particularly if it concluded with a poor outcome in terms of employment and referral to the regulator.

“That was really helpful because just being able to bounce off ideas of how to deal with things ...Just somebody that had other ideas or if I was kind of at the end of my rope with – they kind of...you know you tried presenting it like this or if you said that that might come across better or they might understand it better. So for me it was really good being able to bounce that off somebody who had already been through the process.” (Nurse G, nurse manager)

One preceptor described this as the difference between administering a process to refining it to an art.

“I think that is the art of it, you know, you learn the art of it. So it’s not just the pragmatics of it but the art of, I don’t know, getting the best out of preceptee, or you know what’s required...like people could come up to me and say to me as a preceptor when I had a student, and they’d say what should I be expecting on seeing her and I’d go this, this, this and this, you know? If you can see this, this, and this, you’d be happy. And so that’s what I think what comes from doing it a long time, also you develop an artful way of doing it. Just like nursing practice, because it’s relational, and it’s relationships, and there’s an objective and a subjective nature to it, and so I think that’s what happens from doing over time”
(Nurse N, preceptor)

5.8. Conclusion

From the data provided by the preceptors and nurse managers, four major themes and a number of subthemes have been developed. These findings have provided insight into the experiences of the preceptors and nurse managers and can be utilised to strengthen the SIP/PIP process.

The next chapter presents a discussion of the results providing the platform for the evaluation and recommendations.

6. CHAPTER SIX : Discussion, Recommendations and Conclusions

6.1. Introduction

This chapter discusses the findings and develops ten recommendations for improving the SIP/PIP process. These include developing a start-up information pack for nurse managers and preceptors that gives an overview of the SIP/PIP process, role descriptions and clear expectations for each of the roles. Other recommendations focus on ensuring paid time is allocated to enable feedback opportunities between preceptor and preceptee, and additional preceptor education so they can facilitate reflection on practice with preceptees. Nurse managers should receive more targeted education on employment law and basic employment relation principles.

The chapter concludes with consideration of the limitations of the study with suggested areas for future study. The results and recommendations of this evaluation are important to progress beyond this study and become actions. The researcher is committed to completing the evaluation process loop by presenting the recommendations to the senior nursing team at the DHB, for discussion and endorsement.

6.2. Anonymous Survey

The quantitative arm of the research involved the completion of an anonymous survey by preceptees who had been through the SIP/PIP process. Twenty five invitation emails were sent to the last known contact address for possible preceptees participants. No responses from preceptees were received. There was a risk of a low response rate from the preceptee group given they were a small population and their experiences dated back up to a number of years, especially as a vulnerable group they were being asked to engage in and relive what might have been a traumatic event. However, the researcher felt comfortable with having provided the opportunity for this group to have a voice in the evaluation process. This non response means that triangulation of the data is not completed and one facet of the evaluation is essentially missing. This overall weakens the study's results and will be explored more under study limitations.

6.3. Semi-Structured Interviews

The semi structured interviews occurred with the nurse managers who administer and manage the SIP process, and peer preceptors who provide the assessment mentorship and evaluation of the preceptee performance. The major concepts identified were insight and feedback, self-reflection, self-assessment, relationships with preceptor, adult learning styles and power balance with the SIP/PIP and the SIP/PIP in relation to performance management.

6.3.1. Insight of the Preceptee Linked to Positive SIP/PIP Outcomes

Insight was seen as closely linked to feedback. Both nurse managers and preceptors felt strongly that preceptee insight was the strongest indicator of a successful SIP/PIP outcome. Success in this context was defined as being assessed as clinically competent and returning to independent practice.

The participants linked insight with positive preceptee performance that allowed the preceptee to respond to action whereby the preceptee modified their behaviour or used learning opportunities to increase knowledge which was then translated into safe practice.

Hays et al. (2002) have explored the nature of 'insight' and noted it as a predictor of medical professionals 'capacity to change'. Although this work was used in consideration of medical professionals, it is likely that it is equally able to be applied to other health professions. The concept of 'capacity to change' is viewed as an significant in being able to self-regulate in regard to maintaining competence and as a predictor of likelihood ability to remediate back to a competent level of practice. Preceptees are seen needing three overlapping traits: self-awareness; the ability to be reflective; and finally awareness of others. Insight is seen as dynamic and fluid that can vary at different times during a person's career with the individual displaying insight into certain character traits but not others (Hays et al., 2002). By acknowledging the importance of the preceptee's ability to making changes in behaviour and thus improving competency, can insightfulness be predicted? Hays et al. (2002) have formulated a matrix that compares insight to performance, and suggest that it acts as a predictor as to whether or not an individual is able to remediate their practice. This research supports the view that lack of

insight by preceptees was common in those that did not return to a competent level of practice through the SIP/PIP process. Consideration could be given to introducing Hay's et al. (2002) matrix to assist nurse managers as a prediction tool for preceptees indicating who is most likely to be able to return to a competent level of practice from the SIP/PIP process. The usefulness of this framework as part of the SIP/PIP framework in streamlining the process further.

Table 8 – Insight and Performance Matrix

Insight	High insight Low performance A	High insight Typical performance B	High insight High performance C
	Typical insight Low performance D	Typical insight Typical performance E	Typical insight High Performance F
	Low insight Low Performance G	Low insight Typical performance H	Low insight High performance I
	Performance		

(Reproduced with permission from publishers, Hays, Jolly, Caldon, McCrorie, McAvoy, McManus & Rethans, 2002, p. 967)

Understanding the level of a preceptee's insight may help preceptors develop targeted strategies to assist the individual. For example an individual with high insight and low performance is likely to understand the reason for being taken through the SIP/PIP process and may realise that they need more than just support and targeted education to achieve competence, and recognises that they may not be able to achieve this outcome. However, individuals with high performance and low-insight rating can over estimate their performance or have difficulty in coping with change. The most difficult position on the matrix is low insight low performance. These individuals often over estimate their performance and have no ability to self-reflect or reference themselves

against norms (Brown, McAvoy & Joffe, 2014; Hays et al. 2002; Mantesso, Petrucka, & Bassendowski, 2008).

6.3.2. Importance of Feedback in Improving Performance

Feedback and the way it is provided to the preceptee is the second component of the insight feedback loop and is pivotal to the SIP/PIP outcome. Jarvis (1994) developed an experiential learning model that explains how individuals may have different ways of interpreting and dealing with feedback. Although both may reflect, one may absorb the feedback and develop insight and use learning opportunities to change their behaviour and practice. The other may distort the messages, not accepting the feedback or only making a limited change. Preceptors were concerned about the effect this has on the ongoing relationship between them and the preceptee. Preceptees can use ways to not ‘hear’ the feedback, including deflecting the feedback as misinterpretation, or blaming lack of preceptor skill in assessment, or use excessive validation of why they performed a task or behaviour as they did, as opposed to accepting feedback and reflecting upon it.

Feedback and reflection can cause an emotional response. Preceptors voiced that the most challenging part of the role was the reaction of the preceptee to feedback, finding this the most uncomfortable and potentially conflict inducing component within the partnership. Preceptor’s recognised experience in the SIP/PIP process meant they were more likely to be able to ‘handle’ a negative response to feedback from the preceptee. The more prepared and experienced the preceptor, the more able they were to maintain giving feedback in a calm way, documenting their assessment and not getting distracted by the preceptee’s attempts to divert the validity of the feedback given. Opportunities for peer preceptors to gain practice giving feedback should to be included in preceptor education (Mantesso, Petrucka, & Bassendowski, 2008).

Preceptees are dual partners in the feedback process and as previously discussed in chapter three, the transition to practice from undergraduate to registered nurse has been identified as a time where competence to practice issues can be recognised. Consideration of incorporating the concepts of self-awareness, reflection, with education on emotional intelligence and mindfulness concepts being incorporated into undergraduate programmes may be of benefit in equipping new graduate nurses with tools that enable them to augment any feedback opportunities they receive.

Ende's (1983) landmark article on feedback to students reinforces some of the principles outlined in the SIP/PIP process. These are equally relevant to the relationship between the preceptor and preceptee in a competency assessment setting. These principles include:

- Opening the lines of communication between the partners.
- Setting up a formal time for feedback to occur at the end of the shift including time for moving on to reflect on the day's performance.
- Agreeing to the giving of real time feedback, which has immediacy to a moment of patient care or interaction while not interfering with the therapeutic relationship between the partners, the patient or their family.
- Make the feedback specific as possible, reflecting what has been observed using language that is non-judgmental.

Ende (1983) states "Feedback occurs when a student is offered insight into what he or she actually did as well as the consequence of his or her actions. This insight is valuable insofar as it highlights the dissonance between the intended result and the actual result thereby providing impetus for change" (p. 777). Ende (1983), also identified that feedback and evaluation are two different things. Ideally feedback is formative in that it presents information with no judgement, whereas evaluation is summative, usually presenting an opinion on whether an assessment outcome is achieved or not. This summative assessment by the preceptor can be used as evidence in the competency assessment process. Improved clarity and standardisation of the formative and summative components of the SIP/PIP process could be considered for further enhancement. This would be achieved by making the daily assessment a formative assessment that maximises feedback with ongoing opportunities for improvement sought over the practice week.

The summative assessment would then occur at the weekly review meetings between the nurse manager and the preceptee. From the findings it was evident that the preceptor was excluded from this summative component of the assessment. Preceptors raised in interview that they had valuable understanding and context to both support the preceptee or to validate their assessment in a fair way. They felt that their exclusion left them feeling 'in the dark' about the progress of the SIP/PIP and unsure where to continue

to focus their efforts. A suggested improvement would be the inclusion of the preceptor for the first part of the weekly summative review meetings. The second part of the meeting would be then tagged to deal with more employment relations focused component of the process, which the preceptors would be excluded from to maintain the sense of preceptee privacy, particularly if it was progressing to formal stage of performance management with formal disciplinary outcomes.

With the increase in peer assessments required in nursing since the introduction of the HPCA (2003), it has become more acceptable for nurses to be asked to give feedback. Educationalists House and Frymier (2009) linked a number of positive teacher behaviours that enhance learner motivation and positive response to feedback. These included immediacy that is the delivery of feedback in real time, along with engagement of the learner. The skill of delivering feedback with clarity so as to best express to the learner exactly what is being seen in a straight forward way is vital. This includes clear expectations of what is expected of the learner to successfully achieve the task. Equally, characteristics of the learner were also important within the partnership. The way the learner viewed the situation and their reaction to the teacher indicated their level of empowerment (Houser and Frymier, 2009).

6.3.3. Self-Reflection and Reflective Practice

Currently the SIP/PIP emphasises giving feedback is a task, unlike reflection, which promotes individual professional development more broadly; personally, morally, emotionally and cognitively. It was suggested that the preceptor role could be expanded whereby they facilitate the adoption of reflective practice by the preceptee. Education literature supports the view that reflection and reflective practice are essential actions in practice to maintain professional competence (Mann, Gordon, and MacLeod, 2009; Schön, 1987). Branch and Paranjape (2002) describe reflection as “the consideration of the larger context, the meaning and the implications of an experience and action allowing the assimilation and re-ordering of concepts, skills, knowledge and values into pre-existing knowledge structures” (p. 1185).

If feedback is pivotal in gaining insight then Brown’s et al. (2014) work on insight and competency improvement suggests that action plans should include ways of optimising the preceptee opportunities to gain insight in this case through reflection.

Brown et al. (2014) believes that although insight is necessary for remediation in adult learning situations, insight is not static and is capable of being developed. This may be enhanced through a process of guided reflection where the preceptor and the preceptee review the preceptee's practice together to try and gain a real world view of the preceptee's practice.

Interviewees related that the feedback sessions at the end of each shift were at times compromised, forfeited, shortened or even boycotted by some preceptees. There is an identified need to strengthen the understanding of nurse managers and preceptors utilising the SIP/PIP framework, of the importance of giving feedback and creating dedicated time for the preceptee assisted by the preceptor to reflect on practice. The introduction of a learning contract to outline clearly at the beginning of the SIP/PIP process to the preceptee, the expectation of their participation within the SIP/PIP process and periodic return to review progress against the contract. It is acknowledged that if the preceptee is unable or unwilling to participate in this part of the SIP/PIP process then it is likely that the focus of the SIP/PIP will become more a performance management process. This will be discussed further in the chapter.

Preceptors were concerned about the amount of time allocated to the end of day review and how this could result in extending their work day. Mann et al. (2009) found that a busy clinical environment where no protected time was built in, could act as a barrier to reflective practice. Nurse managers using the SIP/PIP process must recognise the importance of this review time for opening up opportunities for reflection. One solution is creating ring fenced time and/or agreeing to pay overtime for a specified timeframe per day to accommodate this meeting or alternatively arranging an early patient handover of the pair's patients. This would allow reflection time to occur within normal shift hours. The addition of the reflective process to compliment what currently is deemed feedback time may contribute to improved insight for the preceptee. This would align well with the Employment Relations Act, (2000) standard where the employer is legally bound to support the employee to have the best opportunity of improvement by providing paid time for this to occur and for the preceptor as a fellow employee not being expected that their role continues into after hours as unpaid time.

Mann et al. (2009) describes influential elements that enable reflection. These include a "facilitating context, a safe atmosphere, mentorship and supervision, peer

support and the time to reflect” (p. 614). They believe reflection should be considered a tool to improve opportunities for learning, which if modelled by peers and managers can be seen as a useful mechanism by a willing learner. The employer and regulator’s position as outlined in the Nursing Council competencies is an expectation that the preceptee will genuinely attempt to be a willing learner especially if competence is called into question.

Consideration needs to be given to both reflection – in – action, (examining what is happening during the care event) and reflection – on – action (where reflection happens away from the practice environment at a later date). Reflection can offer an understanding of the preceptee’s insight into their strengths and weaknesses and help tease out where support and education could be focused. The assumption is the reflective process will lead to new learning from experience and thus an improvement in competence. It is acknowledged that there is no definitive literature to show that reflective practice improves competence or patient outcomes. However, there is also no evidence that it creates harm so it remains a tool that can be utilised to help support all practitioners, but more those that have competency issues to address (Mann et al., 2009).

It is imperative that the preceptor role models practice excellence but also excels at building up a trusting relationship with the preceptee so preceptees can ‘hear the feedback’ and finally guide them through reflection towards new knowledge, skills and behaviour.

6.3.4. Capitalisation of Positive Preceptee and Preceptor Relationships

This study indicates that the development of a positive relationship between preceptee and preceptor to allow productive learning to occur is seen as an important part of the assessment process to get the most positive and functional relationship between the participants. The input by the preceptee into the selection of the preceptor is seen as an important initiating step in the SIP/PIP process. Nurse Managers who allowed the preceptee some choice in preceptor, benefited from the opportunity for setting a foundation for starting a positive preceptee/preceptor relationship.

“Preceptors need to be apt at quickly establishing a relationship with the preceptee, one preceptor in the study achieved this by letting the preceptee tell

their story, “I start off with a general chat, just acknowledging that it is a pretty crap situation that they are in, letting them tell me what are the circumstances that have led to them being in this situation, hearing their side of it.” (Nurse E, preceptor)

Another aspect to building a positive relationship between the preceptee and preceptor was clarity about how the SIP/PIP process was going to be carried out. The study indicates that the SIP/PIP process is not clear as currently structured. It would appear that standardising the process could provide added benefits. Use of a SIP/PIP start up briefing document given to the preceptee and preceptor prior to the first day of working within a SIP/PIP could offer guidance on the following things:

- How to structure workload, including standardising the understanding that the preceptor is supernumerary and the preceptee takes a full workload as outlined by the [Trendcare⁷™.] acuity tool.
- Establishing a meeting which detailed the SIP/PIP steps prior to the partnerships first working day together may offer a chance for the preceptor to “hear” the preceptee’s story.
- Completion of the learning contract outlining as a formal document that outlines the expectations of the preceptee e.g. mandatory time for reflection at the end of the shift.
- Outlining the importance of building a strong positive foundation for the partnership.

Addressing concerns raised by some preceptors about how their role affected their working relationship with the patient could be addressed in preceptor training. Equally important is the preceptor role modelling sound therapeutic relationships with the patients that the preceptee/preceptor partnership cares for. Schon’s (1987) work on adult learning styles suggests that open ended questions prompt reflection. It is necessary to move away

⁷ Trendcare © 2015 Trend Care Systems Pty Ltd is the DHB’s current nursing workload acuity tool used to measure hours of nursing work needed per patient per day.

from the concrete observations in feedback to promote more reflective thinking, which often evokes a more emotional response to the clinical situation being reflected on. The preceptor taking a facilitator role optimises the usefulness of the learning opportunities in practice. There is dual benefit for the preceptor working as a facilitator which contributes to their own professional development, enhancing the preceptor's practice skills and could be considered a tangible preceptor reward. (DeWolfe et al., 2010).

6.3.5. Use of Self-Assessment

Preceptors identified that preceptees were not required to undertake a self-assessment of their clinical performance. Preceptors expressed concern that even if the preceptee was to return to a competent level of practice, what kept them competent if they had no sense of accurate self-assessment? Self-assessment is seen as a skill closely associated with experiential learning (Nicol & Macfarlane-Dick, 2006), and reflective practice. Self-assessment offers more to the learning experience encouraging self-responsibility for measuring individual performance (Arco & Du Toit, 2006; Cato, Lasater, & Peeples, 2009). It is thought to be useful when compared to other more formal assessments, because it also involves comparison between their own assessments and those of the external assessor. It can also increase assessor's knowledge of the preceptees perception related to their level of practice. If the preceptee's external assessment has improved and they are aware of the improvement then it is likely that they will be able to remediate their competence level. If the gap remains wide then the assumption is that the chances of remediation are less. Marienau (1999) summarises this concept stating "situated in the centre of the learning process is a self as the interpreter of experience and the agent of future actions" (p. 136) undertaking self-assessment has positive impacts on learning and performance with participants finding self-assessment useful. Kline and Saunders (1993) support this stating "as we perceive ourselves more realistically, we become better able to guide our own learning and thus continuously improve our work" (p.17).

Ehrlinger et al. (2008) showed that poor performers responded least to feedback and reflection while in contrast strong performers continued to improve with feedback and opportunities for reflection and learning. Handfield-Jones et al. (2002) describe how an individual's performance should not be thought of as linear process of improvement

but rather fluctuates around the norm, dipping and surging dependent on internal and external factors. Hays et al. (2002) believes any performance improvement process needs to be “highly individualised assessed and targeted to known problem areas” (p. 971). These findings align with the study results. Preceptees who had insight could internalise feedback and move through to a process of reflection. Those preceptees that could not were unable to modify their practice and reach competency requirements moving into the performance management phase of the SIP/PIP.

6.3.6. Adult Learning Styles

Both preceptee and preceptor need to work in an integrated way to best maximise the opportunity for preceptee improvement. The preceptor requires a broad range of tools and skills and also needs to be able to adapt these to individual situations in order to individualise learning opportunities for preceptees. Skills required include understanding adult learning styles and a basic understanding of the ways in which adults learn. Preceptors also need to find the most effective ways to make the connection or engagement with the preceptee.

Preceptors stated that they felt they were being prepared well in their preceptor study days, which was seen as an enabler to the SIP/PIP process, including gaining knowledge of the importance of adult learning styles to help them tailor more individualised SIP/PIP experiences for the preceptee. This supported retaining two yearly update study days for all preceptors working with SIP/PIP to continue to expose preceptors to adult learning theory. Researchers have identified certain characteristics that may influence how we learn as adults. These include the influenced of personality types, early educational specialisation, professional careers, current job roles, and adaptive competencies (Kolb, Boyatzis, & Mainemelis, 2001).

6.3.7. Resolving Power issues within the SIP/PIP process

Some preceptors identified that they were aware of the power imbalance within the preceptee/preceptor relationship, and recognised that their preceptor assessments had potentially far reaching outcomes for preceptees. Cusack and Smith (2010) believe that nurse managers have a responsibility to understand the impact that workplace

competency based assessments can have on all members of the team. The process must be seen as fair, just and transparent, meeting the requirements of the Employment Relations Act (2000). Both nurse managers and preceptors expressed the level of accountability and responsibility that they felt in the SIP/PIP process. They felt that having a standardised process helped them manage competence issues. This data endorses both the nurse manager and preceptor support for the SIP/PIP process overall continuing.

Cusack and Smith (2010) supports research into giving voice to those directly involved in the competency assessment process being the preceptee, nurse manager and preceptor. Acknowledging the power inequities between all the roles is vital to recognise ways of rebalancing the power and avoiding unfair outcomes, including consideration by nurse managers that they have the power to make the experience either empowering or disempowering for the preceptee. Being honest, authentic and showing fairness should be the pervasive attitude of the nurse manager and preceptor.

The establishment of a clinical learning environment that invests in education and support encourages continued learning by all staff, which invests, although labour intensive, recognises the value of this investment towards improved competence and can act to rebalance power in a SIP/PIP situation. Cusack and Smith (2010) believe workplace culture where assessment, feedback, reflection and learning are seen as things everyone participates in supports the maintenance of competence.

Experienced skilled preceptors who are trained in providing feedback in a constructive and fair way, and are able to keep an accurate documentation of the process using real examples to validate the assessment, introduce a measure of objectivity into the process that enables it to be trusted and thereby minimising the likelihood of unfairness (Mantesso, Petrucka, & Bassendowski, 2008). Other supportive behaviours include contemplating how and when feedback is given to maintain the dignity of the preceptee, investing in ensuring supernumerary time is allocated for, feedback and reflection and for clinical supervision for preceptors. Recognition of the stressful nature of the SIP/PIP process and the impact this can have on the preceptee can be offset by offering appropriate employee assistance support programmes. Power rebalance could also occur by including a self-assessment component to empower the preceptee to have their view of their performance in the SIP/PIP process. Finally ensuring that the process remains confidential and is handled sensitively by preceptors, managers and workplace peers appeared to be strongly endorsed by both the preceptor and nurse manager groups.

6.3.8. SIP/PIP Performance Management Process

As previously stated employers are required to provide opportunities for remediation by the preceptee if performance issues occur. The PIP does help provide clear evidence gained through assessment, confirming the preceptee's poor performance in a fair and transparent way, ultimately keeping the public safe from unsafe practitioners. The consequences of non-performance are clear, as the employer has to maintain a safe level of practice within their organisation.

The Nursing Council of New Zealand Code of Conduct for Nurses (2012) also supports this. Principle Four outlines specifically the need for nurses to maintain competence, preserving health consumer trust by providing safe and competent care. The DHB accepts the nursing profession's code of conduct, adopting it into its own code of conduct. It is this clause that is used to determine whether misconduct has occurred, with the SIP/PIP process providing the supporting evidence on which the grounds to terminate employment ensues.

Results from the data analysis supports the PIP process as a tool which is helpful to the nurse manager, whose role is to manage the performance of an employee. Nurse managers commented on the need to get timely support from the HR department, particularly for assistance with formal letters and meetings, this being seen as an enabler to the SIP/PIP process.

6.4. Limitations

The limitations of this evaluation research are important to consider. The largest limitation was the non-response rate of the preceptee group. This effectively changed the research from a mixed method to a solely qualitative study. The resounding lack of participation by preceptees is open to interpretation. The assumption is that the method was not acceptable to the preceptee group although actual definitive reasons cannot be concluded. The small population size of the preceptee group along with being a potentially vulnerable population are all considerations. The experience was a learning opportunity for the researcher, and on reflection careful consideration needs to go into the viability of a study design so the right tools are selected.

A review of reasons for failure of survey participation in the literature raises some important points. Sheehan (2001) reviewed a number of ways of improving survey response rates. This includes the use of incentives to improve survey response rates but was not considered appropriate for this population. New email survey technology allows some data analysis, including the number of undelivered emails, and indications whether the survey was opened and/or deleted but this was not considered due to the potential to identify this information against potential respondents. Other reasons for low return rates in email surveys is 'churn'; that is the rate at which subscribers change their internet providers which, unlike residential contact addresses, can occur multiple times in a short time frame, meaning email address information may have become quickly outdated (Sheehan, 2001).

For some preceptees, a time period of up to four and a half years had passed since their participation in the SIP/PIP process. Depending on the outcome for the individual preceptee, the experience may have been one on which that they did not wish to reflect. The researcher has questioned how best in the future to evaluate the preceptee perspective, but accepts that this may be more complex and outside the parameters of this study. One possible consideration for the future is to engage with the preceptee closer to their involvement with the SIP/PIP process. Development of an evaluation tool to specifically capture the preceptee experience administered at the end of the SIP/PIP process may create more motivation for the preceptee to respond.

A further limitation was the use of an independent interviewer who was not totally familiar with the SIP/PIP process. An orientation to the framework may have assisted to aid exploration of particular aspects of the SIP/PIP more fully with the participants.

Finally, the novice level of experience of the researcher must be recognised. Undoubtedly experience adds vital knowledge leading to the enhanced development of research ideas, and methods.

6.5. Recommendations

The analysis of the findings has led to a number of recommendations being developed that could further improve the SIP/PIP framework.

Recommendation 1: Improve process clarity by providing a clear outline of the framework which could include role descriptors, information sheets for each of the participant groups.

The evaluation of the SIP/PIP process by the nurse manager and preceptors showed there were areas where process clarity could be improved. Both groups wanted more written information to be available on the SIP/PIP framework in the form of introductions to the framework, outline of the SIP/PIP process and more clearly defining the expectation of the role of the preceptor. They believed that this would better prepare them to participate fully early on in the SIP/PIP process. The information sheets would be particularly beneficial to new nurse managers who commented in the study of their initial lack of understanding about how the SIP/PIP framework worked, which increased their stress levels in the first SIP/PIP processes they carried out.

Recommendation 2: Maintain the scoring system that produces data to be presented to the preceptee measuring their performance.

The SIP/PIP was useful in providing objective data in the form of scores against each of the competencies which were being measured. This in turn allowed the graphing of a body of evidence identifying competencies the preceptee was not competent in as measured over time. Respondents were happy with the use of the scoring system to capture outcomes and highlighting areas for the preceptee to target for improvement.

Recommendation 3: Consideration be given to ways that preceptors can be supernumerary to the clinical workforce to enable high quality feedback in real time and assist with reflective practice.

Both the nurse managers and preceptors wanted more clarity on the core components of the SIP/PIP framework, including the importance of maintaining the supernumerary time for the preceptor to directly observe the preceptee's practice, giving feedback as clinical practice occurred. Mandating that supernumerary time must be given when embarking on a SIP/PIP allows the nurse manager to undertake this and seek support from higher up line managers or daily operation managers to help them achieve this. It would also be seen as an acceptable variance on the monthly staff budget accounts.

Recommendation 4: Ensure that time for preceptor/preceptee introduction and questions and answers. Outline expectations of the preceptee to demonstrate commitment to learning, which includes expectation of completion of learning packages or learning tasks assigned by the preceptor.

The introduction of a meeting prior to the commencement of the SIP/PIP to outline the process and provide information on the process for the preceptee should be implemented. This would potentially empower the preceptee, providing them the opportunity to tell their story to the preceptor. This would create a more structured platform on which to start the SIP/PIP, also creating a more positive start to the relationship between the partners.

The second important clarification was the importance of the meeting at the end of the day between the preceptee and the preceptor. This meeting provided an important opportunity for the preceptee to be able to gain an overview of the day's global performance and for reflective time with the preceptor. This was also a time for the preceptee to have a voice articulating how they believed their performance was going and for the preceptor to listen to their self-assessment. The introduction of a learning contract would make it explicit that this meeting must be attended and providing protected time to optimise reflection on practice.

Recommendation 5: Introduce a self-assessment component into the SIP/PIP framework by the preceptee to be completed daily against each of the identified competencies.

Self-assessment was seen as element that was missing from the SIP/PIP framework and may be useful in understanding the preceptee's view of their performance, matching it against what the preceptor was observing. This ongoing self-assessment may indicate the degree of insight the preceptee had or was developing through the SIP/PIP process. As the gap between the preceptee self-assessment and the preceptor assessment lessened, this may indicate a shift in insight. This improvement in self-assessment was thought to be useful as a means to educate the preceptee on what a competent level of practice was so they could continue to more accurately self-monitor in the future.

Recommendation 6: The nurse manager protects the meeting time at the end of the shift between the preceptee and preceptor by instigating an early handover or paying overtime to both parties so this can be achieved.

Valuing the review time at the end of the shift needs to occur with the nurse manager instigating either an early patient handover by the preceptee to allow the meeting time to be achieved within the work shift as preference, or agreeing to pay overtime to both parties so this important part of the practice day is capitalised upon.

Preceptor education on adult learning styles and how to optimise learning opportunities through guided reflection where the preceptor and the preceptee review the preceptee's practice together to try and gain a real worldview of the preceptee's practice should continue for preceptor study day topics.

Recommendation 7: Offer further education on Employment relations principles to nurse managers towards gaining a fuller understanding of the Employment Relations Act (2000).

Nurse Managers commented on the importance of support from the Human Resource department during a SIP/PIP process, particularly if this was progressing into the PIP component where it was important that sound documentation and prompt turnaround times for letters outlining outcomes from the weekly management meetings with the preceptee and the nurse manager occur. Overall, HR education on the basic concepts of employment law for nurse managers needs to be increased so they understand the principles of being 'a good employer'; 'acting in good faith' and with 'good reason' was outlined, matched with a sound SIP/PIP process to support them. Although most nurse managers commented that they gained more confidence with each SIP/PIP process they carried out, the first time they undertook a SIP/PIP process was for some, a nerve wracking experience.

Recommendation 8: Work in collaboration with HR department advisors to format standardised templates for letters used in the SIP/PIP process to decrease variance in process and decrease turnaround times for letters.

Frustration was voiced by the nurse manager group that the turnaround times for HR letters to be sent to preceptees to progress the SIP/PIP process especially if the nurse was not responding to the SIP/PIP process, was too long. The nurse managers found it

stressful and it financially impacted on their staffing budget and the good will of preceptors if there were delays in HR letters being prepared, so particularly the PIP component of the process could move forward.

Recommendation 9: Invite the preceptor into the first part of the weekly summary meeting.

Including the preceptor in the first part of the weekly summary meeting will offer a better opportunity for the preceptor to feel part of the summative feedback of the weekly performance. By allowing the preceptor to present their assessment findings and the preceptee to hear these will allow transparency to the process, the preceptor can provide context to the daily assessment sheets. The preceptors can also feel more empowered in the process through participation in the planning and goals for the following week. The preceptor would be excluded from the second part of the meeting, where any HR issues can be discussed, which requires confidentiality between the preceptee and the nurse manager.

Recommendation 10: Consider development of an evaluation form which is administered anonymously and potentially completed online or in hard copy provided to the preceptee directly at the end of the SIP/PIP process. Create and maintain an open feedback channel through a permanent email address to allow the preceptee to come forward if and when they are ready to provide feedback.

Failure to receive any data from the preceptee group was disappointing but, as mentioned, it was important to attempt to connect with the preceptee group, being those most directly affected by the SIP/PIP process. This population is identified as small, with the impact of moving through any process where assessment occurs, particularly where it is suggested that practice does not meet the expected standard, is inherently stressful for the nurse involved. An alternative strategy needs to be tried to elicit the views of this group. Timing may provide the key to getting response from this group. Consideration of providing an evaluation form to the preceptee directly at the end of the SIP/PIP process may generate a response, as this is the time when the most 'feeling' around the process is most likely at its strongest. Sensitive consideration will be needed to offer an opportunity for the preceptee to provide feedback to the organisation on their experience from the SIP/PIP process.

6.6. Conclusion

Has the research question posed been answered?

The researcher accepts that the research question has only been partially answered as this study captures the experiences of only the peer preceptors and nurse managers and only inferred impacts on the preceptee from the interview data. The findings are able to inform recommendations for improvements that could be made on this basis.

Although it was intended that a mixed method approach would be used lack of preceptee response meant that all data collected and analysed was qualitative. However there is important information from the two other participant groups which has been very valuable to form the final evaluation. The findings indicate that the SIP/PIP framework offers a transparent and clear way of addressing competency issues in the DHB. It presents a framework to enable nurse managers and preceptors to evaluate preceptee competency. It offers a supported experience for the nurse manager to undertake a performance management process for those preceptees identified as unable to return to a competent level of practice.

Finally the process of evaluation only reflects in a moment of time. Further and continuing evaluation is recommended to continue to assess the usefulness of the SIP/PIP framework ongoing. There remains a gap, with a need to capture the experiences of the preceptee group potentially in a more general sense related to both the employment level and the wider regulatory competency assessments frameworks and could be the focus for further research.

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APPENDIX A – SIP / PIP Process Overview

Identifying the need for a SIP

Initial investigation by the nurse manager into any allegations about competence issues made against a nurse, needs to be sensitively followed up in a timely way. The nurse manager should undertake a preliminary investigation including examining the allegations by interviewing the staff or the consumer bringing forward the allegation and documenting this meeting. If there appears to be evidence or doubt as to a nurse’s level of competence, the employer is obliged under the HPCA, (2003) to undertake a competency assessment of the nurse’s performance to ensure ongoing safety of the public.

In the SIP process, the nurse is informed in person, which is followed up with a letter outlining which of the competencies are not being met and asked to meet to discuss the allegations. The letter invites them to a meeting to allow them the opportunity to answer the claims made. The nurse is encouraged to bring a support person with them as this process is acknowledged to be inherently stressful for the nurse concerned.

Meeting and SIP Formulation

A meeting between the nurse manager, the preceptee along with any people supporting the preceptee at this meeting outlines the issues and the results of any initial investigation of allegations of lack of competence. The preceptee then has the opportunity to disclose any extenuating intrinsic or extrinsic factors to be considered which may be impacting on the preceptee’s performance. Factors can include ill health, addiction, family situations or personal crisis that can influence work performance. These need to be explored and any support provided including employee assistance programmes or encouragement to seek professional help. Once these factors have been reviewed and the need for a SIP established, a SIP planning meeting takes place.

The SIP/PIP framework is outlined to the nurse involved (known as the Preceptee) by the nurse manager. Identified practice deficits are listed and linked to the competences that are not being met within the nurse’s scope of practice. Once the problem is defined and the relevant competency identified, it is pivotal for the preceptee to understand what they have to do to demonstrate competence for each identified competency. It is evident that some preceptees do not have a clear understanding of how to demonstrate the individual nursing council competencies moving forward. This is where an important part of the SIP/PIP process occurs. Competencies are redefining back out to the preceptee nurse giving tangible examples about how the preceptee can demonstrate competence for the particular competency (Table 9).

Table 9 – Competency Identification and Examples to Demonstrate Individual Competency

Identified Clinical Deficit	Competency not being met	Example of how to demonstrate competence in this competency
RN not giving antibiotic treatment on time as prescribed or missing treatments such as wound care dressings.	Competency 2.1: Management of nursing care-indicator: “Administers interventions, treatment and medication, (for example: intravenous therapy, calming and restraint), within legislation, codes and scope of practice and according to authorised prescription, established	Use of a daily planning sheet, (aids with time management). Having all patient medications and treatments timetabled out for the duty. <i>The acceptable evidence would be using the planning sheet and showing that all medications and treatments were given on time.</i>

	policy and guidelines.” (NZNC 2012)	
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This process of interpreting into the Nursing Council competencies and back out into tangible ways to evidence meeting the competencies occurs for each competency that has been defined as not being met. It is these evidenced goals that are evaluated by the preceptor with the preceptee at the end of each shift. Feedback in real time is expected to occur throughout the day between the preceptor and preceptee. A 10 minute over view meeting at the end of the shift, discuss each competency with the completion of scoring and documentation and give a global view of the day’s overall performance.

As each competency is viewed independently as improvement occurs, individual competencies can be signed off as soon as there is reasonable confidence by the preceptor and the nurse manager that the competency is being consistently demonstrated. As the number of competencies being dealt with decreases, more effort can be targeted to outstanding competencies. This creates a positive motivating sense of achievement for the preceptee for those competencies that have been signed off.

Preceptor Selection and Level of Supervision

The level of supervision of the preceptee nurse is made at the outset of the plan, based on an evaluation of clinical risk to ensure that patient safety is not compromised. The levels of supervision by the peer preceptor range from working ‘alongside’, with each nurse having their own workloads, through to a totally supernumerary preceptor who observes, assesses, mentors and supports the preceptee.

Preceptor selection is also undertaken at this initial meeting. This preceptor selection process is designed to allow the preceptee some input into their choice of preceptor. The preceptee is asked “Who is the nurse whose clinical practice you admire most in the ward?” This acts to try and match the preceptee with someone who they respect for their clinical practice, so in essence they will be more likely to respect and accept the assessment and feedback given by the preceptor. If the preceptee picks someone who is not a trained preceptor, is unavailable or not considered suitable (e.g. has a close personal friendship with the preceptee) the preceptee is asked to pick again until a mutually agreeable preceptor is found.

Moving from SIP (informal) to PIP (formal)

The SIP and PIP can be thought of as on a continuum, with all processes starting with a SIP and only a small portion of preceptees continuing to move on to the PIP stage. At no time during the SIP component of the process are any employment related disciplinary actions taken. If performance continues to not reach a competent standard of practice then the process moves into the PIP phase of the process. The PIP is essentially the same model but enters a formal HR employment stage that could result in disciplinary action, including dismissal and reporting to the regulatory body if an accepted level of competence is not obtained. All meetings for the SIP and PIP process with the preceptee are undertaken with an invitation to bring a support person and or a union representative and follow sound Employment Relations Act (2000), principles.

Scoring Matrix and Interpretation

In the daily assessment meeting at the end of each shift between the preceptee and preceptor, each of the identified competencies being worked on is evaluated. Each competency is scored using a simple scoring matrix (Table 10).

Table 10 – Scoring Matrix

Scale	Standard Procedure	Quality of Performance	Assistance
Accomplished 4	Safe and accurate	Proficient, coordinated, confident, ethical and clinical role model for others.	Anticipates consistently and assists others
<i>Independent</i> 3*	<i>Safe and accurate</i>	<i>Competently performs tasks within an acceptable timeframe</i>	<i>Works independently without supportive cues</i>
Assisted 2	Safe and accurate Most of the time requires prompts from preceptor	Can perform tasks but needs support and guidance, takes longer than expected to complete tasks	Occasional verbal and physical directive required to complete the task
Marginal 1	Safe with direct supervision	Unskilled, inefficient requiring a prolonged time period to achieve nursing outcomes	Requires direct supervision frequent verbal and physical directives in most areas

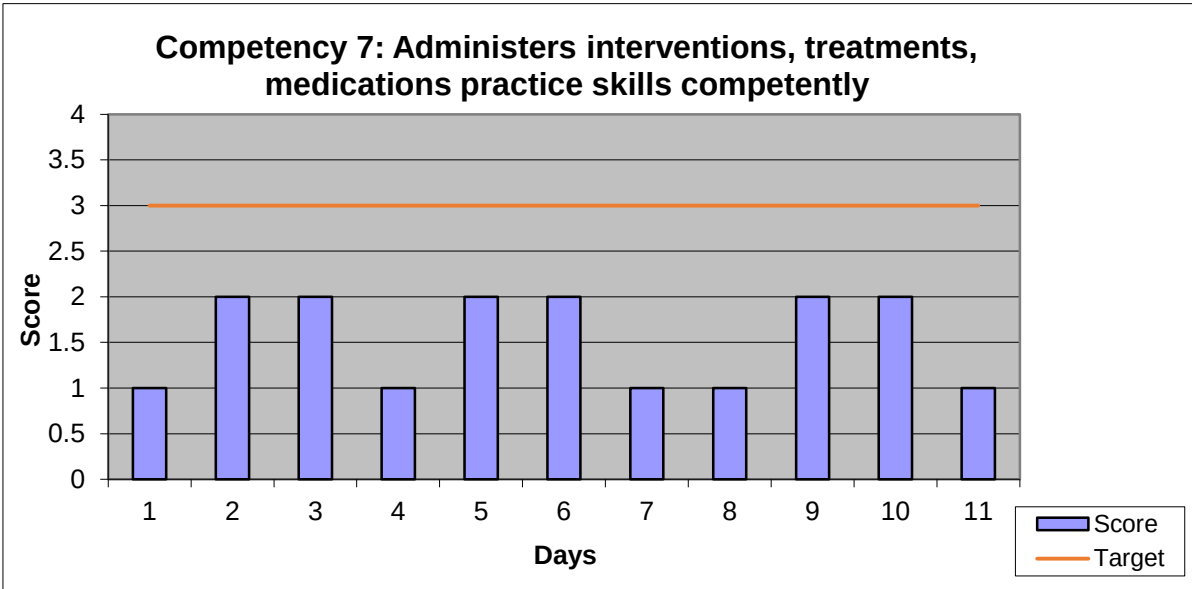
* Scores of 3 are deemed to have reached competence

- 1- Marginal performance, which requires direct supervision with repeated verbal and physical prompts from the preceptor to meet the goal.
- 2 – Assisted, can perform the task but needs reassurance, guidance and takes longer than expected to achieve the goal or task and may require an occasional verbal prompt by the
- 3 – Achieves goal at the baseline competent level is safe and accurate and completes the task in an acceptable timeframe and works independently.
- 4 - Performs the tasks with skill, proficiency and shows evidence of linked assessment and planning with good time management. Is a resource and provides support to others.

Criteria for Evaluation of Clinical Competency

A daily evaluation scoring sheet using the scoring matrix is completed against each of the competencies to monitor progress. The data generated can be transferred to a simple excel spreadsheet and then graphed. This visual expression of the data can assist in interpreting overall progress. It also can help provide visual feedback clearly on the aspects of care not being met, which may assist the preceptee with gaining insight into their practice. An example of graphed results is presented in Table 11.

Table 11 – Practice Skills Competency



Weekly Nurse Manager and Preceptee Meeting

Weekly meetings with the nurse manager and nursing director focuses on progress made to date, reviewing the progress graphs and discussing the objectives for the coming week. This is where any competencies scoring 3’s consistently are signed off and occasionally another competency that needs assessment is added. The decision to stay in the SIP process is reviewed and any decision to stop the SIP process or to progress to the PIP phase is discussed with the preceptee. Prior to the weekly evaluation meeting, the preceptor will have discussed the week’s progress with the nurse manager who can bring up at the meeting any examples that could be relevant to discuss either for clarification, or to illustrate a consistent example of not meeting the competency. The preceptee is fully informed of the process and has the opportunity to have their support person with them to the weekly evaluation meetings.

Concluding the SIP / PIP

If the decision is made to stop the SIP as there is sufficient evidence of competent practice, then this is fully documented and a letter is sent to the preceptee stating that the SIP has been completed and the nurse is now assessed as practicing competently. If there is labile or static underperformance and there has been sufficient reasonable time given for improvement, then a formal HR meeting is held to signal moving into the PIP phase of the framework. This phase continues with the same support, mentoring and assessment by the preceptor. However a timeframe is attached to expected improvement being demonstrated and if this does not occur then a disciplinary outcome in the form of written warnings can be issued. As the SIP/PIP process is labour intensive and financially costly in terms of paying a preceptor to support the preceptee as supernumerary, the DHB needs to have an end point if competent performance cannot be demonstrated. This only occurs after discussion with the preceptee and their support people following a sound HR process, moving to final written warnings and then dismissal and reporting the preceptee to the regulatory body being the NCNZ.

APPENDIX B – Thematic Tree

Theme	Secondary Node	Primary Nodes	Conclusions	Recommendations
Process Clarity	Measurement	- Preceptor level of practice – not measuring against own practice, understanding where competence is measured too. - Novice to expert - Scoring accepted scoring tool - Subjectivity – preceptor harder on more experienced nurse - Use of scoring tool and graphs - Need for standard templates		- Scoring acceptable – keep in programme - Graphing recommended
	Variation interpretation	- Changing preceptor to check assessment - Feedback meeting at end of day - Teasing out assessment vs. support and mentoring - Subjectivity in assessment process. - Expectation that nurses have demonstrated other components of competency assessment education hours, practice hours, appraisals		- Remove variation – explain the need for each part of the SIP/PIP process - Standardise templates - Clarify New Grad vs experienced nurse practice, use novice to expert, use example of changing areas
	Length of SIP	Allowing preceptor rotation		- Consider effect on length of SIP/PIP on preceptor or need to rotate preceptors - SIP/PIP remain flexible to be individualised to meet preceptee needs
	SIP/PIP preparation and information prior to starting process	- Preceptor allowing time before 1st work day to meet and discuss process and ‘hear the preceptee’s story’ - How to ‘shoulder’ preceptee when providing supernumerary observation of preceptee - Maintaining patient safety allowing preceptee time to auto correct errors through recognition. - Preceptor preparation - Preceptor study day evaluation - Understanding external things effecting preceptee performance e.g. health issues - Preceptor not fully understanding their role in SIP/PIP process. - Role of ward educator versus preceptor in supporting nurse with competency concerns.		NCNZ competencies are useful, familiar used in other processes including PDRP, appraisal, and peer review. Accepted use of NC competencies to measure competence
Participation in the SIP/PIP, relationships & rewards	- Reward-intrinsic/extrinsic - Preceptors want to input into in weekly meetings more actively - NM improved personnel management - Confidence with SIP/PIP - Experience power imbalance between preceptee and NM/Preceptor	- Preceptor feeling responsible for preceptee failure. - Support for preceptor - Reaction of preceptee towards preceptor if SIP/PIP not showing improvement. - Preceptor role sharing support of preceptee in ward setting - Novice to expert –perceived that New Graduate should be measured differently to someone with more experience - Debriefing, stand down time for preceptor when completed SIP/PIP - Preceptor wanted to be included in weekly feedback meetings with NM/preceptee. Preceptor felt not updated on decisions that may affect the next week of clinical assessment. - Preceptor seeking feedback on their performance from Nurse Manager - Transparency about the purpose of the preceptor role, is it ‘support’ or is it just assessment? - ND support useful and evident - Motivation to do SIP to keep patients safe - Robust framework helpful - SIP/PIP framework removes emotion response and is more objective - NM improved using SIP after doing one - NM improvement in handling performance issues generally following managing SIP/PIP - NM more likely to consider impact on ward roster covering in preceptor selection - Preceptee privacy- staff did not ask questions about details of SIP accepted it was taking place and were supportive of process - Ward staff had ‘unwritten code’ not to ask questions but accept precepting of preceptee - Relationship between preceptor and preceptee has to be positive for preceptee to hear the ‘feedback’.		NM package clarifying role, where to get support, overview of SIP process for role Preceptor pack- clarifying role, where to get support and overview of SIP process for role Preceptee pack – overview of SIP process, learning contract, outcomes - Wider education to all nursing staff - Endorse payment for overtime worked to support SIP/PIP meetings at end of the day or ring fence in hours’ time for this to occur - Invite preceptor to participate in first part of weekly meeting with preceptee and NM and understand the preceptee goals for the upcoming week. - Clarify multifaceted role of preceptor as assessor, support, teacher - Provide preceptor support with clinical supervision, debriefing and stand down periods between SIP/PIP processes
Barriers and Enablers to Implementing SIP	- Difficulty in operationalisation of supernumerary role for preceptor by NM - Difficulty achieving time to meet at end of day between preceptee/ preceptor impact of SIP/PIP - Preceptor workload with SIP/PIP - Preceptee external influences on performance - Support for NM from HR - Employment law education for NM - Support for NM - Support for preceptee particularly debrief - Financial support for SIP by organisation - Usefulness of Nursing Council competencies	- Needed protected or extra paid time to give feedback at end of day and during shift - Preceptor very aware of seriousness nature of SIP/PIP with potential outcome of process could lead to job loss and reporting to NC - Potential for role conflict with educator around roles - Length of time of SIP/PIP continues impacts on preceptor – tiredness, stress - Preceptor responsibility in keeping patients safe during SIP/PIP process - Preceptor worried about effect of preceptor relationship with patients when precepting preceptee - Barriers from NM perspective, rostering supernumerary time, financial impact on budget - Who is supernumerary, preceptee or preceptor? - Effect on preceptor workload particularly if not supernumerary (lack of recognition of this by NM) - Motivation to do SIP to keep patients safe (dual also in real time feedback) - Concept of reflection needs to be acknowledge at higher level than feedback and is different - Experience in peer assessment through NC audit helpful - General acceptance of NCNZ competencies as working as a means continuing competence - NCNZ competencies are getting easier to work with as time goes on more nurses accept it as part of normal upkeep of registration and having to demonstrate competence - Competency the bottom line for safe practice - NZNC competencies covers both behaviours and practice deficit - NM not having adequate understanding of employment law - HR support variable		- NM commitment to supernumerary time if this level of supervision is needed - Add in learning contract for preceptee to clarify their commitment to the process - NM monitor preceptor workload identifying a second staff member to support each day if needed.
Feedback- Insight Loop	- Real time feedback - Reverse feedback preceptee to preceptor - Lack of insight a predictor of SIP outcome - Insight used to inform change in practice - No opportunity for preceptee to self-assess their own performance	- Some NM anxiety about impact of giving feedback (consequence of where continuing poor performance leads) - SIP/PIP hard for NM at first but improved with more experience gained in managing SIP/PIP processes - Positive relationship with preceptee helped acceptance of feedback given by preceptor and NM - NM felt good having objectively measured data to back up verbal feedback through SIP/PIP assessment process - Feedback needs to be consistently given over a period of time to be effective - Real time feedback most effective for preceptee learning and gaining insight - NM needs to support time for preceptor to give feedback to preceptee at end of day - Preceptor felt meeting at end of day after all work was completed encroached on end of day getting off on time. No recognition of need for payment relies on preceptor good will - Preceptor wanted to be included in weekly feedback meetings with NM - Preceptee response to feedback impacts on NM and preceptor - Preceptee noted to have a more negative response if they lacked insight into their poor performance - Preceptor noted difference between lazy practice and competence - Some preceptees didn’t recognise seriousness of SIP/PIP process - Preceptee labile practice - How to progress SIP/PIP when preceptee doesn’t accept feedback - Preceptee no recognition of mistakes or lack of performance		- Create expectation that preceptee to have an opportunity give feedback to the preceptor about their assessment at meeting at end of the day. - Consider use of predictor matrix to understand preceptee potential for responding to feedback and gaining insight - Introduce a preceptee self-assessment component to help improve opportunity to gain insight - Acknowledge power imbalance and minimise situations for this to impact on support and assessment - Allow preceptee to participate in preceptor selection - Introduce orientation period with formative assessment before commencing summative assessment. - Work with HR to increase NM education on employment law concepts - Offer debriefing for NM with Nurse Director. - Consider mentoring for new NM from more SIP/PIP experienced NM - Consider central budget to cover supernumerary time, costs of clinical supervision - Reinforce strength of standardized approach using a framework such as SIP/PIP - Develop an evaluation tool for the preceptee to complete at the end of the SIP/PIP process to gain information on SIP/PIP experience from the preceptee perspective.

APPENDIX C – Consent Form

CONSENT FORM FOR NURSE MANAGER AND PEER PRECEPTER PARTICIPANTS

I have read the information sheet concerning this project and understand what the research study is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information such as audiotapes will be returned to me or destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years to meet university requirements.
4. This evaluation research uses semi-structured interviews and involves an open questioning technique. The general line of questioning includes:
 - How you found the SIP process?
 - What improvements would you suggest to improve the SIP process?
 - How well prepared were you to participate in the SIP process?
 - How the SIP process impacted on your clinical practice or role as a nurse manager?

The exact nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage.

5. I understand that the researcher is a Director of Nursing at the Southern District Health Board and that she has developed the Supportive Improvement Plan (SIP) framework. I am comfortable for the researcher to conduct the interview except for those within the Surgical and Medical Directorates in which an independent experienced nurse researcher will undertake the interviews to provide further distance from the researcher. If I find this stressful I can withdraw at any stage from the research project without any disadvantage.
6. There is no remuneration involved for the participants but refreshments will be offered to the participants during the interview process.

7. The results of the project may be published in a Masters thesis and will be available in the University of Otago Library (Dunedin, New Zealand), and every attempt will be made to preserve my anonymity.
8. I am aware that direct quotes may be used in the results and discussion section of the research paper. Dates times, names will be changed to lessen the likelihood of identification of these quotes to me.

I agree to take part in this project.

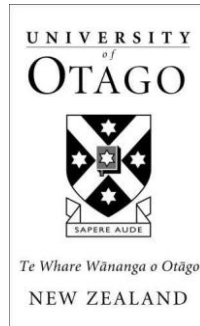
.....
(Print name)

.....
(Signature of participant)

.....
(Date)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

APPENDIX D – Information Sheet



Evaluation of the Supportive Improvement Plan (SIP) process for regulated nurses with competence to practice issues within the District Health Board setting.

INFORMATION SHEET FOR PEER PRECEPTOR AND NURSE MANAGER

Thank you for taking the time to read this information sheet and showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you.

What is the Aim of the Project?

You will have participated in a Supportive Improvement Plan (SIP) process that is currently used by the Southern District Health Board (Southern DHB) to support nurses with identified competency to practice issues. The aim of this research project is to evaluate the SIP framework process and the researcher is seeking your views and opinions of your experience of the SIP process.

The Southern DHB, as the employer with responsibilities for professional practice finds the SIP process useful, however it has not been formally evaluated and input from those that are directly involved with the process is now sought. This is your opportunity to identify whether the process meets your needs and through participating in the study to contribute to further improvement of the process. This research is being undertaken as part of Sharon Jones' Masters of Health Science thesis via University of Otago and is supervised by Jenny Conder and Dr Beverley Burrell.

What Type of Participants is being sought?

Nurse Managers and peer preceptors that have supported a nurse through the SIP process are invited to take part in an interview.

An online survey is being used to gain the input of nurses who have been assessed (described as the Preceptee) using the SIP process.

Recruitment method

You have been identified by the Southern DHB Human Resource Department as having been involved with the SIP programme in the role of peer preceptor or nurse manager. Sharon and her supervisors do not know the names of nurses that are being sent this information.

Selection criteria

As the population sample is thought to be small, it is not anticipated that a selection criteria will be necessary, however should there be more than 6 peer preceptors and/or 6 nurse managers, selection will be on the basis of providing the widest possible range of situations and viewpoints.

Compensation

There is no direct compensation offered but light refreshments (tea, coffee & light snacks) will be offered during the interview.

Benefits to taking part

By taking part in this research, you have the opportunity to influence changes to improve the SIP process.

What will participant peer preceptor and nurse managers be asked to do?

Should you agree to take part in this research, you will be interviewed by Sharon Jones **except for all nurses in Medical and Surgical Directorate** areas or where she is your line manager or provides professional oversight.

For those in the medical and surgical directorate an alternative experienced nurse interviewer has been sought to undertake the interviews to provide more distance from the researcher and increase your potential comfort to take part. The interviews will be transcribed and a pseudonym will be given to your transcript. Sharon will be undertaking the analysis of the de-identified data

What is the time commitment involved?

It is expected that the interview would take up to an hour and can be arranged to be undertaken at the Southern District Health Board Dunedin Hospital site.

Risks in taking part in the research

The interview may unintentionally raise issues for you from your experience of the SIP process that could cause you some discomfort.

Support available

If you are unsure whether you want to participate and you are an NZNO member you can contact Lorraine Lobb, Southern District NZNO workplace advisor, who can give you independent advice as she is not associated with the Southern DHB. Lorraine's contact details are: lorrainel@nzno.org.nz (03) 4746496.

For those nurses employed by Southern DHB you will have access to Vitae services that provide independent support and counselling should you feel this would be helpful to you.

What Data or Information will be collected and how will it be used?

Demographic data will be recorded and your responses to the questions in the interview will be audio taped. A semi-structured interview technique will be used. There are some questions that the researcher will ask all participants interviewed, but there may also be questions that will come up in the course of your interview and can't be anticipated. The general line of questioning will focus on your perceptions of the SIP process and include:

- How you found the SIP process?
- What improvements would you suggest to improve the SIP process?
- How well prepared were you to participate in the SIP process?
- How the SIP process impacted on your clinical practice or role as a nurse manager /peer preceptor?

The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also your right to withdraw from the project without any disadvantage to yourself.

Following the interview the recording will be transcribed into written form. A transcriber will be used for this process. That person will be asked to sign a confidentiality agreement. All interviewees will have a pseudonym assigned to them at transcription to help de - identify the participant. The researcher's supervisor will have access to de-identified transcripts.

Data obtained as a result of the research will be retained for **at least 5 years** in secure storage. Once the research is completed any ongoing access to stored data will be managed by the Centre for Post Graduate Nursing Studies, University of Otago. Any personal information held on the participants such as audio tapes after they have been transcribed may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The results of the project may be published and the completed Masters thesis will be available in the University of Otago Library (Dunedin, New Zealand). In all written reports every attempt will be made to preserve your anonymity.

Your permission will be sought to use quotes within the research results. Where quotes are used, information that could lead to identification of persons will be changed to further protect privacy.

Will the participants have the opportunity to correct or withdraw the data/information?

Participants will have their transcripts returned to them by the Human Resource (HR) person acting on behalf of the researcher for reviewing and to check that they reflect the points they wished to make. This will occur within a few weeks of the interview. You can request to have information withdrawn up until the point of analysis. Once analysed, with themes established, it is difficult to remove individual information.

Will participants be provided with the results of the study?

A copy of the results will be sent to you as a participant at the completion of the study from the HR department

Will participants be given the opportunity to view the data or information that relates to them?

Not after the opportunity to review their transcripts has past. Participants will be sent a copy of the completed research study.

Can participants change their mind and withdraw from the project?

You may withdraw from participation in the project up until the point of data analysis at any time and without any disadvantage to yourself.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:

Sharon Jones
(03) 470999 ext 9354
Sharon.jones@southerndhb.govt.nz

Or

Jenny Conder
Centre for Post Graduate Nursing studies,
University of Otago Christchurch
(03) 4792162 ext 208
jenny.conder@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.