There is more than one way of Nursing: New graduate nurses' experiences of their first year of practice.

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Lisette Ingram

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ABSTRACT

This research was undertaken with the aim of generating a theoretical explanation of the experience of new graduate registered nurses (NGRNs) undertaking a nurse entry to practice programme (NETP) in Aotearoa New Zealand. The objective was to construct a theory from focus group data utilising constructivist grounded theory (CGT) method.

An integrative literature review focused on NGRN experiences of practice showed that there was a strong deficit focus in research, with much written on clinical risk and transition shock. Minimal research focused on the strengths of NGRNs, and what benefit they may bring to the work areas they are a part of. There was no research on the impact of culture on new graduates other than related to negative nursing behaviour. Given that healthcare is multicultural, the workforce diverse, and Aotearoa New Zealand has an expectation of improving equity for Māori, a deficit in research related to cultural need, or indigenous new graduate need, demonstrates an opportunity for research. Waikato District Health Board (DHB) has been running a NETP programme under a bicultural model since 2018, and this provided an opportunity for research in a programme not run elsewhere.

Nurses are continuing to experience a complex and stressful work environment which leads NGRNs to align with workplace culture and preceptor expectations in an attempt to prioritise safety and care that is most visible, but this research showed that NGRNs are also motivated to prioritise cultural safety. This research delivered the theoretical explanation that NGRNs are ‘valuing culture to connect to patient need’.

The ability to value others’ cultures was seen in those who were able to take the time to first explore their own culture. Graduates experiencing NETP within a bicultural programme utilised a safe learning environment to reflect, reached the developmental stage to become aware of and understand other cultures, and over time and with clinical competence were able to discuss cultural needs with patients to connect to need. Through exploring their identity with others as part of their NETP programme, NGRNs had a clear idea of their own identity as nurses and as individuals. Those who were able to prioritise cultural safety and treating the patient as an individual found connection with patients.

Connection was iterative, with NGRNs needing to approach patients more than once, share and communicate their availability and willingness to understand in order for patients to share of themselves. Barriers to valuing culture and making connection were complex and diverse across specialty areas, but short staffing, stress and fear, pressure to work to key

tasks, and lack of insight into the cultural needs of patients from other team members were key features across multiple specialties.

New graduates are entering the workforce with an openness and optimism to meet the expectations of health equity in their nursing care delivery. Graduate programmes need to provide a safe space for reflection and enough knowledge and stimulus to provoke insight and assist them on this journey.

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CONTENTS

GLOSSARY OF TERMS

Aotearoa	The Māori name for New Zealand.
Āwhinatanga	The act of guidance, support and mentorship.
Hauraki	A region of New Zealand's North Island, inclusive of multiple tribes. It covers the Coromandel ranges, North Waikato, and part of the Auckland isthmus.
Iwi	The largest social unit in Māori society, often translated as tribe.
Kaitakawaenga	A role description from Waikato DHB in the context of healthcare- Maori elders who provide cultural support to mental health and addictions service users and their family members.
Kaitiaki	A role description from Waikato DHB in the context of healthcare - A maori elder who offers cultural support for Māori and their whānau, who are accessing General Hospital services.
Kaunihera Kaumātua	Council of Māori Elders from within the area of the Waikato DHB
Kaupapa Māori	The collective vision and purpose of a Māori community.
Kotahitanga	Unity or solidarity. In the context of Waikato DHB values, translated as "Stronger together"
Manaakitanga	To show respect, generosity, and support to uphold others.
Māori plural	The indigenous people of New Zealand. Māori is both singular and
Ngāti Maniapoto	A Waikato-Waitomo Iwi.
Ngāti Raukawa	A Waikato-Taupo-Manawatu Iwi.
Ngāti Tuwharetoa	A central north island Iwi.
Pakeha	A Māori language term in common usage for New Zealanders primarily of European origin. Can also be applied to any non-Māori New Zealander.
Tainui	A Waikato Iwi.
Tangata whaiora	Mental health and addictions service users.
Tangata Whenua	Māori term translating to people of the land. Used to describe Māori / indigenous New Zealanders.
Taonga	A treasure or thing of great value. Can relate to a person, knowledge, or language as well as physical items.
Tauiwi	People who are not Māori, or are a foreigner.
Te Ao Māori	The Māori world
Te Reo	Māori language.

Te Rūnanga O Kirikiriroa	A Māori Charitable trust and mental health and addictions service.
Te Tiriti o Waitangi	A written agreement between more than 500 Māori chiefs and the British monarch signed in 1840.
Tikanga	Correct procedure or customs under Māori protocol and customs. Tikanga differs between iwi.
Tino rangatiratanga	The self-determination of Māori people. Absolute sovereignty.
Whakaruruhau	To protect or shield. Translated by Waikato DHB to mean a safe place to be you without judgment.
Whakatau	A formal process of welcome including the ritual of Karakia (prayer), Whaikorero (speeches), and waiata (song). Followed by Kai (food)
Whanau	Family and extended family. Whānau may include those without kinship ties.
Whanaungatanga	Relationship, kinship. A sense of connection and working together.

1 CHAPTER 1 – INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION.

This thesis is an exploration of the experiences of new graduate nurses (NGRNs) in an Aotearoa New Zealand district health board (DHB) as they participate in a bicultural nurse entry to practice (NETP) programme. The aim of this thesis was to construct a theory utilising constructivist grounded theory method (CGTM) from the shared experiences of NGRNs within their first 12 months of registered nursing practice. Their experiences were shared with the researcher in multiple focus groups of candidates selected from a range of specialty areas across a single DHB in Aotearoa New Zealand. The key outcome of this research was the importance graduates put on cultural connection. There was a clear pattern of graduates describing valuing patients' culture in a variety of ways, leading to increased trust and rapport, which then strengthened the opportunity for connection and patient-centred care. This chapter will outline: the background of Aotearoa New Zealand healthcare and the NETP programme; the rationale for this research; the context of the area of research, the aim and objective of the research, and an overview of the following chapters in this thesis; Chapter two, which consists of a literature review, chapter three sharing methodology and methods, chapter four showing the research findings, and chapter five with a discussion overview.

1.1.1 Nurse Entry to Practice (NETP) programmes background

An Aotearoa New Zealand pilot of the NETP programme was run at three DHBs in 2004. At that time, Australia had been running what they described as 'Graduate Nurse Transition Programmes' across multiple states but without continuity. For example, by 2004 both the states of Victoria and Tasmania described having a NETP programme of 12 months, however, specifics differed. Victoria received $12,600 per graduate in government funding, whereas Tasmania received no government funding for their programme at all (Levett-Jones & Fitzgerald, 2005). In 2006 Aotearoa New Zealand's clinical training authority introduced funding for an NETP programme across all 21 DHBs, with a particular focus on secondary care. More recently, programmes are funded in part by the DHB themselves, and in part through Health Workforce NZ. The aim of Aotearoa New Zealand's NETP programme is to provide a supportive and safe working environment where NGRNs are successfully socialised into their roles as competent registered nurses. Graduates are recruited to roles through a centralised talent pool run by an external organisation, Advanced Choice of Employment (ACE) (ACE Advanced Choice of Employment, 2000).

1.1.2 New graduate nursing recruitment

A central recruitment service through ACE is delivered digitally via a website where prospective NETP candidates with less than 6 months nursing experience may apply for consideration by up to three different DHBs or employer groups. Candidates are then put forward by ACE to employers and, once interviewed, ACE matches graduates with employers using a preferences algorithm for the best possible outcome for both graduates and employers (ACE Advanced Choice of Employment, 2000).

All successful NETP candidates trained at an Aotearoa New Zealand institution have completed their degree, passed state examinations, gained their Aotearoa New Zealand nursing practicing certificate, and are work ready. However, years of international research and experience in practice has identified a clear theory-practice gap (El Haddad, Moxham, & Broadbent, 2017; Mellor & Greenhill, 2014), and what is described in literature as 'transition shock' (Duchscher, 2009) that the new graduate support programme intends to bridge (El Haddad et al., 2017; Rush, Janke, Duchscher, Phillips, & Kaur, 2019), and ensure that this period of shock encourages personal growth (Stone et al., 2014).

1.1.3 Te Tiriti o Waitangi and my position as a Pākehā researcher

This research took place in Aotearoa New Zealand, and I identify as a Pākehā; a New Zealander of European descent (Moorfield, 2005). Within my role as a nurse and educator, advocacy for equity in Aotearoa New Zealand has been an ongoing focus. The World Health Organisation (WHO) outlines health inequity as an international issue, and highlights the importance of healthcare provider policy advancing health equity (World Health Organisation, 2008). Aotearoa New Zealand legislates equity, and has a guiding document in Te Tiriti o Waitangi/the Treaty of Waitangi for upholding the expectation between Māori and those who have entered Aotearoa New Zealand under the authority of the British Crown. This clear and legislated expectation of equity between the indigenous population and all others entering under the authority of the colonising power is quite unique in the international context and brings an added layer of explicit expectations missing in countries less recently colonised. In spite of an increasing focus on equity in healthcare in Aotearoa New Zealand, it remains an unmet goal (Ministry of Health, 2019a, 2019b; Te Manawa Taki Governance Group, 2020).

Came et al. (2017) eloquently describes the inequity of Aotearoa New Zealand's health outcomes as 'an enduring feature of the Health Sector' (p. 106). Aotearoa New Zealand's health outcomes clearly shows that the health system is still not working in ways that are ideal for tangata whenua (Auckland District Health Board, 2020; Capital and Coast District Health Board, 2020; Counties Manukau DHB, 2015). In the context of Waikato DHB's region,

the Rapua Te Ara Matua Equity Report (2021) is a clear call to action, with inequity for Māori clearly outlined at all life stages, and Māori deaths 'preventable by disease prevention and timely access to quality and appropriate healthcare' more than double the rate of non-Māori (Waikato District Health Board, 2021, p. 29).

The Ministry of Health (MOH) stated, 'In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage may require different approaches and resources to get the same outcomes.' (Ministry of Health, 2019a). In a more succinct overview, He Manawa Taki describes equity as ensuring all people have a fair opportunity to attain their full health potential (Te Manawa Taki Governance Group, 2020, p. 2). In 2017 the MOH, under the new Labour-led government, outlined a clear intent to work in partnership with iwi under Te Tiriti, and clearly outlined the goal of reducing health disparities for Māori (Ministry of Health, 2017). This focus was echoed by the Minister of Health in his letter of expectation in 2019 for the DHBs (Clark, 2019). There is nothing vague about the expectation of specifically meeting the needs of Māori as a priority healthcare focus. A key part of this must sit within workforce development, with all staff resourced to meet cultural needs.

1.1.4 The Aotearoa New Zealand healthcare workforce

The vast majority of nurses in Aotearoa New Zealand are women, with men making up only 9% of the nursing population. Māori make up 16% of Aotearoa New Zealand's population and 23% of the Waikato region population; however, data from 2019 shows that Māori representation in the nursing workforce is only equitable with overall population levels in care and support roles, with roles such as senior or medical roles seeing the biggest inequity (Durie, 2019). Lack of representation in health professions limits diversity and has a wide ranging impact on systems and processes. The resulting healthcare outcome fails to meet the health needs of Aotearoa New Zealand's people (Hunter & Cook, 2020a; Waikato District Health Board, 2021).

Aotearoa New Zealand's graduate nursing programmes have an explicit aim to reflect the percentage of Māori in the community in the workforce numbers, however, this is not yet being achieved (TAS Kahui tutui tangeta, 2020). Nursing in Aotearoa New Zealand is a multicultural workforce with 27% of registered nurses trained and qualified overseas, most commonly the Philippines and the UK (Nursing Council of New Zealand, 2019). It is worth considering that the number of UK nurses in Aotearoa New Zealand may be higher than measured since this statistic is self-reported, and some English nurses may identify as Pākehā to reflect their place as New Zealanders. Pākehā reflects the place of a person in Aotearoa New Zealand born of immigrant ancestors as belonging, but by invitation of the

Crown in partnership with Māori. There has been reflection about the use of the term to disassociate from the identity and possible racism of other white New Zealanders (Hepi, 2008).

1.2 RATIONALE FOR THE NEW GRADUATE VIEWPOINT

The rationale for researching the new graduate viewpoint and the experiences of their first year of practice stems from multiple points of interest. Firstly, the NETP programme provides a clear point in time and a certain equality of participant experience given the entry criteria and timeline of programmes. Secondly, the new graduate ability to see what more experienced nurses may overlook as 'normal' may provide unique and valuable insight. Finally, the Waikato DHB programme is run in an explicitly bicultural NETP model which has not been documented from any other NETP programme in Aotearoa New Zealand and therefore presents an opportunity for learning that may not be found elsewhere.

1.2.1 Why the Aotearoa new graduate context? What the literature said

The NGRN experience is complex and emotionally challenging. International research shows that the first 3 months of an NGRN's career is a time of intensive growth and development (Rush et al., 2019), but also vulnerability and risk (Feltrin, Newton, & Willetts, 2019; Hawkins, Jeong, & Smith, 2019b; Thomas, Bloomfield, Gordon, & Aggar, 2018). The clinical environment that graduates are entering is complex (Murray, Sundin, & Cope, 2019b) Graduates have shared that they wish their voices were heard (Spector et al., 2015), but are also afraid to appear stupid, or reveal themselves to be less than work-ready (Malouf & West, 2011). Graduates left without the opportunity to seek support, or raise any concerns they may have, tend to attempt a trial-and-error approach which is a risk to patient outcomes (Spector et al., 2015). Aotearoa New Zealand-specific research clearly outlined the perception of risks of the theory/practice gap recognised in the first three months (Doughty, McKillop, Dixon, & Sinnema, 2018).

In an Aotearoa New Zealand context, Doughty et al's (2018) research shared that nursing directors and graduates alike recognised the support structure of NETP programmes across the country were a valuable part of ensuring workforce-ready nurses. This recognised the importance and value of preceptor relationships, peer support, and a clear orientation period; echoing international research (Henderson, Ossenberg, & Tyler, 2015; Hussein et al., 2016; Ostini & Bonner, 2012).

There is much research internationally presenting the voices of graduates themselves about what they are experiencing, but very little from the Aotearoa New Zealand context outside of assessment of programme efficacy. The subject of this research thesis includes a clear

baseline of the graduate programmes to ensure continuity of support across areas, and the fact that the graduates on the research site are experiencing a bicultural programme not delivered elsewhere. This means there is an opportunity to hear experiences and ideas not yet presented in nursing research.

1.2.2 NETP programme in New Zealand at the time of this research

As of 2019, the NETP programme in Aotearoa New Zealand has both the HWNZ/HWD service specifications (Health Workforce Directorate, 2018), and the national learning framework (Health Workforce Directorate, 2018; The DHB lead Nurses (DoN) group, 2019), which reflect both the expectations of the employer, and the requirements of programme completion. These include that the programme is a minimum of 10 months, and all programme requirements completed within 12 months. Graduates may have a maximum of two clinical placements, however at the site this research was run all NETP candidates have only one clinical placement unless a change of placement area is required for support needs. A trained preceptor is allocated for the duration of the programme and nursing caseload is shared for 6 weeks in total. Graduates attend the equivalent of 12 group learning/study days, which in the case of the research site, includes their six University study days of a 30-point postgraduate paper. All NZ NETP programmes are expected to integrate Te Tiriti o Waitangi/the Treaty of Waitangi into clinical practice, and strengthen and facilitate culturally safe practice with all clients. At the site this research was run, the NETP programme is run under a bicultural model.

1.2.3 Cultural safety in the classroom

The concept that those who descend from immigrants have differing responsibilities to those who have descended from tangata whenua (Nairn, 2002) is not something currently actioned in the planning of education in most new graduate programmes. In almost all programmes, both Māori and non-Māori nurses work in the same class group, discussing meeting their communities needs with the same facilitator. Research in undergraduate education shows that Māori students have an added burden in a classroom where, not only do they have the same learning needs of any other classroom attendees, they experience fatigue that comes with encountering both lack of cultural skill or knowledge from Pākehā classmates (Denzin, Lincoln, & Smith, 2008) Māori students also struggled being exposed to ignorance of their culture, and sometimes even overt hostility from peers (K. Jenkins & Pihama, 2001). Separation of classrooms found benefit for Māori learners as students were able to freely share and debate their experiences of colonisation’s impact on their culture and environment without having to stop to explain or even have to validate their experiences to those who have not lived it (Denzin et al., 2008).

Some undergraduate nursing programmes are run with a Māori stream, allowing Māori students the opportunity to work in their own group with Māori facilitation of learning. In the past, non-Māori nurses have expressed in research that they feel they are missing out when classrooms are split, recognising that they have a need to learn about Māori culture, and anticipating that without Māori learners alongside they may miss out on learning from their peers (A. Jones & Jenkins, 2008; Smith, 2012). This in itself is an interesting expectation - that those most impacted by colonisation also have the added expectation of their peers expecting them to step back from the personal impact and be able to support classmates with their understanding.

A bicultural training programme takes the need to prioritise upholding both the treaty obligations and the clinical expectations of nurses, and meets learning needs by working in partnership with Māori and non-Māori nurse educators. There are learning needs not recognised by standard NETP programmes. Nursing and the Aotearoa New Zealand health system has been recognised as being Eurocentric, and normalising the white New Zealand experience (J. Roberts, 2021). It has been suggested that non-Māori nurses may have experienced what Barnes (2013) describes as 'Pākehā Paralysis', and with the best of intentions may have blundered into attempting to help clients without enough knowledge or skill to meet an individual or whanau need, and been rebuffed. Or have simply anticipated this and been paralysed without even trying (Barnes, 2013). Māori nurses feel a deficit of support, with few Māori nurse educators in practice (J. Roberts, 2021; Simmons, Mafile'o, Webster, Jakobs, & Thomas, 2008).

1.3 THE CONCEPT OF A BICULTURAL NETP PROGRAMME

In 2017 the graduate programmes team at the site of this research met to re-build the NETP programme, starting from a centre of values and expectations rather than task-based learning.

The development of the programme was deliberately slow-paced. With a functioning programme up and running, the team took the time needed to consult and develop in a less pressured way. Time used not just for consultation but genuine enquiry and co-design to ensure the programme was developed with a clear outcome in mind. As well as using past graduate feedback, workshops were done with 40+ clinical nurse educators across all specialty areas. In those workshops they explored the following questions: What do you want in a new graduate nurse by the end of 12 months? What do you want your new graduates to learn and experience in their first year? and, What needs to be prioritised?

Interestingly, in groups of educators who were all Pākehā there was little or no mention of cultural safety, skills working with other cultures, or a need for an understanding of tikanga (Māori practices and behaviours). It was a clear priority for Māori and Tau Iwi educators, and those who were in a group with a Māori educator had no problem engaging with that need once raised. This blindness to a need that is not only clinically shown, but directed at national and local levels, was a surprise to the graduate programme educators. It gave an even greater importance to the inclusion of tikanga best practice (Waikato district health board, 2004), and understanding of te ao Māori within training, with inclusion of nurse educators in the running of the study days, and the need for Māori facilitation and support in the graduate programme.

With a clear gap in skill and knowledge, and a priority focus on equity in outcomes for Māori, the need was clear. The programme's values were developed by the Cultural Support team (C. Baker & Nelson, 2019) and have remained consistent in the programme development and delivery: Whakapapa (ancestry), whanaungatanga (making connections and building relationships), manaakitanga (mana enhancing, empowerment), āwhinatanga (support and mentorship), whakaruruhau (safe place to be you without judgment) and kotahitanga (stronger together), underpin learner centred facilitation of the NETP programme.

The team threaded key themes throughout all the NETP study days with an emphasis on whanau-centred care, health equity for Māori and other high need populations, using a strengths-based approach, care across the continuum of healthcare and home, nursing self-care, critical thinking, reflection and problem solving.

Out of the above programme values and key themes, the graduate programmes team and their study day co-facilitators from the clinical areas developed six study days. These used a bicultural approach to design and co-facilitate the days with both the Cultural Support team, made up of Māori nurse educators and coordinators, and the rest of the nursing education team who are a range of ethnicities and cultures.

Bicultural partnership protocols used in a clinical psychology training programme in Aotearoa New Zealand are outlined by (Herbert, 2002, pp. 112-113) under six key concepts which are based on the Articles of Te Tiriti o Waitangi:

1) Biculturalism and Māori self-determination
2) Equity and equal success
3) Mana whenua
4) Eliminating cultural racism
5) Recognising diversity
6) Personal development

The key aspects of the Waikato DHB bicultural NETP programme have been outlined under these protocols to share their alignment.

1) Biculturalism and Māori self-determination

In the Waikato DHB NETP programme direct Māori input is not only part of study days, but also programme planning, development, promotion, recruitment, and feedback for all graduates. Māori graduates are linked with Māori interviewers at application, a Māori programme educator when recruited, and opportunities to establish network with Māori nurses who are further along in their nursing journey throughout the course of the year. All that is required for a graduate to participate is to identify as Māori. There is no expectation for level of tikanga knowledge, links to marae or iwi, nor te reo fluency or understanding. Graduates who identify as Māori do not have to have been raised by Māori whanau to start their journey with the cultural support team, just whakapapa (ancestry). Classrooms are made up of all cultures, but for two study days Māori and indigenous Pacific Island graduates are given the opportunity to step away from the main group and work together through an indigenous lens.

2) Equity and equal success

Recruitment is set up so that shortlisting and interviews of Māori candidates is done by Māori nurses and clinical leaders. The standards, questions, and expectations of those candidates is the same as any other candidate at interview. The Māori panel ensures that the Māori skills and values those candidates may carry is not missed by a non-Māori interviewer's lack of understanding. In the words of a new graduate on the cultural support at Waikato DHB website video, "I interviewed for three different DHBs… It was the only interview where I felt like this was an establishment who wanted me, and was working hard to impress me." (C. Baker, Nelson, Douglas, & Rolleston, 2020).

As part of the NETP programme NGRNs have access to Māori programme educators who assist to support graduates to achieve in their academic endeavours. This is done by coaching them on how to uphold their knowledge of te ao Māori, tikanga, cultural safety, and culturally appropriate nursing assessment and care in their assignments, while still meeting academic requirements. The insight needed for this may not be well provided otherwise if the university doesn't have a Māori lecturer or professor on that course.

3) Mana whenua

Waikato DHB partners with Ngāti Maniapoto, Hauraki, Waikato-Tainui, Raukawa, Ngāti Tuwharetoa, Whanganui, and Te Rūnanga O Kirikiriroa, Kaunihera Kaumātua (Council

of Māori Elders from within the area of the Waikato DHB), through a formal memorandum of understanding with the number one priority being 'Radical improvement of Māori health by eliminating health inequities for Māori.' (Waikato District Health Board, 2017).

The NETP programme's cultural support team liaises with Te Puna Oranga Māori Health service to ensure alignment with expectations. Māori elders from Te Puna Oranga lead a formal whakatau process to welcome all graduates to the programme and DHB on their first day in a ceremony showing respect and establishing the relationship between the new graduates and their support network at the DHB.

4) Eliminating cultural racism

All NETP study days have equity and awareness of structural racism training woven throughout, with facilitators working together to share up-to-date examples of inequity to raise awareness of racism in Aotearoa New Zealand. Critical reflection is used to draw out examples from graduates' own practice experience, and scenario-based learning is used to improve skills in thinking holistically and empowering patients.

Study day three of the programme has been specifically developed with a central focus on cultural awareness, starting with a centre of self - exploring their own identity first - before exploring how others may differ, and what needs service users and their family may have.

There is no expectation that Māori graduates take any particular focus on the dominant culture, as it is understood that as participants in Aotearoa New Zealand society, they will have had immersion in this culture already (Denzin et al., 2008).

5) Recognising diversity

All NETPs have access to nurse educators from the graduate programme who are available to work alongside them in the clinical area and give feedback and support if needed, above and beyond local area educator support. Māori graduates have access to the same, but their key educators identify as Māori and have a strong focus on cultural support. This develops them to 'ensure that they integrate their culture into their professional practice – so it's not about leaving one at the door; because usually if they leave one at the door it's their cultural practice.' (C. Baker et al., 2020).

6) Personal development

Six NETP study days are run throughout the year and have facilitation by both Māori and non-Māori clinical nurse educators, including representatives from a range of specialty areas.

Two study days are held with Māori and Pacific Island graduates able to attend a class held specifically for them facilitated by Māori educators, with Māori and Pacific Island speakers. This is held on the same day other graduates have the same learning focus areas, but viewed and taught through an indigenous lens.

Monthly group mentorship is available for Māori nurses to meet with other Māori nurses.

Additionally, all graduates have:

- Access to 1:1 debrief with nurse educator or programme educator.
- The opportunity for group hauora check-ins with a programme educator.
- The opportunity to have a nurse educator work alongside them in practice.
- Access to academic coaching if needed through the university or programme educators.
- Supervision relationships set up as needed for graduates requiring a more formal ongoing reflective structure with a more experienced nurse.
- Te reo Māori language courses, available through the DHB at no cost.

1.4 "THIS FEELS PERSONAL": THE AUTHOR'S PLACE IN THIS RESEARCH

The research topic was selected due to a personal passion for new graduates as a valuable workforce, bringing updated practice, fresh eyes, and a strong sense of social justice and optimism to the profession. New graduate nurses cost $20,000 and 12 months to train to RN2 level, not including their pay (Health Workforce Directorate, 2018) which is a huge financial loss if not retained. New graduate dissatisfaction, dysfunction, and lack of retention is an early warning sign of wider systemic issues in healthcare (Coyne, Tuer, & McCulloh Nair, 2020; Ikematsu, Egawa, & Endo, 2019; Kenny, Reeve, & Hall, 2016; Read & Laschinger, 2017; Rush et al., 2019) which means new graduates voices could bring value to sharing the needs of the nursing workforce and visibility of concerns.

Working with the newest of the nursing workforce has several significant benefits. In this research they appeared to take little for granted and wanted to understand the reasoning for the care given. They saw everything with fresh eyes and did not always have the same expectations of nursing or the healthcare setting. They appeared to have less ability than experienced nurses to sit comfortably in an imperfect system, and so strive for improvement.

In addition, I was hearing on study days from the graduates themselves that, other than in task-based ways e.g. “What is the most up-to-date way of doing this?”, they do not feel they have a voice in the multidisciplinary team in their first 6-10 months of practice. Repeated reflective sessions are spent honing their skill in speaking up for safety, asking for help, and advocacy as they learn to have a voice with their nursing colleagues. New graduate nurses are heavily researched but usually using methods that ask a specific question or have a focus already outlined. A research methodology that did not put words in their mouth or lead their ideas was what I was seeking, and as written in Chapter Three, constructivist grounded theory methodology (GTM) met this need.

Aotearoa New Zealand trained in a Bachelor’s degree nursing programme, I moved to Australia in my graduate year and had the privilege of working at the Royal Melbourne Hospital in two rotations that included both the renal and trauma units. I observed there that the Greek community in Melbourne were similarly disproportionately affected by heart disease, diabetes, and suicide as our Māori population in Aotearoa New Zealand. I am ashamed to say that not much in my nursing training prior to this had opened my eyes to the fact the current system itself was inequitable, with most training focusing on the poor outcomes of Māori being related to historic challenges and treatment. Moving to a place where I had not been raised in the community meant I did not have any assumptions in place. The lifestyle choices of Greek people were held up as a healthy ideal for New Zealanders. How could I be seeing a community who had moved to Melbourne with a foundation in their home country of living long and healthy lives then having worse outcomes than the local fourth generation ‘Aussies’ (Renzaho, 2007). It did not take much research to realise that the impacts of living as a citizen with less respect or care given than others have both a psychological and physiological impact (Byrd, Toth, & Stanford, 2018; Levy, Heissel, Richeson, & Adam, 2016), and that these impacts are not only seen in immigrant populations but also in indigenous populations (Australian Institute of Health and Welfare, 2020; Ministry of Health, 2019a, 2019b; Waikato District Health Board, 2021). It was there that my passion for equity over equality began. Aotearoa New Zealand healthcare may have overcome and improved both quality of life and lifespan for all New Zealanders, but the gap between Māori and non-Māori has not improved (Counties Manukau DHB, 2015; Ministry of Health, 2019a; Te Manawa Taki Governance Group, 2020; Waikato District Health Board, 2021).

A memo from a day spent transcribing focus group notes reads:

> “I was expecting to feel *for* the graduates, I wasn’t expecting to feel *personally* about the things I hear around the culture of nursing. This feels personal. I

> need to ensure I am being clear and honest about where my understanding and belief in nursing begins and ends, and keep the graduate voice clear." (Memo, 23rd November 2019).

Grounded theory method provided the opportunity to take a topic that I am professionally enmeshed in and use that passion and knowledge in theoretical sensitivity rather than trying to be neutral in my treatment of the topic. This research is rich with context and may not be more widely usable, however, it will share a snapshot in time and narrative to share the personal experiences of these nurses.

1.5 WHY I CHOSE THIS METHODOLOGY

Constructivist grounded theory method (CGTM) was selected as research method due to its centring of the research participants voices, and the constructivist methodology's acknowledgement that the researcher's own understanding is integral to the development of theory (Melanie Birks & Mills, 2015; Bryant & Charmaz, 2019; K. Charmaz, 2014). This levelling of the hierarchy set by many research methodologies appealed, and aligned with the NETP programme principles of cultural support. CGTM has also been shown in other research to have aligned well with other person-centred research approaches and kaupapa Māori values in Aotearoa New Zealand (outlined below) (Cook, Clark, & Brunton, 2014; Levack et al., 2016; Denise Wilson & Baker, 2012).

Waikato DHB Bicultural programme values

Whakapapa – connects us to each other
Whanaungatanga – establish connections and relationships
Manaakitanga – upholding others strengths and identity
Āwhinatanga – support and mentorship
Whakaruruhau – provide a safe place for you to be you without judgment
Kotahitanga – work together to grow strong and resilient
(C. Baker & Nelson, 2019)

Grounded theory allowed me to run focus groups, transcribe, code, and construct themes in an iterative manner, with each group's codes then informing the work that followed on with the next group (Bryant & Charmaz, 2019; K. Charmaz, 2014). Throughout the research process I kept memos - written records of insights and analytic thought as they occurred - to maintain and observe the flow of thoughts (Bryant & Charmaz, 2019; Cathy Urquhart, 2013). This then provided assurance that there was a clear understanding of when my own thoughts and understanding influenced the construction of codes alongside the research participants' own ideas and shared experiences.

Aims

The aim of this research is to construct a theory from the shared experiences of NGRNs participating in a bicultural NETP program.

Objective

The objective of this research is to use CGTM to construct a theory describing NGRN experiences grounded in the participants own voice (Bryant, 2017; Corbin & Strauss, 2015; Strauss & Corbin, 2008). The experiences of NGRNs in a bicultural programme is of specific interest, with gaps in knowledge internationally.

This thesis provides an insight into the value and challenges that NGRNs bring and experience in their workplace, and the strengths and needs of a bicultural NETP programme. It also explores those who did not fit within the constructed theory and their challenges and barriers to cultural connection. In Chapter Two this thesis will explore the underpinning literature between 2008 and 2019, through an integrative review run prior to the start of focus groups. Chapter Three will then outline the methodology and methods of the constructivist grounded theory research. Research results are outlined in Chapter Four, with excerpts of transcript to illustrate codes. The discussion integrates the results with wider literature relating to NGRN experiences and the wider healthcare context in Chapter Five, and concludes this thesis.

2 CHAPTER 2 - LITERATURE REVIEW

2.1 LITERATURE REVIEW INTRODUCTION

This chapter outlines and details the design, process, and findings of an integrative literature review using thematic analysis to report the results. Firstly, the place of the literature review within the methodology of CGTM. Secondly, design and method of the review is shared, and, finally, findings and the implications for future research that arose from this review are presented.

The literature review was run in the first 3 months (February – May 2019) of research for this Masters programme. Its aim was to identify published research in this area, demonstrating gaps in current knowledge prior to developing my research question (Dey, 1993; Cathy Urquhart, 2013). In keeping with CGTM, the aim was that the literature review did not 'derail the emerging theory' (Nathaniel, 2006, p. 40).

For the purpose of this literature review, the term newly graduated registered nurse (NGRN) is used to describe nurses who graduated within the prior 12 months from a Bachelor's degree in nursing, and are in their first role as a general registered nurse. A new graduate support program (NGSP) includes the following published descriptions: Nurse entry to practice (NETP) programme (New Zealand); Graduate Nurse program, or Transition to Professional Practice Program (TPPP) (Australia); New Graduate Nurse Transition Program (NGNTP) (Canada); Transition to Practice (TTP) (USA).

2.2 RATIONALE

A literature review is required as part of the ethics process of a Masters thesis and should be completed within the first 3 months of a two-year Masters programme. The process of writing the ethics proposal was of significant value to me by identifying research opportunities and ensuring I was demonstrating competence and awareness of fundamental research principles in my work. These helped me to develop a robust research question. Even with the removal of academic requirements, the decision to review literature prior to beginning research is one I would make again, subscribing to CGTM and the attitudes of Strauss and Corbin (2008), Urquhart (2013), and Charmaz (2014) that the literature review holds a valid place as a starting point for research.

There has been an evolution and branching from original GTM as described by Glaser and Strauss (1967). In their early descriptions of GTM the literature review would not occur until after the coding of data. Glaser's key objections to a literature review in the initial stages was

the risk of side-tracking the researcher with other interpretations, and the concern that the theoretical contamination has problematic implications for *a posteriori* theory emergence (Glaser, 1998). There is an acknowledged tension between the Glaserian position on GTM methodology - with his understandable call to not bring assumptions to the research - and the value of a scoping literature review in GTM.

Strauss and Corbin (1998) discussed and debated finding a place for the literature review in the initial stages of GTM research, recognising that 'the researcher brings to the inquiry considerable background in professional and disciplinary literature' (p. 49). This resonated heavily with me as I have worked nearly a decade focusing specifically on new graduate nursing support and, simply by function of role, skill, and experience could not come to this research as a blank slate. Charmaz (2006) highlighted that the review should begin in such a way that the researcher's thoughts are not influenced by pre-existing concepts but that the literature provides a start point for the subsequent research. It has never been a question of reviewing the literature or not; only when it should occur. Constructivist methodology supports the literature review in early stages in a way that early GTM methodology argued against (Ramalho, Adams, Huggard, & Hoare, 2015). Charmaz (2014) gave space to the possibility that a researcher who is able to clearly ground their work in the data may then embrace the process of constructing themes as a melding of both the research and their 'shared experiences and relationships with participants and other sources of data' (p. 239).

2.2.1 Rationale for an Integrative review

An integrative literature review provided a clear and systematic strategy to examine the range of studies published focussing on a single topic, even if the methodologies differed. Integrative literature review methodology has been raised as of specific importance to nursing science and practice (D. Evans & Pearson, 2001; Whittemore & Knafl, 2005), and is recognised outside of healthcare as relevant to addressing emerging topics or recognising opportunities for research (Snyder, 2019). As visualisation of the breadth of research available on the topic is required it was important not to unnecessarily exclude research just because a literature review methodology demanded that the research be easily comparable, such as in a meta-analysis (Nathaniel, 2006; Sandelowski, Barroso, & Voils, 2007).

To ensure a clear process, systematic processes were followed (Pope, Mays, & Popay, 2007). A Preferred Reporting System for MetaAnalysis (PRISMA) flow chart was used in the process of exclusion and inclusion criteria (Shamseer et al., 2015), and the exclusions work and final papers included were reviewed by an academic supervisor before proceeding.

The review aimed to address:

'How are the experiences of nurses participating in a New Graduate Support programme explained in existing literature?' As well as seeking to explore the above question, I sought to identify the themes arising from the literature and any gaps in research.

2.3 Study Identification and Selection

In preparing for a literature review it is important to ensure that the question boundaries are well defined. This is so studies which could be of importance are not accidentally excluded, nor to retrieve so much general data to render it meaningless (Torraco, 2005).

2.3.1 Eligible studies

To be included in this review, papers had to share at least one of the inclusion criteria, and studies were ex excluded if they had one or more of the exclusion criteria indicated in table 1.

Inclusions	Exclusions
Studies exploring the RN graduate nurse experiences in their first year of practice while under a NGSP.	Studies not published in English.
Studies exploring the attitudes, thoughts, or feelings of graduate nurses in their first year of practice while under a NGSP.	Studies which were not peer reviewed.
Studies describing the attitudes or outcomes expected by those supporting graduate nurses in their first year of practice while under a NGSP.	Studies focused on Nurse entry to *specialty* practice programmes.
Studies identifying the outcomes of graduate nurses in their first year of practice while under a NGSP	Where separate studies shared the same data, only the most comprehensive study was included so as not to over-represent the findings.
	Studies focused on outcomes only specific to a specialty area, so not comparative to more broad nursing expectations or experiences.

Table 1. Inclusions and exclusions chart.

2.4 Search Strategy

Date parameters were set between 2008-2019 to exclude research prior to 2008 as this ensured that expectations and the nature of the programmes were still relevant to today. Databases were selected for the widest variety of coverage of nursing focused papers (Table 2), and some test runs of search queries ruled out less medical focused databases due to lack of appropriate results.

Database	Description

Scopus	An abstract and citation database inclusive of more than 5,000 publishers from science, technology, medical sciences, and social sciences journals and references. Relevant to this research, Scopus is 100% inclusive of the Medline database
CINHAL *(Cumulative Index to Nursing and Allied Health Literature)*	An abstract and citation database inclusive of the professional literature of nursing, 17 allied health disciplines, biomedical science, and healthcare.
DISCOVER	DISCOVER is an integrated abstract and citation database that is inclusive of EBSCO discovery, eBooks, and Massey Research online as well as publicly available content, and scholarly articles through university licensing.
Medline	Accessed through the Scopus search, Medline is an abstract and citation database of biology, plant and animal science, and broader science research. It has a strong focus on biomedicine. It is the U.S. National Library of Medicine.

(Burnham, 2006; Wright, Golder, & Lewis-Light, 2015)

Table 2. List of Databases

A list of synonyms was developed for NGRNs and graduate support programmes by looking at the research and publicly available programme information for terms used. An asterisk was used with Nurs* to allow for: Nurse, Nurses, Nursing, and Nursed, as well as Graduat* allowing for: Graduate, Graduates, Graduated, Graduating. In Aotearoa New Zealand they spell programme differently to the USA, and so truncations were allowed for with an asterisk. The search terms are clearly outlined in table 3.

Familiar Term	Synonyms used as search terms

New Graduate RN	“Novice Nurs*” OR “Nurse Entry to practice” OR “NETP” OR “New* graduat* nurs*”
AND	
Graduate support programme	“Graduate program*” OR “Support Program*” OR “Transition support*” OR “Transition Program*” OR “Practice Support”

Table 3. Search Strategy

Once exclusions were applied, there were 126 results. The following flow chart (Fig 1) illustrates adherence to the PRISMA reporting system (McInnes et al., 2018).

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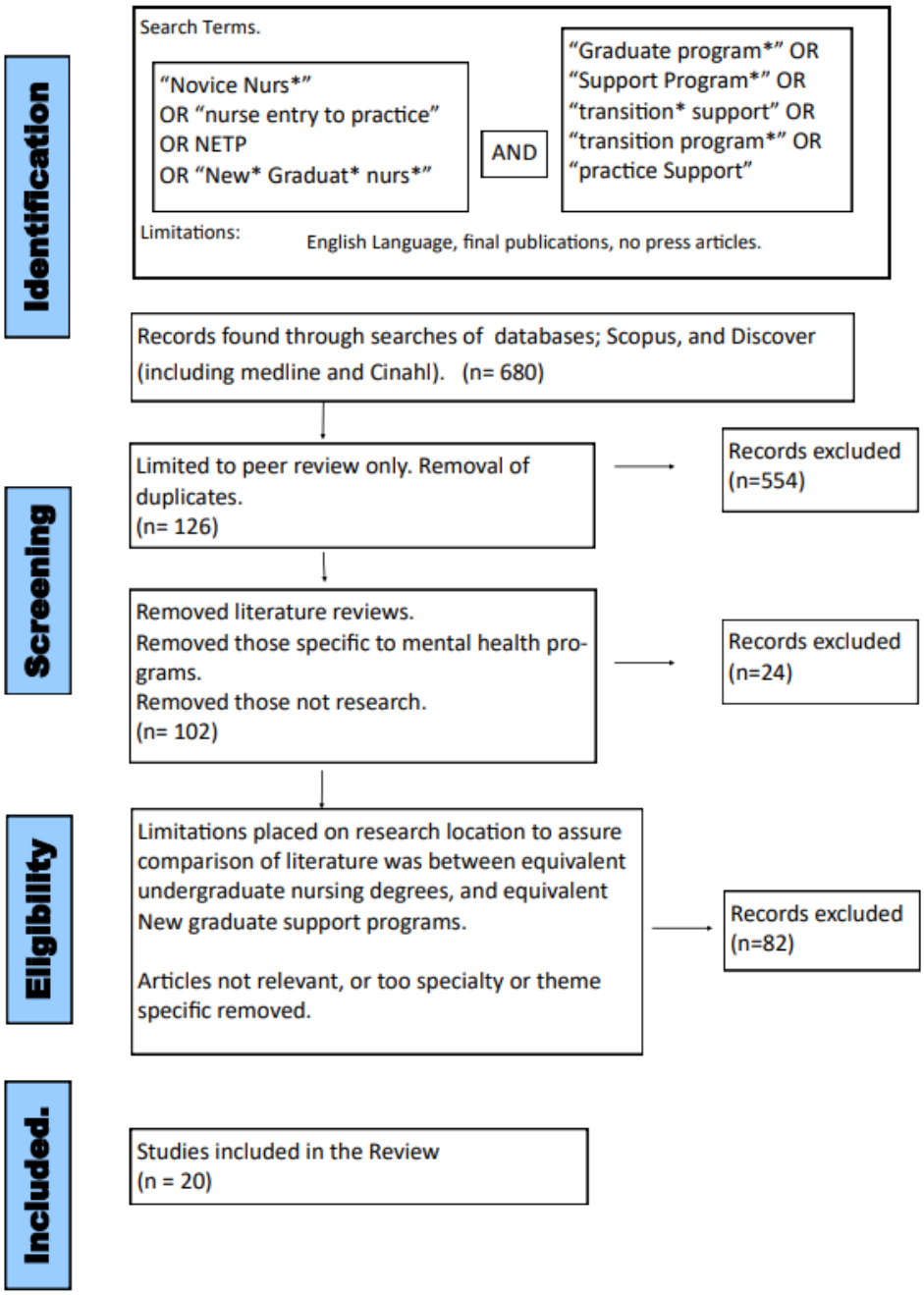

Figure 1. Prisma flow chart.

Upon review of abstracts, 15 literature reviews were removed as were papers that related to the history of NGSPs, not current research.

Next, 102 papers were examined for content and it became clear that the concept of 'graduate' and range of graduate support programmes were not equivalent internationally, with a wide range of nursing training programmes and transition support. I sought advice on

what I was recognising, and upon consultation from a senior RN and researcher I added one more exclusion:

- Exclusion of studies from countries outside equivalent training and postgraduate support programmes.

This reduced the number to around 75 papers which were manually processed and read for exclusions not able to be screened for in the search limitations. A spreadsheet was set up and simultaneous EndNote was used to track what had and had not been read, and sorted research into eligible or ineligible for review. All articles not relevant or too specific to a topic or specialty, such as only focusing on leadership or preceptorship skills, were excluded. Once completed, these papers were cross-checked against eligibility and exclusion criteria by the academic supervisor acting as second checker.

Eventually 20 papers from 19 studies were included. These originated from Australia (n=12), Canada (n=4), the USA (n=3), and New Zealand (n=1). Combined, these represented 9224 NGRNs, with studies ranging from 5 to 3,484 participants. Table 4 presents an overview of the included studies.

Table 4. Literature review research overview

Authors	Year	Title	Purpose	Research design	Country	Summary points
Ankers, M., Barton, C., Parry, Y.	2017	A phenomenological exploration of graduate nurse transition to professional practice within a transition to practice program	To explore the experiences of NGRNs participating in a NGSP.	Hermeneutic phenomenology - thematic analysis of interviews.	Australia	NGRN transition can cause negative emotions due to new demands and shock. Support from educators and senior nurses is valuable in constructive responses to this.
Baumann, A., Hunsberger, M., Crea-Arsenio, M., Akhtar-Danesh, N.	2018	Policy to practice: Investment in transitioning new graduate nurses to the workplace	Analysis of RN perspectives on a NGSP's impact on RN care delivery.	Cross sectional design survey.	Canada	RNs who developed through a NGSP had higher mean scores on key aspects of care delivery.
Chappell, K., Richards, K., Barnett, S.	2014	New Graduate Nurse Transition Programs and Clinical Leadership Skills in Novice RNs	To find predictors of leadership skills for NGRNs.	Hierarchical regression modelling	USA	Perceived quality of the NGSP was highest indicator of leadership skill outcome, with assigned mentors making a positive difference, and support of >24 weeks increased likelihood of retention in comparison to those who had support for 12 weeks or less.
Doughty, L., McKillop, A., Dixon, R., Sinema, C.	2018	Educating new graduate nurses in their first year of practice: The perspective and experiences of the new graduate nurses and the director of nursing.	To explore experiences of new graduate nurses and a director of nursing's perceptions.	A qualitative exploratory design using focus groups.	New Zealand	There is a national lack of consensus around the delivery of NETP in New Zealand. NGRNs experience substantial workload, and support structures are not always in place.
El Haddad, M., Moxham, L., Broadbent, M.,	2016	Graduate nurse practice readiness: A conceptual understanding of an age-old debate	The perspectives of nurse unit managers and new graduate programme coordinators on the practice readiness of NGRNs.	Classic Grounded theory with symbolic interactionist framework.	Australia	Opinions of what constitutes practice readiness varies, which means meeting those expectations is challenging. Collaboration is needed between clinical areas and academic providers to share responsibility.
Feltrin, C., Newton, J., Willetts, G.	2018	How graduate nurses adapt to individual ward culture: A grounded theory study	To understand NGRN strategies to integrate into the professional environment.	Grounded theory.	Australia	Adapting to a department culture is complex and multi-staged, with ongoing reflection and adaptation.
Henderson, A., Ossenberg, S.	2015	What matters to graduates': An evaluation of a structured clinical support program for newly graduated nurses	To explore NGRN perceptions of their NGSP.	Mixed method. Survey and focus group	Australia	A NGSP was of value to NGRNs with significant importance placed on emotional support and collegiality which are not measured by those developing NGSP.
Hussein, R., Everett, B., Hu, W., Smith, A., Thornton, A., Chang, S., Salamonson, Y.	2016	Predictors of new graduate nurses' satisfaction with their transitional support programme	To explore the impact of NGRN situational and personal identifiers on practice environment satisfaction.	Cross sectional survey including Manchester clinical supervision scale and practice environment scale Australia.	Australia	Clinical supervision and local work area support has a high impact on NGRN satisfaction, with older graduates less satisfied with the practice environment than younger.
Hussein, R., Everett, B., Ramjan, L., Hu, W., Salamonson, Y.	2017	New graduate nurses' experiences in a clinical specialty: a follow up study of newcomer perceptions of transitional support	To examine changes in perceptions of NGRNs' over their first year of practice.	Convergent mixed methods design using a survey.	Australia	Most attitudes of satisfaction didn't change across the course of the year, and the key areas of negative response were around workload increase, and support levels not meeting need.
Kenny, P., Reeve, R., Hall, J.	2015	Satisfaction with nursing education, job satisfaction, and work intentions of new graduate nurses.	To investigate connections between satisfaction and intention to leave nursing.	Structural equation modelling of survey data.	Australia	Work environment related job satisfaction is most effective retaining new graduate nurses. This is ahead of wage changes or work hours.

Authors	Year	Title	Purpose	Research design	Country	Summary points
'Malouf, N., West, S.	2011	Fitting in: A pervasive new graduate nurse need	To seek insight into the Australian NGRN experience of their transition into nursing, in an acute hospital environment.	Constant comparative analysis of interviews.	Australia	Current NGSP may be overly focused on orientation rather than transition. Graduates are highly focused on fitting in and rotations into new areas can disrupt this.
McKenna, L., Newton, J.	2008	After the graduate year: a phenomenological exploration of how new nurses develop their knowledge and skill over the first 18 months following graduation	To explore development of knowledge and skill across the first 18 months of practice.	Focus group analysis using Colizzi's Framework.	Australia	Graduates are still progressing in learning beyond the timeline of their first 12 months, and are still developing independent practice and becoming part of the team.
Mellor, P., Greenhill, J.	2014	A patient safety focused registered nurse transition to practice program	Exploring the nature of support given to NGRNs participating in a NGSP in rural areas.	Grounded theory.	Australia	Three key themes: "Under prepared for practice", "overwhelmed and abandoned" and "need for clinical supervision".
Newton, J., McKenna, L.	2009	Uncovering knowing in practice during the graduate year: An exploratory study	To explore experiences of new graduate nurses through Carper's ways of knowing.	Thematic analysis of focus groups.	Australia	Reflection could assist, but social and organisational culture is creating barriers to graduates' development of knowing and practice.
Ostini, F., Bonner, A.	2012	Australian new graduate experiences during their transition program in a rural/regional acute care setting	To examine NGRN experiences in rural nursing.	Interpretive analysis of interviews.	Australia	Graduates are challenged and need support in rural placement, with role ambiguity reported. Orientation and supernumerary periods assisted with development.
Read, E., Laschinger, H.	2017	Transition experiences, intrapersonal resources, and job retention of new graduate nurses from accelerated and traditional nursing programs: A cross-sectional comparative study	To examine and describe resources, experiences, and retention of new graduate RNs.	Descriptive cross-sectional comparison of a questionnaire.	Canada	New Graduate nurses all require support and preparation, and this is the same across all different ages, career, and work backgrounds they may have had prior to nursing.
Regan, S., Wong, C., Laschinger, H., Cummings, G., Leiter, M., McPhee, M., Rhaume, A., et al.	2017	Starting Out: qualitative perspectives of new graduate nurses and nurse leaders on transition to practice	To describe NGRN experiences of their transition to RN role from both NGRN and nursing leader perspectives.	Descriptive qualitative study utilising content analysis of focus group and interview data.	Canada	NGRNs require resources and transition support, but nursing leaders often face limitations due to organisational restraints.
Rush, K., Adamack, M., Gordon, J., Janke, R.	2014	New graduate nurse transition programs: Relationships with bullying and access to support	To explore relationships between work access, bullying, and NGRN experiences within a NGSP.	Quantitative analysis of an online survey as part of a wider mixed methods study.	Canada	Bullying remains prevalent in nursing, and has serious implications. NGSP provide support, and should include bullying preventions as well as training to ensure preceptors and senior staff are empowered to support NGRNs.
Spector, N., Blegen, M., Silvestre, J., Barnsteiner, J., Lynn, M., Urlich, B., Fog, L., Alexander, M.	2015	Transition to practice study in hospital settings.	To examine the outcomes and retention of NGRNs in an evidenced based NGSP, and compare with NGRNs working at sites who had pre-existing programmes.	Longitudinal randomized, multisite design. Using surveys, error data, stress questionnaire, job satisfaction index, and competency tools.	USA	An evidenced based NGRN transition programme does improve outcomes for NGRNs, and increases retention.
Williams, F., Scott, E., Tyndall, D., Swanson, M.	2018	New Nurse Graduate Residency Mentoring: A Retrospective Cross-Sectional Research Study	To examine 1-1 and group mentoring impact on NGRN development, turnover intention, and comfort as an RN.	Retrospective cross-sectional research.	USA	There was no significant relationship between turnover intention and the types of support given, however those who experienced high discomfort were more likely to leave nursing.

2.5 DATA ANALYSIS

Studies that met the inclusion criteria were all read through at a deeper level, to obtain a sense of familiarity with the content and trends. Initial reading found several studies that were by the same first author, however, in the cases of the two included (Hussein et al., 2016; Hussein, Everett, Ramjan, Hu, & Salamonson, 2017), the studies read were seeking different outcomes, with different measures.

Four studies were published between 2008 and 2013, five studies published between 2014-2016 and 11 studies were published between 2016-2018 showing an increasing amount of published research on the topic from the regions of focus.

Only one study provided comparative measures with an alternative programme group (Spector et al., 2015). Two studies were retrospective; with one using hierarchical regression modelling (Chappell, Richards, & Barnett, 2014), and one using cross-sectional analysis of secondary data (Williams, 2018). Four papers used GTM including El Haddad et al. (2017); Feltrin, et al. (2019); Malouf and West (2011); and Mellor and Greenhill (2014). Seven papers used surveys with a range of follow up analysis, some as part of mixed method studies: Baumann et al. (2018); Henderson et al. (2015); Hussein et al. (2016); Hussein et al. (2017); Kenny et al. (2016); Read and Laschinger (2017); Rush et al. (2014). Six papers by Ankers et al. 2018); Doughty et al. (2018); McKenna and Newton (2008); Newton and McKenna (2009); Ostini and Bonner (2012); Regan et al., (2017) were focus group and interview focused, founded in a range of qualitative paradigms.

The participant NGRNs ranged in age from 20 to 58 years-old (where the age was noted) with the mean age of participants of most papers around 28 years-old. Nine papers did not report on age of participants. Since the research all focused on NGRNs the expectation was that the ages of participants in research would echo the national statistics of nursing registration, which they did, unless specifically focusing on mature students.

The majority of participants were female in all studies which reported on gender, which is consistent with nursing registration statistics both in Aotearoa New Zealand and internationally (Clayton-Hathway, 2020; NZNO, 2018).

Upon second reading, notes were taken on key elements for the tracking spreadsheet to compare each paper. Studies were then synthesised using thematic analysis. Each paper was read, and re-read with themes developed. The actual method of this was far messier than anticipated, as due to an unanticipated need to physically interact, rather than working digitally, I eventually chose to use a large blank wall space and an assortment of bright post-it notes with concepts scrawled across them.

> "As someone has always felt at home working it was a surprise that I had such a strong need to *feel* the concepts tangibly and move them around in the physical world to help thoughts connect (Memo, 14th December 2019)

This memo is shared to illustrate how I engaged in the process of memo writing which is one of the key features of CGTM.

Themes that developed were analysed to seek any trends that existed between studies. Three key themes arose from nine major trends identified in the research. These themes were 'listening and being heard', 'a sense of growth,' and 'overwhelmed.' Table 5 demonstrates the themes and sub-themes generated from the literature review, and where papers share a theme.

	Listening and being heard			A sense of growth			Overwhelmed		
Author	Communication	Support	A need for connection	Recognition and accomplishment	Clinical practice development	Leadership skills	Inequity	Heavy workloads	Confronting experiences.
Ankers, et al., 2018			√						
Baumann, et al., 2018	√		√		√				
Chappell, et al., 2014						√			
Doughty, et al., 2018		√			√		√	√	
El Haddad, et al. 2017							√		
Feltrin, et al., 2019.	√		√						
Henderson et al., 2015		√	√	√	√				√
Hussein et al, 2016		√					√		
Hussein et al, 2017		√	√				√	√	
Kenny et al.2016		√	√						
Malouf & West, 2011	√		√						
McKenna, & Newton, 2008			√		√				
Mellor & Greenhill, 2014	√						√	√	√
Newton & McKenna, 2009					√				
Ostini & Bonner, 2012		√	√		√				
Read & Laschinger, 2017		√							
Regan et al., 2017		√					√	√	√
Rush et al. 2014		√							√
Spector et al. 2017		√							
Williams, 2018		√						√	

Table 5. Literature review themes.

2.6 DESCRIPTION OF INCLUDED STUDIES

Four papers used GTM - El Haddad et al. (2017); Feltrin et al. (2019); Malouf and West (2011); Mellor and Greenhill (2014) - with all four being run in Australia. The largest GTM study included 21 NGRNs at the stage of almost having completed their programme (Mellor & Greenhill, 2014). The smallest study had seven NGRN participants (Feltrin et al., 2019). All four GTM studies used purposive sampling which, while appropriate, may mean that those who chose to participate may have a different perspective on the topics raised than those who declined to participate.

Six studies were phenomenological with the analysis of focus group and/or interview data (Ankers, Barton, & Parry, 2018; Doughty et al., 2018; McKenna & Newton, 2008; Newton &

McKenna, 2009; Ostini & Bonner, 2012; Regan et al., 2017). The smallest group had five NGRNs as participants (Ostini & Bonner, 2012), and the largest had 42 (Regan et al., 2017). Mckenna et al. (2008) experienced an attrition of participants over their period of research. Only nine nurses remained for the duration of the study which may not have been a fair representation of the 16 others who contributed their voices in the first 12 months of the study. Two studies had too small a number of participants to achieve saturation (Ankers et al., 2018; Ostini & Bonner, 2012). Doughty et al. (2018) had a lack of consensus in their results, making clear that there is a need for further research with a larger population group that outlines differing views. Newton and McKenna (2009) acknowledged that in the time since the research was undertaken, changes and developments had been made to the graduate programme. Two studies (Ankers et al., 2018; Regan et al., 2017) sought feedback on their analysis and themes from the participants, demonstrating validity through trustworthiness. Others did not mention this.

All six phenomenological studies had varying ways of recruiting applicants. Some processes of recruitment, such as posters, may not have reached all potential participants. Others would have been a barrier to participation such as needing email access, or a time limit to respond. All cases required graduates to feel motivated and willing to share, effectively excluding those who may have been disengaged for any reason.

Two papers used quantitative non-experimental retrospective design (Chappell, 2014; Williams, 2018), both based in the USA. Chappell (2014) was seeking to determine the predicting factors for clinical leadership skills from a population of NGRNs. The response rate of 6.6% would not reach the expectations of statistical significance in a study of this nature. Williams (2018) sought to examine the influence of one to one and group mentoring on NGRNs and had a sample size large enough to demonstrate statistical significance. In both studies, although the data were from a diverse sample of graduates, their results were limited to self-reported responses from participants which raises the risk that it was reliant on accurate recollection of data or, in the case of Williams (2018), accurate self-awareness of skills and comfort levels.

Seven papers were sharing the quantitative arm of a wider mixed methods study, with the method being a survey and the analysis of its results (Baumann, Hunsberger, Crea-Arsenio, & Akhtar-Danesh, 2018; Hussein et al., 2016; Kenny et al., 2016; Read & Laschinger, 2017; Rush, Adamack, Gordon, & Janke, 2014). Baumann et al. (2018) may have had a selection bias – exhibited by a greater proportion of baccalaureate prepared nurses in their study than the population sampled. They were also working with self-reported data relying on accurate reporting from memory. Hussein et al.'s (2016) questionnaire was administered in a way that

makes it hard to ensure candidates would have been fully open in their responses, with those collecting the data having roles linked to the participants. Kenny et al. (2016) acknowledges a lack of causal association due to their choice of data, and only one third of the cohort completing the survey.

Two studies reported on both the qualitative and quantitative arms of a mixed method study (Henderson et al., 2015; Hussein et al., 2017), with both studies recruiting via face-to-face requests from the research team and/or nursing leadership. This may have resulted in graduates feeling pressured to participate or be less candid due to the power dynamic.

One study was a comparative longitudinal, multi-site design and delivered a survey to subjects at three points across their new graduate year (Spector et al., 2015). It was subject to volunteer bias and the organisations themselves may have been overly motivated to show the success of their programmes. The data around errors was subjective and self-reported with no triangulation from the organisations themselves as nursing errors are protected information.

The results from all studies using a self-report process are prone to subject bias with either memory or reporting errors with candidates wishing to meet socially desirable expectations, and no corroboration of information from another source.

All papers who shared ethnicity data had population groups where white participants were the majority. It may not reflect all communities that those hospitals serve, or the nursing community the population is drawn from. It is worth considering what the impact the centring of white experience is doing to perpetuate a Eurocentric style of healthcare delivery. Similarly, consideration that indigenous nurses or culturally and linguistically diverse nurses may have their own experiences of practice not fully examined in the new graduate research reviewed.

2.7 FINDINGS

Historically, graduate nurse transition was viewed as an adjustment period with transition shock to be expected (Ankers et al., 2018). Relatedly, nursing retention is a focus for healthcare internationally. Kenny et al. (2016) found that participation in a NGSP reduced the probability of NGRNs expecting to leave their current job. All the studies expressed a need to integrate graduates with the workforce and specific clinical needs of the areas they are working in. However, the key themes varied resulting in nine overall themes arising from the literature. These lead to three key topics: ‘listening and being heard’; ‘a sense of growth’; and ‘overwhelmed’. These three topics are further explained below.

2.7.1 Listening and being heard

Listening and being heard was the key topic that arose from the three themes of 'communication', 'support', and 'a need for connection'.

Communication

Four studies outlined communication as both a priority of learning needs, and also an outcome of the NGSPs- with communication linking with the theme of a need for connection (Baumann et al., 2018; Feltrin et al., 2019; Malouf & West, 2011; Mellor & Greenhill, 2014). Feltrin et al. (2019) recognised that graduates saw the opportunity to share learning needs with colleagues and as a way to show transparency. In Malouf and West's study (2011), where participants expressed a fear of appearing stupid, perceptions were being shared that the graduates lacked knowledge and felt shame in their perceived lack of skills on arrival to a new department. Their study identified actions such as withholding knowledge gaps and pretending to understand terms in order to fit in, putting belonging ahead of their learning needs. Mellor et al. (2014) highlighted that there is understatement of the risk of the transition and the need for a focus on patient safety. Graduates who do not feel they have a voice to raise concerns, or are being left to attempt a 'trial-and-error' process without oversight, are a patient risk (Spector et al., 2015, p. 57). Participants reported on the difference between the advertised support they had expected in an area versus what they were actually receiving on the floor each day. Nurses participating in a transition programme scored higher in their self-ranking of communication with both other staff and patients than those not in a programme, with confidence increasing over time (Baumann et al., 2018).

Support

Support was the most common theme arising from the research, with 11 studies raising it as a key aspect of a successful NGSP (Doughty et al., 2018; Henderson et al., 2015; Hussein et al., 2016; Hussein et al., 2017; Kenny et al., 2016; Ostini & Bonner, 2012; Read & Laschinger, 2017; Regan et al., 2017; Rush et al., 2014; Spector et al., 2015; Williams, 2018) with orientation, peer support, and formal relationships all being raised as of benefit. Rush et al. (2014) shared that more than 60% of NGRNs in their study highlighted the 1 to 3-month period in their graduate year as the time of greatest need of support.

A director of Nursing in an Aotearoa New Zealand hospital, and participants of NETP programmes expressed that the support structures in place were a key strength of their programmes (Doughty et al., 2018). Not only 1:1 preceptorship, but also wider team support and awareness of the needs of the graduates was found to be of benefit to NGRNs (Doughty et al., 2018; Hussein et al., 2017). This included peer support from other NGRNs in the same area (Henderson et al., 2015). Ostini and Benner (2012) elaborated that the informal peer

relationships were found to have equivalent impact on transition as more formal supports such as preceptors. It is of note that Read et al. (2017) described that although those coming into nursing from an accelerated programme had more life, critical thinking, and workforce experience, they needed just as much support as less mature NGRNs. Although they may have had more experience, they also may have a greater level of self-critique and more self-awareness of gaps in learning, deflating their sense of confidence.

Orientation was highlighted by both NGRNs and nursing leaders in Canada as a valued requirement of the graduate programme, with mentorship/preceptorship (these terms were used interchangeably throughout) recognised to be of value, and missed when not provided in a continuous way (Regan et al., 2017). This finding is echoed in Hussein et al.'s (2016) research linking satisfaction in orientation and clinical supervision to overall satisfaction with the graduates' practice environment. The importance of preceptorship is shared in their literature review describing transition support as a protective mechanism against transition shock (Hussein et al., 2016). Specific to the needs of an orientating NGRN, Williams et al. (2018) found that mentoring helps in transition to practice, with the frequency of contact being important; those who had mentoring set up but had low levels of contact showed higher intention to leave the organisation.

A need for connection

The theme of a need for connection was found in nine studies (Ankers et al., 2018; Baumann et al., 2018; Feltrin et al., 2019; Henderson et al., 2015; Hussein et al., 2017; Kenny et al., 2016; Malouf & West, 2011; McKenna & Newton, 2008; Ostini & Bonner, 2012), with anticipatory anxiety around fitting in (Malouf & West, 2011) signalling that it starts before the role even begins. McKenna (2008) identified that rotations between specialties limited NGRNs ability to belong, and described graduates only finding a sense of belonging towards the end of their year. Kenny et al. (2016) found that only one job satisfaction component of their research, work environment satisfaction, predicted intention to leave, with all other markers such as staffing, support, and professional development having less impact.

Two studies linked graduates' connectedness with their team to a greater transparency and awareness of their skill levels (Feltrin et al., 2019; Henderson et al., 2015). Henderson (2015) specifically outlined the new graduates' preceptors as key to assisting NGRNs to bond with their new nursing colleagues and wider team. They also highlighted study days as a key point to engage, support, and connect with NGRN peers. With regards to those links, Hussein et al. (2017) heard from graduates that introductions to other team members on their ward or unit were not always done well, but graduates who were well introduced and welcomed highlighted this action as making a difference to their success. Understanding a

graduate's individual capabilities, and giving a strong local area orientation, led to an increased foundation of success and protected them from unreasonable expectations (Hussein et al., 2017; Ostini & Bonner, 2012).

Baumann et al. (2018) demonstrated that respondents to their survey who were part of a programme showed higher commitment to the nursing profession and organisation supporting them, and this increased over time. They speculated that nurses who have been in the workforce longer have a deeper understanding of the complex practice environment.

2.7.2 A sense of growth

A sense of growth was the key topic that arose from the three themes 'recognition and accomplishment, 'clinical practice development', and 'leadership'.

Recognition and accomplishment

Recognition and accomplishment were highlighted in only one of the 20 studies (Henderson et al., 2015) but was evidently linked to outcomes and retention. The paper highlighted that recognition of the NGRNs work is of importance to the graduates, overlapping with the need for connection and being heard. However, the key standalone issue was that without the ability to make an impact in their work areas and influence changing practice, graduates ranked dissatisfaction high in relation to the issue (Henderson et al., 2015). Recognition and a sense of accomplishment were ranked highly by graduates as a priority.

Clinical practice development

Six studies linked the NGSP with clear outcomes of clinical practice development (Baumann et al., 2018; Doughty et al., 2018; Henderson et al., 2015; McKenna & Newton, 2008; Newton & McKenna, 2009; Ostini & Bonner, 2012). Participants in NGSPs had a statistically significant higher rating of their confidence and clinical decision making compared to those not in a transition programme (Baumann et al., 2018). Study days were referenced as a safe space to put theory together with shared experiences, supporting NGRN development in a pressure free space (Doughty et al., 2018; Henderson et al., 2015; McKenna & Newton, 2008). The theory-practice gap was specifically highlighted as a concern by Doughty et al. (2018) with graduates feeling their knowledge clashed with the 'way they've always done it' in an area. The theory-practice gap was found to be settled by around the 3-month period for rural new graduates in Australia (Ostini & Bonner, 2012).

McKenna et al. (2008) identify independence as one of the three main themes arising from their research. Graduates identified the ability to work independently as a possible outcome of the support of the graduate programme providing a protective space. Newton and McKenna (2009) separated graduate knowledge under Carper's four ways of knowing

(Johns, 1995), with graduates learning how to emotionally regulate responses to their new roles and apply theory to their practice through self-knowing. Personal knowing was limited until graduates had completed their first 6 months of practice. During this period of practice graduates portrayed a very task-focused, busy attitude that potentially created a barrier to reflection. As graduates shifted to a more aesthetic knowing style, they began demonstrating a maturity to their practice and an ability to transition to a more participative practice role.

Leadership

Chappell et al.'s (2014) hierarchical regression modelling of 4,617 NGRNs found that the strongest predictor of increased clinical leadership skill was participation in a new graduate transition programme. This was a unique finding in the review but due to the high number of graduates included in the study and the strength of prediction it was of value to include, and was key to the constructed theme of 'a sense of growth'.

2.7.3 Overwhelmed

Inequity

Inequity was a varied theme from six studies (Doughty et al., 2018; El Haddad et al., 2017; Hussein et al., 2016; Hussein et al., 2017; Mellor & Greenhill, 2014; Regan et al., 2017) with the difference in programmes, specialties, and the needs of specific graduates varying. Doughty et al. (2018) shared the concerns of a Director of Nursing in an Aotearoa New Zealand DHB that the NETP programmes are not available to all graduate nurses, and those working outside of DHBs may not have the same levels of support. Also of concern was the fact that some DHBs only provided a limited contract, meaning graduates experienced insecurity of knowing if they had ongoing employment, adding pressure to their performance. Canadian research showed that some NGRNs were employed on casual contracts which were identified as increasing the anxiety of the graduate (Regan et al., 2017).

On-call procedures, preceptorship, and orientation in South Australia were delivered in inequitable ways, varied between departments, and left some graduates feeling that the support was insufficient. A graduate working without sufficient support is at risk due to tending to adopt a trial-and-error approach to decision making (Mellor & Greenhill, 2014; Spector et al., 2015). The experience of graduates working in an Australian tertiary hospital highlighted the variability in what support graduates were exposed to in their work areas and highlighted the risk that varied exposure, combined with the increasing workload and challenging nursing skill mixes, raised. Graduate exposure to entirely new scenarios while feeling as though they had less support than they needed added an additional barrier to building confidence and competence (Hussein et al., 2017). With regards to the individual

graduate's life experience, Hussein et al. (2016) described nurses graduating at an older age (>23 years-old) were less likely to feel satisfaction in their clinical environment than younger graduates. They speculate that life responsibilities create higher levels of work/life conflict, or that older graduates with experience in other roles may have higher expectations of the role and be more critical of themselves and the work area. El Haddad, et al. (2017) delved into the data of graduates' lived experience in their first year of practice to develop the theory that the graduate nurses are 'inhabiting disparate realities' (p.391). This finding describes the overlapping and interplaying features and expectation of RN practice from the graduates and their stakeholders.

Heavy Workloads

Five papers highlighted the issues of heavy workload from either the graduates' perspective, or that of their support and leadership teams (Doughty et al., 2018; Hussein et al., 2017; Mellor & Greenhill, 2014; Regan et al., 2017; Williams, 2018).There was discrepancy between the graduates' expectations and confidence in themselves, and the expectations and workload of their work areas. Graduates sometimes described working "outside their scope of practice with heavy patient loads" (Hussein et al., 2017, p. 6). Heavy patient loads were raised as a risk for graduates, along with increasing acuity of those patients.

Graduate programmes exist with and without the inclusion of a Post Graduate (PG) paper in Aotearoa New Zealand as a completion requirement. Interestingly, most of the discussion of too big a workload came from participants in a DHB not requiring the PG paper. They found their programme workbook excessive and "didn't get much out of it" (Doughty et al., 2018, p. 104). The discussion from most graduates around workload, regardless of the source, was focused on trying to keep a work/life balance.

Mellor et al. (2014) discuss that as a student nurse's workload is so limited and controlled, they do not have the opportunity to provide the full range of care and lack insight into the full RN role. This resulted in a key theme of their research; 'Under prepared for practice' (Mellor & Greenhill, 2014, p. 54). They also found the theme of 'overwhelmed and abandoned' with graduates reporting that they felt they were expected to work independently well before they felt capable of doing so. In Canadian new graduate programmes high workload and high patient acuity was seen as a factor impeding transition, with safety concerns described around the patient acuity vs skills of NGRNs. The nursing leaders raised graduates being too task-focused and not adapting well into their areas as a concern. There did seem to be insight that the work areas were too high acuity for a NGRN, but this was not shared in the same context as the concern around graduates being too task-focused, or not coping with the frequent changes and high acuity of care (Regan et al., 2017). Williams et al. (2018)

showed clear correlation between nurses who described their comfort level in the role of a staff nurse as “uncomfortable” and those who described their intention to leave as high or definite. There was also correlation between those who had less frequency of mentoring and higher turnover intention.

Confronting experiences

Separate from the issue of feeling underprepared or unsupported, graduate nurses shared experiences that were confronting. Bullying and harassment were raised in two papers (Regan et al., 2017; Rush et al., 2014), Regan et al. (2017), highlighted incivility and intimidation as themes in their interviews. Workplace harassment or bullying was experienced by 39 percent of NGRNs sampled in Rush et al.’s 2014 study which included 242 graduate nurses opinions. Exposure to bullying and harassment was equal in both of Rush et al.’s groups; those in and those not in a graduate support programme. Where they differed was that those who were in a programme were more likely to access support and show improvement. In both papers NGRNs were aware of dysfunction in unit culture and had concrete examples of it impacting them when peers or senior staff were intimidating or uncivil (Rush et al., 2014).

Australian based research by Henderson et al. (2015) highlighted that after hours was a specific point where challenges seemed greatest, with less resource staff and support for nursing teams. Between 6-8 months into the programme, the team supporting a graduate may have started to forget how new they are and not realise they haven’t experienced something before. One example given is a patient death. Graduates found informal supports such as a network of people they can link in with to talk through these confronting experiences in a low threat environment (Henderson et al., 2015).

2.8 Literature Review Discussion

This review highlights the three themes of ’listening and being heard’, ’a sense of growth’, and ‘overwhelmed’; found across the review of 20 papers. The themes are found in a variety of ways throughout the range of papers reviewed. Together they paint a picture that echoes the concerns across the history of new graduate research; it is a time of steep learning, high need, and perceived and real high risk.

Listening and being heard: It would be easy to simplify the findings of this literature review into separate themes of communication, support, and connection, as they were clear themes with ‘support’ and ‘connection’ in almost all papers. However, where the research described the extremes (strong programmes with excellent support, or graduates who described dysfunction), the result was either the raising up or muting of the NGRN voice. It was with

this in mind that the three themes were subsumed into the main theme of ’listening and being heard’.

In this review the most prominent theme was how NGRNs seek support and connection and was identified in 16 of the studies. Socialisation in the workforce shapes student nurses’ behaviours professionally (Dorsey, Kelly, Luetkemeyer, & Lojovich, 2018; Pai, Huang, Cheng, Yen, & Lu, 2020). Two papers proposed that communication barriers have been linked to patient risk (Malouf & West, 2011; Mellor & Greenhill, 2014).

A perceived lack of knowledge, or feeling like an outsider, can lead to graduates choosing to hide their lack of knowledge or avoid asking, leading to attempting tasks without the support they feel they need (Malouf & West, 2011; Mellor & Greenhill, 2014). The culture shock of starting as a RN can be significant (Hampton, Smeltzer, & Ross, 2021). Support for NGRNs, when received at the time of key risk (Rush et al., 2014), is highly valued (Kim & Yeo, 2021) - and both graduates and support teams are aware that there are variations in what the graduates are promised in support, compared with what they receive on any particular shift (Doughty et al., 2018; Henderson et al., 2015). The focus on the first 3 months in Doughty et al. (2018) echoes concerns highlighted by other research regarding the expectation that NGRNs are up to full pace and skill with their RN peers by the time they have completed orientation (Rush, Adamack, Gordon, Lilly, & Janke, 2013). It is relevant beyond high acuity and large hospital settings; Lea and Cruickshank (2015) highlighted that the graduates develop uniquely on different timelines and staged workload and specific support is needed when examining the experiences of NGRNs transitioning to rural nursing practice.

Fear of causing trouble (Hawkins, Jeong, & Smith, 2019a) and barriers to speaking up mean that having support structures in place and accountable may decrease the risk of graduates working alone (Jarden et al., 2021). Graduates are anxious on arrival about becoming part of a new team (Malouf & West, 2011) and communication, connection, and inclusion can help them settle enough to trust the team. Successfully fitting in to the nursing team reduces risk for NGRNs (Chung, Li, Ho, Cheung, & Chung, 2021). With regards to retention of staff, a sense of belonging is key, with Kenny et al. (2016) identifying that when predicting likelihood of a NGRN leaving, the only job satisfaction marker related to intention to leave was work environment satisfaction. Interestingly, finding a sense of belonging and trust is echoed in other ways in nursing research. Trust is not limited to in-person interaction, graduates gained a sense of belonging from in person NGSP support (Hampton et al., 2021; Kim & Yeo, 2021), as well as a digital mentoring programme (Pimmer, Abiodun, Daniels, & Chipps, 2019). Authentic nursing leadership increased trust in NGRNs which impacted on satisfaction (Alkaabi & Wong, 2020).

A sense of Growth: Clinical practice development is one of the key pillars of all NGSPs internationally, with six papers specifically outlining it within their research (Baumann et al., 2018; Chappell et al., 2014; Doughty et al., 2018; Henderson et al., 2015; McKenna & Newton, 2008; Newton & McKenna, 2009; Ostini & Bonner, 2012). New graduate nurses in NGSPs show higher confidence and decision making compared to those not supported within one (Graf, Jacob, Twigg, & Nattabi, 2020; Hampton et al., 2021). A sense of growth is an unsurprising finding given the amount of practice development in a nurse's first year. For example, graduates are rarely sufficiently prepared to work with dying patients prior to practice (Kent, Anderson, & Owens, 2012; Puente-Fernández et al., 2020). A sense of growth is not just recognised by NGRNs through career progression and leadership skill (Chappell et al., 2014), but also task and communication-based outcomes (Lusk Monagle, Lasater, Stoyles, & Dieckmann, 2018), and graduates own attitudes towards keeping up with the pace of a clinical work area (Baumann et al., 2018; Ostini & Bonner, 2012). This theme of Growth was highlighted in relation to patient death, within the focus of facilitating a 'good death' (Zheng, Lee, & Bloomer, 2016, p. 320) where nurses benefitted from the challenge and recognised their growth. Graduates and nursing leaders recognised the value of study days away from the clinical area to safely grow, share experiences without judgement, link theory with the sometimes-jarring realities of practice, and recognise their learning (Doughty et al., 2018; Henderson et al., 2015; McKenna & Newton, 2008). A sense of growth was also found through the ability to emotionally regulate themselves in response to what they are being exposed to as nurses, and work independently in a less task-based way (McKenna & Newton, 2008; Newton & McKenna, 2009).

Overwhelmed: The term overwhelmed is used not just in the context of the graduate, where it is used in their own language (Ankers et al., 2018; Mellor & Greenhill, 2014), but also in the context of nursing leaders seeking to find equity for graduate experience across a country with differing programme delivery and resourcing (Doughty et al., 2018), and the healthcare system itself which is seeing increasing patient acuity (Doughty et al., 2018; Hussein et al., 2016; Hussein et al., 2017; Mellor & Greenhill, 2014; Regan et al., 2017; Williams, 2018). With acuity high, and graduates reporting lower staffing after hours (Çamveren, Arslan Yürümezoğlu, & Kocaman, 2020), exposure to extremely complex or traumatic events is expected in acute areas, but not necessarily well supported (Henderson et al., 2015; Regan et al., 2017; Rush et al., 2014). Interestingly, an Aotearoa New Zealand study following a small cohort of more experienced nurses echoed the theme of missed nursing care and feeling overwhelmed leading to moral distress (Winters & Neville, 2012). This shows that it is not necessarily an issue unique to NGRNs, but a far wider concern

around the nursing workload (L. J. Labrague & McEnroe-Petitte, 2018; Moloney, Boxall, Parsons, & Cheung, 2018; Murphy et al., 2021).

Graduates are also exposed to bullying and harassment, whether in a NGSP or not (Rush et al., 2014), and dysfunctional unit culture can stem from stressors (Alkaabi & Wong, 2020). This is echoed in wider research, with Evans et al (2008) reflecting that NGRN self-esteem and self-identity were heavily impacted by not only the way they were treated, but the way they believed the NGRN role was viewed Interestingly, the themes arising for NGRNs echo the results of an Aotearoa New Zealand study of why older nurses were leaving the workforce, and their strongest themes were inadequate staffing, inability to deliver appropriate care, and workplace bullying activity (Hawkins et al., 2019b; Walker, Clendon, & Willis, 2018). Studies also describe bullying in nursing outside of graduate experience (Hartin, Birks, & Lindsay, 2018; Tabakakis, McAllister, Bradshaw, & To, 2019). It appears that the inexperience or vulnerability of NGRNs is not necessarily the cause of bullying, but perhaps as NGRNs or students seeing the systemic issue, they are more willing to speak up. An important consideration is that there is research to demonstrate that nurses who have experienced bullying show ‘decreased resilience’ (Tabakakis et al., 2019) and so for a NGRN to begin their career with this experience, they are essentially starting on the back foot.

The issue of NGRNs being too task-focused appears to be international (Doughty et al., 2018; Newton & McKenna, 2009; Regan et al., 2017). Little connection in most studies appears to have been made by senior nurse research participants between the NGRNs being out of depth with the acuity of patients, and the ‘task-focused’ coping mechanism this may cause (Murray et al., 2019b). Mellor et al. (2014) highlighted the gap between student experience, where workload is carefully controlled and tasks are key, and the NGRN requirements of being able to change tack frequently and think critically. They describe this as a clear under-preparation of student nurses for practice. This is echoed internationally in literature from a range of new graduate experiences (Duchscher, 2009; Edwards, Hawker, Carrier, & Rees, 2015; El Haddad, Moxham, & Broadbent, 2013; Kelly & Ahern, 2009).

Most research on new graduates includes no identifiable focus on cultural aspects of the role, or how a graduate’s culture may impact practice. When research did focus on culture, it was the culture of the work area being centred, and whether the graduates could fit in. This in itself is an interesting observation when nursing is such a multicultural workforce, and the patients and families they are caring for do not fit comfortably within the medicalised culture of acute services (Graham & Masters-Awatere, 2020; J. Roberts, 2021), which tends to be led by a Eurocentric culture and values in Western countries (Degrie, Gastmans, Mahieu,

Dierckx de Casterlé, & Denier, 2017; D. Wilson & Barton, 2012) and was described in the Aotearoa New Zealand context as ‘ Pākehā Tikanga’ (Barton, 2008, p. 64)

2.9 Literature Review Conclusion

The NGRN experience continues to be multifaceted with clinical, professional, personal, and emotional learning requirements. The exposure to high acuity, fast paced nursing is occurring within the first three months of practice, and the literature identifies both perceived and actual risk. Research highlights the need of graduates to feel as though they belong, have a voice, are valued, and are safely supported in their new role. The concerns of a new graduate’s first year of practice being a time of high risk for both NGRNs and their patients is echoed by nursing leadership as well as NGRNs. There appears to be opportunities for further research and programme developments to help meet these needs and decrease the risks, however organisations have limited resourcing.

There is a great focus on the needs of new graduates, and the clinical and personal risk of NGRNs. In deficit focus research there is little about the strengths new graduates may bring to the workforce. There is also little research looking at the cause of task-based focus, only that it occurs, and there is an opportunity for future research on workload impact on the critical thinking abilities of NGRNs. There is no research specific to new graduates regarding the impact of culture on NGRNs, and how their identity or the culture of the workplace may make a difference in their experiences.

3 CHAPTER 3 – THE RESEARCH PROCESS

It is standard to start the methodology chapter with a review of the methodological choice and why, but in this case the reasoning is steeped in a local and international drive for equity, and the Aotearoa New Zealand context. Therefore, this chapter will begin with the context of new graduates in Aotearoa New Zealand, moving into describing the research overview, ethics, and methodology, and finally outlining the methods in more detail.

3.1 THE AOTEAROA CONTEXT

There is increasing understanding that health research in Aotearoa New Zealand has historically perpetuated inequity. Research lead by, written by, and shared with non-Māori researchers historically excluded Māori, other than as subjects (Smith, 2012). Harm was caused where research conflicted with Māori values, undermined self-determination, and re-colonised participants (M. Baker, 2008; Denzin et al., 2008; Smith, 2012).

This research is set in the context of Aotearoa New Zealand focusing on NGRNs. The nurses are from a range of cultural, geographic, and ethnic backgrounds, and for the purpose of research recruitment the only ethnic identity noted is Māori or non-Māori. This is self-identified by the graduates at the time of application and is part of their file. Ethnicity at recruitment was collected for the purpose of ensuring recognition of the representation of Māori participants and their voices, and ensuring that the data of their voices is valued and shared.

As the researcher, my expectation is that Māori have tino rangatiratanga (authority) over their taonga (treasures) which includes Māori knowledge (Came, 2013; Hudson, 2010; Smith, 2012). There is a clear obligation to ensure that any learning arising from Māori willing to share their knowledge should be shared to benefit Māori.

As a Pākehā it is not my place to lead kaupapa Māori research as this would only provide further power imbalance and risk misinterpretation, which is in conflict to the outcomes I aim for as a researcher. To take kaupapa Māori research as the central methodology as a Pākehā risks undermining Māori autonomy and perpetuating colonisation (Denzin et al., 2008), centring a Pākehā voice. CGTM research aligns well with bicultural partnership protocols (Herbert, 2002), and the values leading the Graduate programme being researched. These alignments assisted in clear ethics to better meet the needs of both the participants, and those who may use this research in the future. Figure 2 illustrates the Bicultural partnership values, graduate programme cultural support values, and GTM concepts, and where they align.

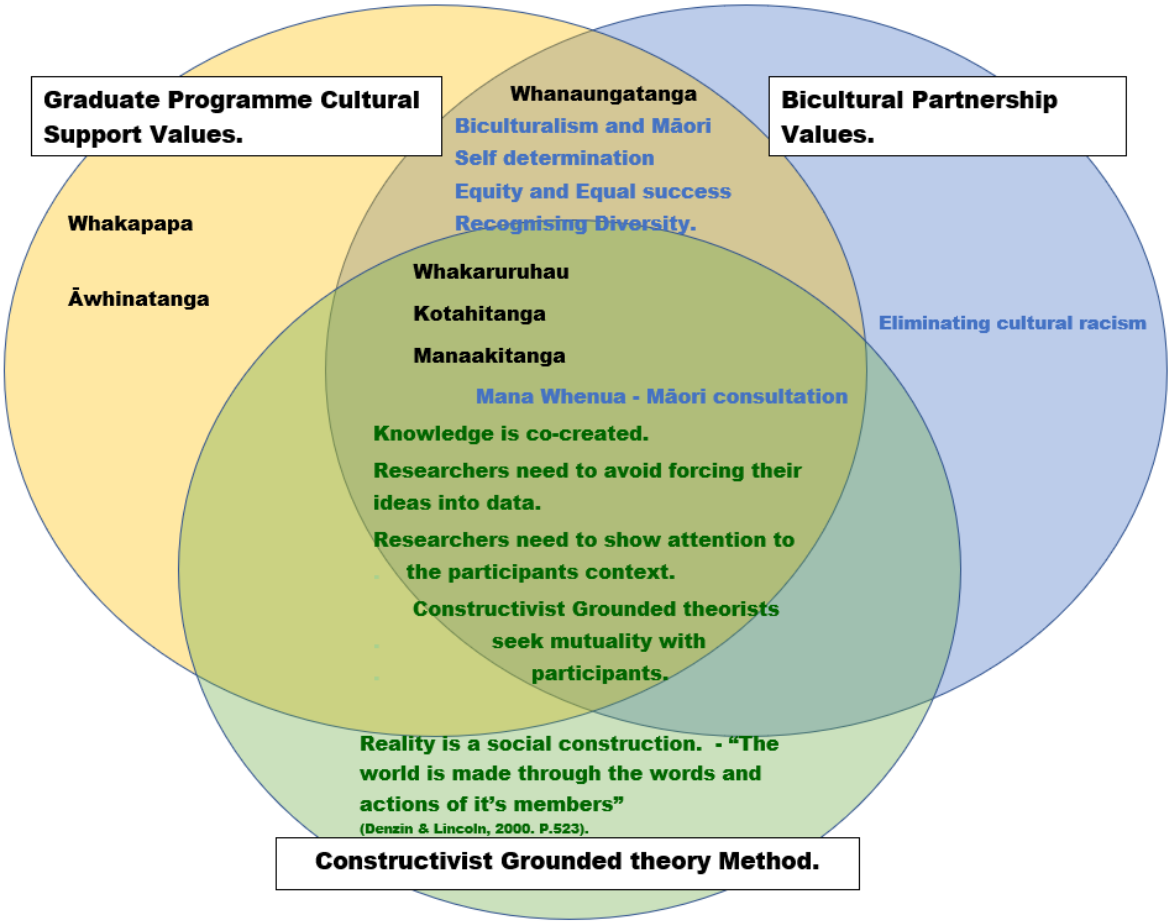

Figure 2. This image shares the bicultural partnership values, the graduate programme cultural support values, and GTM concepts alignment.

3.2 Overview and Methodology

3.2.1 Constructivist Grounded Theory Methodology (CGTM)

This section will outline CGTM and how the action of constructing a methodology is different to the usual expectation of many other qualitative research methodologies. Specifically, that it explicitly acknowledges that reality is socially constructed, and assumes that the researcher is not distanced from their subjects but expects that the knowledge is co-created with the participants (K. Charmaz, 2014).

Constructivist Grounded Theory (CGT) was chosen after the analysis and comparison of a range of qualitative methods. It appeared to be a methodology that had fitted well within other Māori centred research approaches and kaupapa Māori values in research ethics (Cook et al., 2014; Levack et al., 2016; Denise Wilson & Baker, 2012) and so would work with the aim to uphold the DHB NETP bicultural programme principles within this research. Constructivist GTM had evolved from Grounded Theory, first described by Glaser and Strauss (1967) Grounded Theory Methodology (GTM) has branched into separate concepts

as it evolved through multiple movements. Much writing separates its initial branching into Glaserian or Straussian, however this ignores both the impact and writings of those authors in the continued development of GTM, and the nuances of the evolution. So instead this chapter will use the term Classical GTM for what is initially described as Glaserian (Glaser, 1992), and Evolved GTM to describe Straus's initial evolution (Jane Mills, Ann Bonner, & Karen Francis, 2006a; Ramalho et al., 2015), and CGTM to describe the further development of GTM by Charmaz (2006). It is not as simple as three distinct schools, and there is much debate over how separate the three are (Ramalho et al., 2015; Rieger, 2019).

Grounded theory methodology is set within a relativist ontology and subjective epistemology (Denzin & Lincoln, 2005), with CGTM sitting at the furthest extreme of this continuum to Classical and Evolved GTM (Jane Mills, Ann Bonner, & Karen Francis, 2006b) GTM is described as an interpretivist methodology with the aim to reach "abstract understandings that theorize relationships between concepts" (K. Charmaz, 2014, p. 228) which do not focus on causality. The central tenets of all methodologies of GTM include beginning with inductive logic, simultaneous collecting of the data and the analysis and theory construction, memo writing, and the generation of a grounded theory (K. Charmaz, 2014; Corbin & Strauss, 2008; Mills et al., 2006a). It is the procedure of data analysis, and the role of the researcher, that differs between the different branches of GTM (Rieger, 2019).Constructivist GTM appealed to me due to its natural alignment with cultural support programme values (C. Baker et al., 2020), and bicultural partnership protocols (Herbert, 2002). Reciprocity and seating the learner as the expert, and exploring learning concepts from their perspective and experience, is at the centre of the Waikato DHB NETP programme. Constructivist GTM required that I committed to a reciprocal relationship with those participating in the study, and acknowledged that knowledge is co-created.

At the core of CGTM is Chamaz's focus on the researcher being an integral part of the collection of data and development of theory. The researcher and their experience is a part of that, not set to one side as in other GTM methods (Melanie Birks & Mills, 2015; K. Charmaz, 2014). What is also unique about CGTM is the reduction of hierarchy. The traditional hierarchies of research are less overt with CGTM and the reflexivity is expected from the researcher with memos used to ensure reflexivity and commit to an ongoing exploration of their thought process and transparency within the research. Historically the relationship was minimally examined in initial texts, however, this has developed to be more explicitly outlined in more recent writing (Bryant & Charmaz, 2019; Cathy Urquhart, 2013).

In selecting CGTM the researcher makes a commitment to a relationship with the participants of the research. In order to do this a consideration of the power imbalance must,

and has been, made. The overlap of prioritising the co-ownership of the knowledge of participants is shared in Figure 2 above.

Following a key feature in the recruitment for grounded theory, I did not pre-determine the number of participants, instead theoretical sampling was used. Theoretical sampling was an innovation of early GTM, grounded in the data collected (Glaser & Strauss, 1967; Strauss, 1990) and aligns with the iterative nature of GTM. Once interview and analysis has begun, further recruitment can occur (Bryant & Charmaz, 2019). For example, when it was noted that in the first two focus groups all attendees had recurrent categories of belonging and connection, but almost all of them had studied at the same site, theoretical sampling allowed me to reach out to continue recruitment to allow for a group of candidates working in a site where they had not studied and were entering as outsiders. This allowed an opportunity to ensure this recurrent category was not simply as a result of circumstance.

3.3 METHODS

3.3.1 Ethical Considerations

In the context of CGTM research, the relationship between researcher and those participating is to be examined, not eliminated or ignored (Melanie Birks & Mills, 2015; Corbin & Strauss, 2015; Cathy Urquhart, 2013). The relationship between researcher and participant is not without a power dynamic. In the case of this research, conducted on the same site in which the researcher is working as an educator; the role affords a perception of power even if there is no ability to affect the career, grades, or outcomes of the NGRNs. As I reflected on the tensions of power, employment, leadership, and support, it was clear that it was not enough to simply disclose the dynamic; all routes to participation must be without pressure or obligation (Denzin & Lincoln, 2018; Holloway & Galvin, 2017; C. Urquhart, Lehmann, & Myers, 2010).

The research was designed so that all participants were self-referred following the opportunity to read the information in full and contact the researcher or supervisor ahead of volunteering. To avoid coercion, a third-party administrative staff member not associated with the graduates' employment or programme was the source of the recruitment email, and information was sent to prospective participants through a group mailing list of all graduates who started the NETP programme in 2019. The email contained an overview, participant information sheet, and consent forms for the nurses to review. If they wished to participate, they then self-referred via email directly to me.

The next concern was empowering participants who might change their minds or wish to stop or withdraw from the study. If a participant changed their mind mid-focus group, they may wish to withdraw. It is standard ethical research practice to include the right to withdraw in any research plan, however, in the case of a focus group the individual's right to withdraw may not overrule others right to participate and have their material recorded and used. Due to this, it was clearly outlined in the participant information sheet that if participants withdrew once recording started, then they could stop participating at any time but the recording remained. As well as understanding their right to withdraw, in order to feel safe participating, participants needed to know that their participation in the research would not be linked to them and would remain private.

There are multiple touchpoints for ethically protecting participants in Aotearoa New Zealand research. The New Zealand Privacy Act (1993), DHB and university ethics processes follow the standard operating procedures for health and disability ethics committees (Ministry of Health, 2008). More recently the National Ethics Advisory Committee has published a national ethical standards for health and disability research and quality improvement expectations (National Ethics Advisory Committee, 2019).

Participant identity, work area, and any identifying detail was anonymised by the researcher in the process of arrival at the focus group. All participants chose a letter to call themselves, and have others call them by so that even in the recordings, names are not used. The consent forms with identifying information were stored separately from all other research material, transcripts, and recordings to ensure their identity was protected. The digital data storage for the DHB computers where this research is being stored meets the requirements of the New Zealand Privacy Act (1993) with a secure server and logins on all devices, and files were held in a folder only accessible to myself. Computers are also protected from external device transfer by only allowing secure login protected memory sticks provided by the DHB. The biggest risk for unsecure information was possibly the participants themselves since they were in a group for their sharing of experiences.

Each participant was asked to sign a form that included a confidentiality agreement to agree not to speak about the research with others. The majority of participants in the programme are between 21 and 27 years-old and are confident and fluent on multiple social media platforms. In the orientation discussion it was outlined that sharing your own or others participation in research on social media may mean you have inadvertently breached confidentiality. This generation of new graduates have been trained with the Nursing Council of New Zealand Nurses guidelines on social media and electronic communication (Nursing council of New Zealand, 2012) and have had training in e-professionalism in undergraduate

training and workplace orientation. There are clear boundaries set and the graduates expressed confidence in understanding these. Although they were all very clear on these concepts, it is also outlined in the participant information sheet (PIS) that confidentiality cannot be promised due to the participation of other participants. Before beginning their participation, they all had this clearly outlined in writing, and signed to acknowledge their awareness. Ethics approval was submitted through both the DHB and Massey University, See appendix B, approval number SOA 19/57.

3.3.2 Focus Group and Transcription Methods`

Focus groups, as discussed in the ethical considerations section, were made up of graduates in their first 12 months of practice in self-selected groupings. Three participants were Māori. Two focus group participants identified themselves in the group as Māori as part of conversation, the third did not share being Māori in their focus group. Five identified themselves as having been born outside Aotearoa New Zealand, as it was relevant to the context of what they shared. The rest were unidentified ethnically. The key features of participants is shared in table 6 below.

Identifier	Identity shared	Months in practice	Gender
A	Not shared	3	Female
B	Māori	3	Female
C	Māori	3	Female
D	First Generation New Zealander	3	Female
E	Not Shared	3	Female
F	Not Shared	9	Female
G	Not Shared	10	Female
H	Not Shared	10	Female
I	Not Shared	11	Female
J	First Generation New Zealander	4	Female
K	First Generation New Zealander	4	Female
L	First Generation New Zealander	4	Female
M	Pākehā	10	Female
O	NZ European	10	Female
P	Pākehā	10	Female
Q	Not Shared	12	Female
R	Not Shared	5	Female
S	Not Shared	5	Female
T	First Generation New Zealander	5	Female
*note: one person who chose not to share identified as Māori.			

Table 6: Overview of research participant identities.

The context of not identifying other ethnicities is the risk of misidentifying, or erasing, identity. What it means to identify as a New Zealander is not only ethnicity, but geography and

number of generations since arriving in Aotearoa New Zealand. It is not as simple as where we are from, but also where we are, how long our family has been here, and where our people still are. In the words of Ella Kahu, “What it means to be a New Zealander or to be in this place (and those are not necessarily the same things) may be quite different for different people.” (Cain, Kahu, & Shaw, 2017, p. 11). To place people into either ethnic backgrounds, or geographic identities, would be to use their identity in a way they may not choose to self-identify.

For this reason, only Māori have been the identified group in order to uphold and ensure inclusion in this research. All others are grouped together, with those who chose to identify as first-generation immigrants able to do so and reflect this on the record as it arose. This was not a planned outcome but arose out of the participants own sharing.

Interestingly, in one group two participants identified themselves as Pākehā when asked if anyone identified as Māori. The third person very deliberately differentiated themselves as ‘New Zealand European’. This is a clear example of three Aotearoa New Zealand born white New Zealanders who choose to identify differently based on their cultural understanding of their identity.

The focus groups were held in a meeting room away from any clinical area thus affording privacy and confidentiality. In some focus groups, graduates chose to share their personal ethnic, religious, or geographical backgrounds as a setting for the conversation around their place in workforce, or the impact of training. Where this has been done, I have used their own terms of identity in the data with their permission.

The set up and running of the focus groups aligned with Baker et al.’s (2020) six key values from the graduate programme itself.

Whakapapa –what connects us to each other
Whanaungatanga – establish connections and relationships
Manaakitanga – upholding other’s strengths and identity
Āwhinatanga – support and mentorship
Whakaruruhau – provide a safe place for you to be you without judgment
Kotahitanga – work together to grow strong and resilient

Manaakitanga is a te reo Māori term meaning to show respect and care for others (Moorfield, 2005). Actioning this was more than just supplying food and drink for focus groups. For example, candidates were contacted individually by myself to identify any dietary needs. and the whole group was informed ahead of time what would be provided, how their needs would be met, and were invited to arrive early if they wished additional time for

greetings and to ask questions. It is not simply the provision of resources, but the act of helping people feel welcome to them. At the end of each session candidates were invited to take the food away with them to reinforce that it was theirs, not my own.

Each graduate was introduced to the others on arrival and I made sure that, prior to starting, they went outside for at least five minutes to wait for the next person before starting the group. This meant I was out of the room when participants first arrived so they could take their time reading the printed materials again, and discuss any questions and concerns with each other out of my presence. It was noted that this seemed to mean that there were plenty of questions asked ahead of time as they had the chance to process as a group prior to being asked if they were happy to participate. Several groups asked questions with the preface 'We have a question' which would imply they had discussed things, and opted to have a spokesperson to empower them.

At the end of each focus group - after turning off the recording device, thanking them all for their time and releasing them to take food with them when they left - I ensured I sat back and moved into a physical position of relaxation, put the pen down, and asked, "How did that feel? Was that ok? Does anyone have any questions?" Using body language to send the message that there was all the time available to them and no pressure to leave. One group in particular chose to stay on and discuss what research looks like in nursing and ask questions about academia, using me as a resource – reciprocal value being found in conversation. As Anne Oakley shared in Robert's book, "there is not intimacy without reciprocity" (H. Roberts, 1981, p. 61).

Graduates self-selected the groups they attended, and all but one group chose the time and day. This meant that graduates attended focus groups with people they already had a level of comfort with which decreased barriers to speaking up. Focus groups were run in a comfortable space that was seen as being away from the work area and the groups were given time to connect without the researcher prior to starting. The opportunity to meet at a site of candidates' choice was also given but not used.

As well as efforts to ensure the physical space was safe, it was important that graduates emotional and spiritual wellness was supported as they participated in the research. All graduates were given access to free confidential counselling support contact details at the time of the focus group in case anything arose from the shared stories. They were also offered 1:1 professional supervision that could be set up through the DHB peer support process.

At the same time as starting the recording for groups, a timer was started for my own reference. The timer's purpose was two-fold. One was to ensure the session did not go over

time, the second to enable detailed notes to be kept, organised by time on a run sheet. What is described as a ‘run sheet’ was a template holding columns for time, speaker, and notes. This meant as the focus group progressed I could note the time and who it related to, reflecting either on what they said or make a note of their body language, responses, and tone that may not have come across in the audio-recording at the time. This provided a valuable resource later in transcription. An example was that someone’s statement may have felt straightforward if I had not put the note ’looked around, appeared to realise they weren’t in agreement, and quickly changed topic‘. This gave the insight that a candidate may have felt far more strongly that they shared, but did not have their peer group’s support. This meant that the graduates’ individual feelings or emotions were not overlooked, but also I did not make them feel unsafe by pressuring them to share more than they felt comfortable with.

Dr Bevan Eruiti BEd, PhD, MEd(Hons), MEd, Senior lecturer and Associate Dean for the Massey University School of Health Sciences, was kind enough to speak with me, and this consultation provided a plan for clarifying terms at the time as well as closing the loop with feedback on transcripts if te reo Māori language or concepts were used, to ensure that participants agreed that they were not misinterpreted. It was important that any graduate of any background was well understood in relation to their meaning and the context of what they shared, and so probing questions done in a thoughtful way were used to ensure that I was aware of full context of meaning (K. Charmaz, 2014).

Transcription of recordings was done on the weekend following a focus group day. This gave me sufficient time to reflect on the experience and make notes on assumptions of what was heard prior to transcription. In one particular case, the notes on the perception of what someone had meant were quite different from what they had actually said once transcribed. This particular example was someone who spoke English as a second language and gave me a significant appreciation of the value of transcribing for a researcher, forcing them to immerse themselves in the words and language in a way that may not have happened simply reading it. There was significant ‘disruption’ to the transcription because, as the researcher, it was not merely a simple task of typing. Pauses were often made to make notes as I remembered and reflected on what was being said, making note of my instinctive responses to what I was hearing in a way that had not happened while in the room with the graduates.

3.3.3 Coding Methods

Grounded theory is ‘a rigorous method of conducting research in which researchers construct conceptual frameworks or theories through building inductive theoretical analyses from data and subsequently checking their theoretical interpretations’ (K. Charmaz, 2014, p.

343). This section will first outline an overview of the overall process of coding and categorising and then focus on the individual types of coding and construction of categories.

Coding is the process of assigning a label through interpretation to the ideas of a person or group through concepts and categories constructed from the data of their language (Saldaña, 2016). There is a wide variety of approaches to coding with Saldaña describing more than forty. The importance is not focused on which approach is used, but that it is layered with multiple analytical possibilities used in an iterative manner (Saldaña, 2016). In the context of GTM, coding is 'bottom up', with codes found through the data at the level of words and sentences (Cathy Urquhart, 2013). All GTM methods are rooted in Symbolic Interactionism which acknowledges the many meanings that people can place and describe, and behave in response to these differing understandings (Strauss & Corbin, 2008).

Constant comparative analysis was used, with data collection (focus groups and transcription) occurring at the same time as ongoing coding. Each focus group was considered a new package of data, and codes compared from each to the last recurrently to best allow clear codes and categories to develop from the data. Constructive GTM is most simply described as iterative; moving between data collection and levels of analysis repeatedly as data is collected (Bryant & Charmaz, 2019; Morse, 2016), which makes a linear description challenging to say the least.

I used Pre-coding and Initial Coding before moving on to Focused Coding and Theoretical Coding to construct categories with constant comparison between my codes and categories.

Before outlining detailed methods, it is worth describing the first (and failed) attempt at coding.

Unsurprisingly, as an inexperienced researcher it was a struggle to separate concepts, being too focused on the words themselves. Working digitally and seeing the words themselves almost as individual data-sets, it was a challenge to describe those sections of text with a code (labelling phenomena). The volume of content and individual ideas was overwhelming. This first attempt resulted in only the first page being coded, with around 45 individual terms being noted, without any insight or sense of understanding. The attempt was stopped and I went to my supervisor for support and direction. There was a risk that with my preconceptions around the bicultural programme I would be overly focused on bicultural aspects, and allow this to influence my process. A line-by-line coding process was implemented to help protect against pre-conceptions (Mills et al., 2006a; Cathy Urquhart, 2013), but in the attempt to avoid pre-conceptions I was treating language like numerical and static data, not considering meaning or action that the language could share. The content needed to be viewed as a whole first, without worrying about the outcome of codes. My

supervisor sent me to re-read content to refresh the constructivist paradigm that I, as researcher, was part of this research and the construction of codes came through me, not as a passive viewer. My memo from that day is an insight into how much previous methodologies had taught me to step back, and how now stepping closer was a genuine step in development and learning. The following memo demonstrates my development.

> "Oh my god, I forgot I am PART of this, no more trying not to have an opinion. Have it, note it, remember it is mine; and GET ON WITH IT." (Memo, 18th January 2020).

Pre-coding was not part of the research plan initially- but was started after that first coding attempt almost immediately resulted in an over-saturated, almost numerical assessment of the text, while coding line-by-line.

3.3.3.1 Pre-Coding:

Each interview transcription was printed and the hard copy was manually scanned with a highlighter and pad of post-it notes. The initial scan was loosely seeking key phrases, terminology or concepts that 'leapt out'. This is described in Saldaña (2016) as Pre-coding. This permission to allow the opportunity to perhaps 'jump' to a conclusion was appropriate in the context of CGTM; the researcher's own understanding and their immersion in the topic is of value to the construction of codes and categories (Ramalho et al., 2015; Cathy Urquhart, 2013). It helped gain an overview without overthinking, and a careful note was kept of these conclusions in memos as they gave insight into my own thoughts and conclusions.

3.3.3.2 Initial coding:

Open coding with the technique of line-by-line coding was used initially to avoid the risk of missing important details, or diverting to a specific focus area and force attention to the smallest details. This became particularly important in the later data where concepts were developed prior, but I needed to see new data with clear eyes for the first time, and 'remain open to exploring whatever theoretical possibilities we discern in the data' (Kathy Charmaz, 2006, p. 47). The initial line-by-line coding was not a quality outcome worth sharing, but a starting point to work through the data. In this coding I was seeking to avoid a simple description and trying to develop a more analytical one (Cathy Urquhart, 2013).

Of importance to process, as I continued to run focus groups and transcribe new data for coding, it became clearer how important it was that initial coding was 'provisional'; meaning that I remained open to alternative codes and possibilities in the analysis (Kathy Charmaz, 2006). I continued to return to codes from previous groups and re-develop them as more

data were gathered. Many early codes were re-worded to frame them in a tighter concept than initially given due to data developed later.

Gerunds, a verb functioning as a noun, were a valuable asset in coding. They assisted in finding processes and development in a timeline (Bryant, 2017). On a personal note, in a memo I noted early on:

> "Gerunds allow me to see this data in multiple dimensions and also see things in a timeline – where they may begin to interact with each other; seeing an action allows me to visualise so much more easily the connections between concepts" (Memo, 8th February 2020).

The above memo is a snapshot of what Charmaz (2006) described as fostering theoretical sensitivity, due to the visibility of 'enacted processes' (p. 136).

Moving codes around physically and clumping them together helped 'see' similarities or trends and recognise patterns. Post-it notes, and the spare wall in my home became a 3m x 5m brainstorm wall. This 'clumping' is a colloquial description of Selective coding. Selective coding groups codes into categories.

3.3.3.3 Focused Coding:

Focused coding is described as making decisions about which of the previously constructed open codes work within the analysis of categorisation (K. Charmaz, 2014). Focusing on codes appearing more frequently in the initial coding allowed me to re-code and categorise in a more conceptual way, and allowed the abstraction of categories. Having used gerunds initially, the focused coding had the added benefit of being able to see dimensions of cause and effect.

3.3.3.4 Theoretical Coding:

By the end of focused coding I had developed what Glaser would have described as conceptual description (Bryant & Charmaz, 2019). Theoretical coding moved the work from the simple attachment of labels to recognising and describing the relationships and patterns between them.

Birks and Mills (2015) described Theoretical Coding as 'the use of advanced abstractions to provide a framework for enhancing the explanatory power of a grounded theory (p. 181). Charmaz (2014) described Theoretical Coding to be useful to the analysis of data, however, it was outlined recently that a well-developed grounded theory cannot be achieved without Theoretical Coding providing the explanatory power required (M. Birks, Hoare, & Mills, 2019).

3.3.3.5 Inductive and Abductive Logic:

I moved between data and concepts. Inductive logic was used to develop a code or come to a conclusion from the data. Time was spent trying to describe or explain the initial observations and then confirm or disprove those concepts to explain them clearly. Abductive logic was used reflectively, to look at all the groups as a whole, and describe hypotheses to attempt to explain not only the data, but causes, conditions, and meanings (K. Charmaz, 2014). A prime example of this is found in Chapter Four, in the description of conditions of connection. Initially when using abductive logic, I hypothesised that connection leads to meeting need but, upon further examination and analysis, it became clearer that the condition was valuing culture; without that, connection could not occur at all.

3.3.3.6 Concurrent data generation and analysis:

Each category that arose in my research had multiple dimensions and possibilities. Every word had multiple meanings, or even just a range within one meaning. Te reo Māori in particular has words used by Pākehā for one concept and by Māori people in quite another way that is not captured or recognised in Eurocentric culture. Strauss (1990) describes categories having 'dimensional ranges' (p.70), the same way that each simple colour can be seen in a range of hues. My categories were diverse and needed to reflect the full range of dimensions, or they risked over simplification and lack information I needed to convey.

3.3.3.7 Theoretical Saturation:

Whilst coding, I used a constant comparative approach, and inductive and abductive logic testing both the robustness of the codes constructed, and comparing newly collected data with already existing codes for alignment, differences, or codes that are similar or lead to each other that could describe a pattern or category.

In order to reach data saturation, I sought representations (codes) of what was being described in the focus group to the point where no new concepts were being raised, as what was being shared had a code assigned earlier. As theories were described I also tried to recognise conceptual gaps. It is of note that Group Four was recruited from those who had volunteered and moved to their work location from out of region. There was a strong category in previous groups about belonging and fitting in, and the majority of participants in Groups One to Three NGRNs were trained in the same region they worked in, so started there as 'insiders' of a sort. In spite of this different experience there were no new categories arising in Group Four other than those specific to working in a smaller location which was specific and unique to that hospital setting, which meant I felt confident to describe

Theoretical Saturation. At that point 19 graduates had participated throughout four focus groups.

3.3.4 Memos

Memo writing is quite an open concept where the key task is creating ‘clear written records of analysis” (Strauss & Corbin, 2008, p. 197). More casually referred to by Saldaña (2016) as brain dumping - the objective is reflexivity with thought and data arising. As with GTM itself, the advice and guidance on memo writing has evolved over time. Ideas began prior to the digitisation of academia (Glaser, 1992; Glaser & Strauss, 1967; Strauss & Corbin, 1997), and ranges from paper and pen, to more modern digital methods (Melanie Birks & Mills, 2015; K. Charmaz, 2014; Denzin & Lincoln, 2018). Whether processing memos by mechanical or digital methods, the central advice is that memoing is essential, and the method must fit your own style of information processing and sharing, allowing for a spontaneous and natural flow of ideas and a collection of thoughts and concepts as they arise (Melanie Birks & Mills, 2015; Saldaña, 2016).

I process information best by interacting with it, conversing and debating with others. However, this work had to arise from my own thoughts and research, and another voice would complicate this process. So, my main method was to free write. I typed my thoughts up as I spoke aloud, not worrying about spelling or grammar, just getting the concepts down as they flowed. I then read it through and spoke aloud as though debating or agreeing with myself. These amendments were added in, in the second read, in a different coloured font, to see the evolving thought process. In addition to this I enjoyed drawing connections between ideas, and uploading it as an image file, which I could tag with relevant concepts to allow me to search for it later. I was not concerned that my concepts might seem confused or abstract to others, as long as they were comprehensible to me.

As advised by Charmaz (2006), I set out to raise a new memo for each and every new code and category, and the patterns that arose. Each memo was dated, and had ‘tags’ at the top – single work terms that described the concepts arising – these are searchable using my spreadsheet.

In order to get in the habit of writing my thoughts, I kept a tracking spreadsheet from day one of my Masters, to keep track of ideas as they arose, breakthroughs, success, delays, etc.

This continues to be used as a reference point to each memo itself, and allows me to cross-reference or remind me if a concept has already arisen in a memo before which is still open. It also allows me to save my non-analytical ideas such as personal impressions or reactions.

3.4 COVID-19 IMPACT ON METHODS

I held and transcribed my final focus group in mid-February 2020 and found that after coding the data from this group, I had reached saturation. On the 21st of March 2020 the Aotearoa New Zealand 4-level COVID-19 Alert System was announced with the nation placed at Level 2. I reached out to the university and received a 6 month extension which allowed me to focus singularly on supporting Aotearoa New Zealand's covid response. I began work on my research again in October 2020.

3.5 CONCLUSION

This research utilised CGTM, while upholding bicultural programme principles set by Baker et al. (2020) in application. Consultation occurred to uphold the values and understanding of Māori participants, and safety parameters were set up within the ethics process to ensure support for both participants and researcher.

Theoretical sampling of participants in focus groups was conducted until saturation of data was reached. Recruitment and focus groups were iterative, occurring alongside of coding and analysis. Participants selected the day and group they wished to attend. One group proactively sought to meet with just their group of three. Theoretical saturation was reached with the completion of coding of the fourth focus group with no new codes arising.

Participant ethnicity as Māori or non-Māori was collected during recruitment to ensure inclusion of Māori, but other ethnicity data is from the participants own description as they chose to share. Memos demonstrated transparency of my thought processes and collaboration of ideas.

This research process allowed for the construction of a grounded theory that may provide useful insights for employers and educators of new graduate registered nurses.

4 CHAPTER 4 – RESULTS

4.1 INTRODUCTION

The aim of this thesis was to generate a theoretical explanation of graduate experiences of practice in their first 12 months as a registered nurse.

This results chapter provides an overview of the theory of 'Valuing culture to connect to patient need' which explains the relationship between the three categories: 'Exploration of Self', 'Valuing Culture', and 'Connection'. The details of each category, including their underlying codes, will then be provided and supported by quotes from the participants. Finally, this chapter will explore the conditions of connection with patients.

Within this chapter, interview transcript excerpts will provide evidence for the categories constructed in this thesis. Quotes are verbatim in the participants own language, however there has been minor editing to remove repetition or disruptive phrasing such as 'Um', 'Ah', 'Like', 'You know'. Where phrasing has been removed an ellipsis indicates the gap in the text. Brackets [ ] are used to identify my explanations that were added later to provide an account of what was physically occurring at the time the person was speaking. For example: [all others at the table nod and murmur agreement]. Memos are shared verbatim as an insight into the data grounding inductive and deductive reasoning cycles. Memos were compiled into a single document covering the two and a half years of work and are referenced to allow for definition that it is the author's own work from a specific point in time in this research.

4.2 THE EXPERIENCE OF NEW GRADUATES – AN OVERVIEW

Three key categories were constructed from the codes created from data of participant focus groups. Those were *'Exploration of Self', 'Valuing Culture'*, and '*Connection'*. See Figure 3 for a diagrammatic representation of the three main categories with their underlying codes. All graduates described *Exploration of Self* in a variety of ways: themselves as individuals, as nurses, and as part of the healthcare system. Graduates spoke of their journey to awareness of valuing other people's cultures as something comparatively new. A few referenced learning of other cultures from undergraduate study, but many discussed entering nursing as an eye-opening process, being exposed to a much wider world, with a culture shock associated. Graduates spoke consistently of the challenge of connecting with patients and families as they worked at a fast pace to keep up with the demands of the

modern nursing role. There was significant discussion of the tension between getting tasks done in a timely way, and taking the time to engage holistically with their patients.

Graduates had common themes of challenges in practice: time limitations; pressure to achieve key sign-offs within shifts; department cultures; needing to advocate for best practice; and, staffing impacting on learning and stress levels.

Graduates shared stories of patient or family gratitude, with feedback from cards or physically, such as a warm farewell hug of thanks. They also knew of the inverse, where they heard from patients and their families that needs had not been met previously and they felt uncared for, although the medical or surgical reason for admission had been resolved.

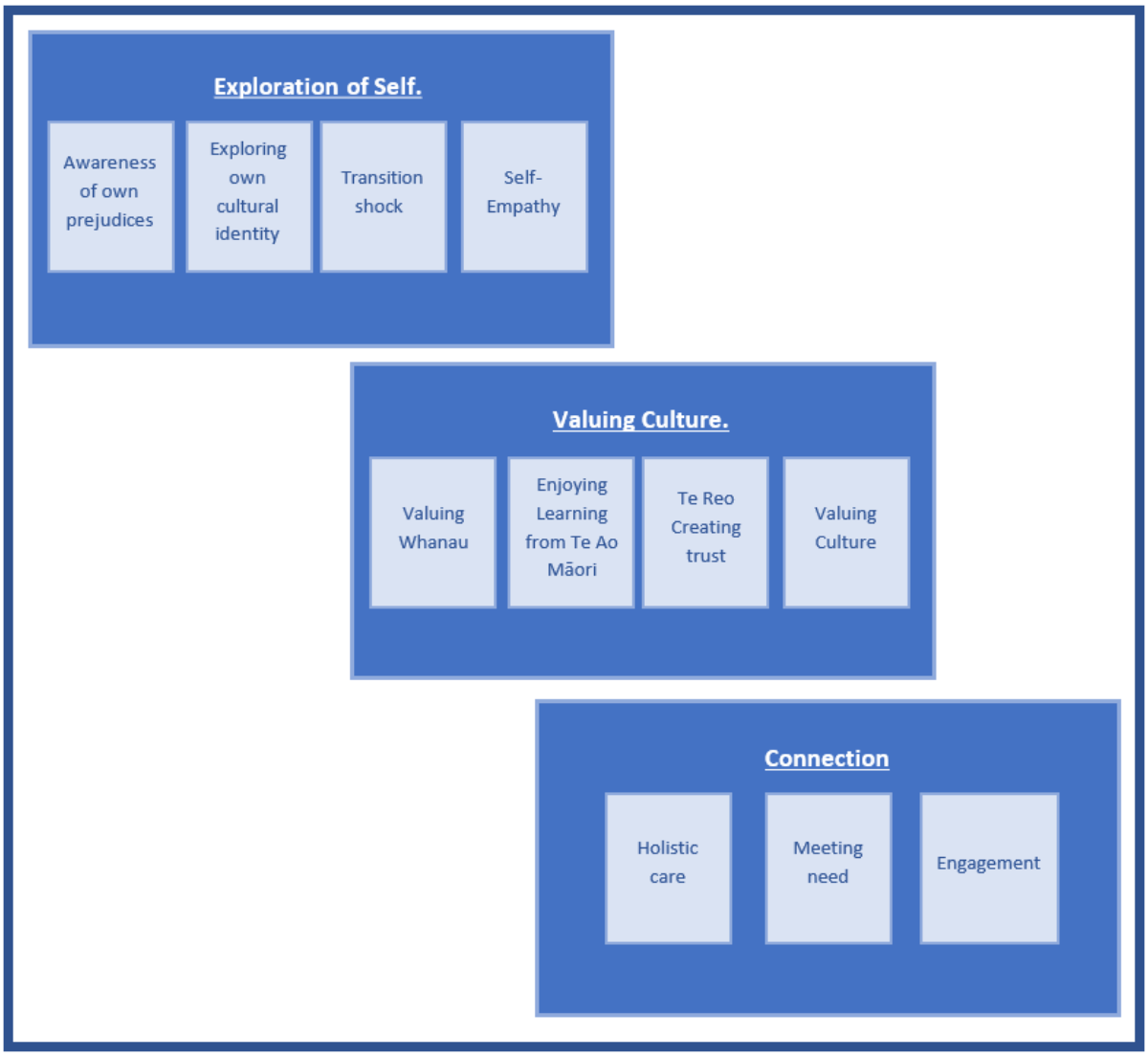

Figure 3. Categories and underlying codes relating.

4.3 THE RELATIONSHIP BETWEEN CATEGORIES

As categories were developed, it became clear that those who had not moved from valuing the self into valuing others' cultures had no codes regarding connection with patients. Closer examination of the categories and the language used by participants showed that there was an order to this connection. See figure 4 below that illustrates how the graduates move through the categories providing the conditions are right.

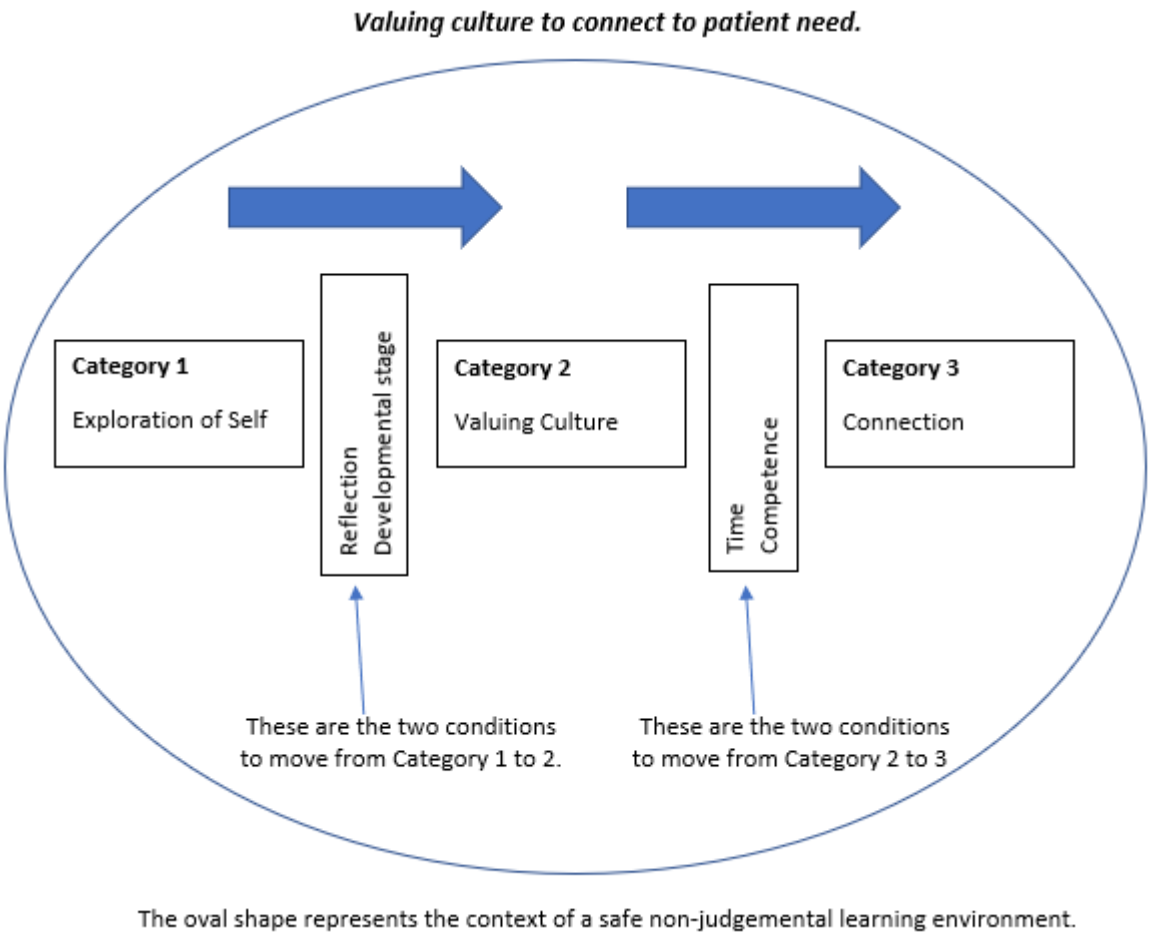

Figure 4. Thesis theory – Graduates' value culture to connect to patient need.

All graduates spoke clearly and empathetically of themselves, the importance of their own culture, and self-empathy on their nursing journey. Some never moved out of that space in their focus group and only spoke of the self, sharing stories of patients only to show or clarify a point relating to their own practice or feelings. Those who shared stories of how they had learned of new cultures, were interested and curious about others' needs, or spoke of learning to get past old beliefs or prejudices; all had stories of connection. This was not only from cultures more familiar and included in the graduate programme curriculum, but also those less familiar; such as a graduate who shared of a patient who she could not give care

to without asking the husband's permission first. There was a clear pathway from valuing other cultures, to genuine connection with patients to meet need.

For those who moved into valuing culture in others, there were conditions. They needed a safe space to explore and learn about other cultures without feeling defensive or shamed about their own culture or beliefs; time and space in clinical practice to ask questions and to have gained the skill set to be able to do that without anxiety.

For those moving from valuing culture into connecting with patients and their family, graduates needed to have time in the clinical area to speak with patients and family members. They needed clinical competence development from focusing on manual tasks and the dexterity challenges of manual nursing skill to focusing on what patients were saying. And they needed to already be valuing culture. Without that sense of empathy and interest, patients themselves would hold back, declining to share information with a nurse they had yet to feel comfortable with.

Interruptions to conditions and missing conditions meant graduates remained stranded at self-exploration, and without insight into why patients were not willing to share information with them.

4.4 Exploration of Self

Exploration of self is a category constructed from the codes *Awareness of prejudice, Self-empathy,* and *Awareness of own culture.* Exploration of self was a key aspect described by graduates in all focus groups. They described the growing awareness of their new identity as registered nurses, professionals, and the responsibility they hold. Many spoke of how nursing had been an eye-opening career to allow them to see lives they had not otherwise recognised, and how that had changed their view of themselves, and their awareness of their judgement or prejudice against others. Graduates' perceptions of themselves became more empathetic as they gained more experience. Figure 5 illustrates the codes that formed the category of *Exploration of Self.*

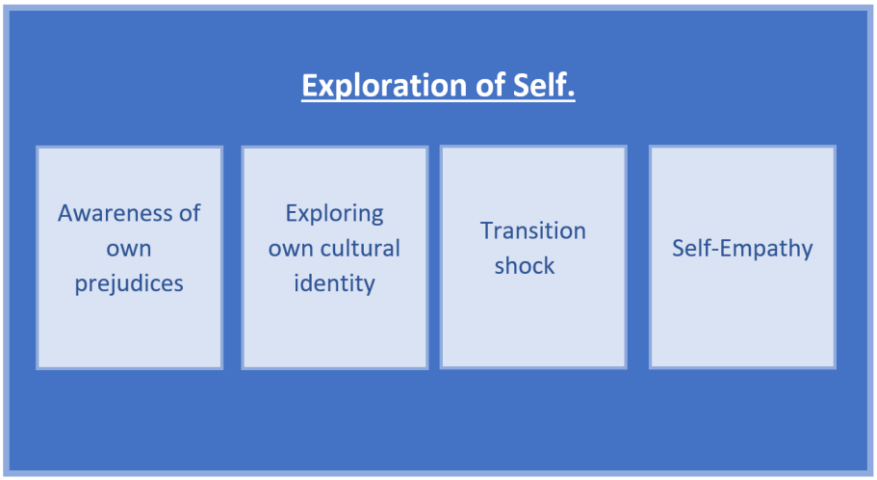

Figure 5. The codes underlying the category of 'Exploration of Self'.

Those towards the end of their programme sometimes talked about themselves from earlier times as though it were someone else entirely in need of their current advice to get through. This showed they felt that they themselves had changed that much in the last 10-12 months:

> *"It [starting as a nurse] is a huge jump and I think I remember as an undergraduate in a final assignment writing what kind of nurse I am, and the answer was I had no idea and it's almost just over a year since, and the answer would be completely different."* (M. p.11)

Graduates had experienced a wide array of humanity as student nurses and so this exploration of self may either be a continuation from student experience, or the student experience may not have been a sufficiently safe space to reflect on themselves, or enough time to reflect without pressure of assessments looming. The NETP is their first nursing work experience without assessment at almost monthly intervals.

4.4.1 Awareness of own prejudice

During focus groups graduates spoke without hesitation regarding previous prejudice, or their increased awareness that they had judgement towards others which they recognised when they were exposed to a wider community as nurses:

> *"We do have a bit more, um, like a wider range of different patients that we come across so it just helps me to be a bit more understanding of their cultural needs or preferences and withholding my prejudice from around them."* (B. p.2)

All participants who shared awareness of their own prejudices or biases acknowledged that it was something that they were working through or had already worked through to avoid

impacting on their patient care. They were comfortable sharing and acknowledging the challenges of caring for those very different to themselves:

> *"I think the study days have been really good, to make us more aware of the different cultures and different beliefs people have, and I think it can sort of expose, like, maybe the prejudice that you maybe didn't realise that you had and just helps you reflect on that, and then take that into your practice, and when you have those kinds of patients just making sure that you are really non-judgemental, accepting, and empowering of their cultures and beliefs."* (H. p.2)

There seemed to be a culture within the NETP peer group that it was ok to be on a journey to understanding. No one interrupted or contradicted anyone discussing their personal understanding and in all four groups there was a clear culture of speaking aloud to learn and better understand their own beliefs. Prejudice and stereotyping were discussed in the context that they are something to explore and learn and move on from, rather than a set negative attitude.

> *"I think it [NETP programme] has also allowed me not to be so stereotypical".* (D. p.7)

This awareness of prejudice was not limited to any one ethnicity or culture of graduate, and the focus groups were made up of more than seven different ethnic identities including Māori.

4.4.2 Self-Empathy

Many graduates spoke of, what has been described in nursing literature as Transition Shock (Duchscher, 2009) and shared their understanding how hard they had found the year.

> *"It's such a big change and you realise, actually what you learnt in nursing school is like, a fraction of the amount that you learn once you graduate. You learn SO much in all things."* (Q. p.2)

They shared this without guilt or judgement, an empathetic reflection with sympathetic peers:

> *"I found it [nursing] challenging, it's a lot different than what I expected... Especially in the first few months out of supernumerary - I would be by myself doing something, and there was no-one else around that I could just help, and I would get quite panicky, because there were so many jobs to*

do, and I didn't know how to do this, and there was no one to ask, and I felt quite stuck a lot of the time." (R. p.3)

All groups had content able to be coded as self-empathy, however, graduates who had been in the programme more than four months had far greater content in this code.

"I was taking it hard on myself in the beginning, of my first few months of NETP programme. Exploring the realities of nursing, and how when you are wearing a uniform, like, we are actually nurses, and like, you go into practice, everyone is working in a certain way." (J. p.4)

The inverse statement would be that those in the first three months of their NETP journey still had high expectations of themselves, and had yet to develop the self-empathy or understanding that a hard shift is not just their perception, they are working in an imperfect system:

"Often, it's a lot of things out of your control that goes wrong, it's not because we've stuffed up. [laughter and 'yeahs' from all three participants] Like, in the early days you would second guess yourself and 'oh man, I should have known'." (O. p.2)

Self-empathy overlapped with other codes of 'fear' and 'anticipatory fear'. The graduates seemed to realise later in the year that they were part of a team and it is OK to not know everything, their self-empathy tied into their ability to ask for help. Without that understanding that they do not have to be perfect, asking for help itself was a fear:

"Just that initial feeling of 'oh my god I've gotta do this on my own and I've gotta recognise when a patient is deteriorating' you know? And being comfortable enough to stand up and say 'hey, I need help' this is a bit terrifying for me, like I'm a week in! you know?" (S. p.2)

Participants reflected empathetically on their own learning and the fact it took repetition, describing learning in an iterative fashion, layering knowledge on top of experience:

"*I started in February 2019, so 11 months now, and I would say the majority of the year has been mainly growing more comfortable in the setting that I am in. which is helped with having lots of support and mainly just grabbing every opportunity to try a new thing this year, and each time you try a new thing again and again you kind of remember how to do it, or what you did last time, and reacted. And it's meant you learnt a lot*

quicker, and can build upon what you have already done just in the first year at least." (I. p.1)

Participants discussed finding nurses who they could or could not trust.

"You learn quite quickly who you can talk to and have trust in, and maybe ones… not so much. A lot of the frustration is when you are trying to figure out who is helpful and who is not so helpful." (M, p.9)

They did not explicitly outline the negative behaviour of other nurses but spoke in code using the word trust, to imply some people could not be trusted.

"They will try and teach you what is not protocol, because it's what they have done for so many years" (S. p.3)

Lack of support once the graduates did not have their preceptor was discussed, with more senior nurses (>5 years in practice) without leadership roles being seen as the ones to avoid.

"Sometimes you will get a nurse who says 'go and have a look in that book". (S. p.3)

"She just said "it's not that hard, I don't really need to show you how to do it. This is how you do it, you don't need to come and watch.' And she just wouldn't let me come and watch. Which I thought was a really bizzare thing" (Q. p.3)

Almost all graduates understood that their first year was for learning, but those earlier on had less self-empathy and more codes of guilt when needing support from others. Those further along had a clearer understanding that needing help was reasonable and those who were unwilling to give it were in the wrong. Outlining that few nurses were deliberately obstructive but you had to ask.

"They are probably less willing to help. Willing to help if you are really really stuck, But not necessarily proactively." (R. p.3)

4.4.3 Exploring their own culture

In the context of discussing their development in the NETP year, a substantial number of graduates chose to disclose parts of their identity to give context to stories, or share how

their culture affected how they work or feel about their NETP year. They shared their own culture in the context of finding similarities with other cultures, or how they differed.

> *"I have lots of culture, lots of bits and pieces from here and there [laughs]. I don't have formed values like, 'I'm just going to follow this culture and just do it this way' I'm not like that, I'm very flexible and open minded to all cultures, and I don't think too deep into that.* (T. p. 5)

> *…As I learnt more about Māori people – me and my partner lived with a Māori lady – we found out it's really similar to our culture, more family… It's similar in my culture. I don't see it as very different*. (T. p.8)

- T moved to NZ from overseas.

Some found it harder than others to identify what made their culture unique or different, or struggled to identify what culture they belong to. Those who had the code of 'what is my culture' or 'missing out on my culture' belonged to Pākehā and NZ-European identities.

> *"I don't really have a culture, I'm just a New Zealander. And I don't know what that means really. I remember going up to Waitangi and knowing more about all of that than... I mean I know that is part of my culture as well being a New Zealander, but I don't even know what other places I am from!"* (S. p.7)

One group of participants focused heavily on their feelings about their missing culture as they felt specifically their culture was not as included in NETP classroom work. This was coded as 'missing out on my culture':

> *"I do not mean this in any way to be offensive, but it… it… feels like there's so much, um, emphasis on the Māori culture that we almost miss our culture. Like, a European culture, or Pākehā culture."* (P. 3)

> *"I feel like there is a lot of entitlement these days around like, oh this is my culture so you would be disrespecting me if you disagree or you know, this is why we make it such a thing now to talk about culture, and the bicultural programme. You know?"* (O. p.14)

To clarify what was meant by 'European culture' or 'Pākehā culture' that group was asked specifically:

> *"If they were to rewrite the programme to centre your culture, what sort of things would you want to be included? What sort of gaps are there if we are centring Māori and not where you are coming from?"* – Ingram.

Two of the three were able to share that their Christianity is something they felt was not explicitly included, and their religious affiliation was the key aspect they identified and spoke of. Beyond religion, none of the three could outline a specific gap, only that they felt as though their culture was not a priority. This ranged from mild disappointment to genuine feelings of persecution.

> *"And we need to respect everybody and everybody's culture but for some reason, I mean there's thousands of Christians and people who get persecuted every day just for saying that [saying they are Christian] so it does make it a bit harder I guess, to talk about."* (O. p.14)

This group had no other cultural needs they could share that they wished included within the programme and struggled to identify what their culture was beyond being New Zealanders. They did not use ethnic, geographic, or skin colour identifiers when prompted to share what of their culture was being missed in the classroom focus, but were all white, and had grown up in the same region of Aotearoa New Zealand, with overlapping social interests and were around the same age.

The majority of graduates shared their identity to give context to stories about how they work, or how they fit in at work, or how they see the healthcare environment – expressing that their cultural identities impacted on how they approached others. It was not always from a strengths-based comment, some had problematic relationships with their identity or background:

> *"My [family member] is pretty racist. My [family member] is the kind of person who goes "you know those Māoris'…" she is one of those sorts of people. So growing up around that environment you sort of… Like I knew she was wrong, but I sort of didn't have any confirmation around me that she was wrong. Because I didn't know any Māori people growing up."* (Q. p.7)

There were overlaps between exploring their own culture and 'Valuing culture', however, for the reason that there was a clear visible difference between those who had the codes of valuing culture in others vs themselves. They have been separated between categories as they have clear differences.

4.5 VALUING CULTURE

The category of Valuing culture was constructed from the codes *Enjoying learning from te ao Māori, Valuing whanau, Te reo creating trust,* and *Wanting to learn from Māori colleagues* as shown in figure 6 below.

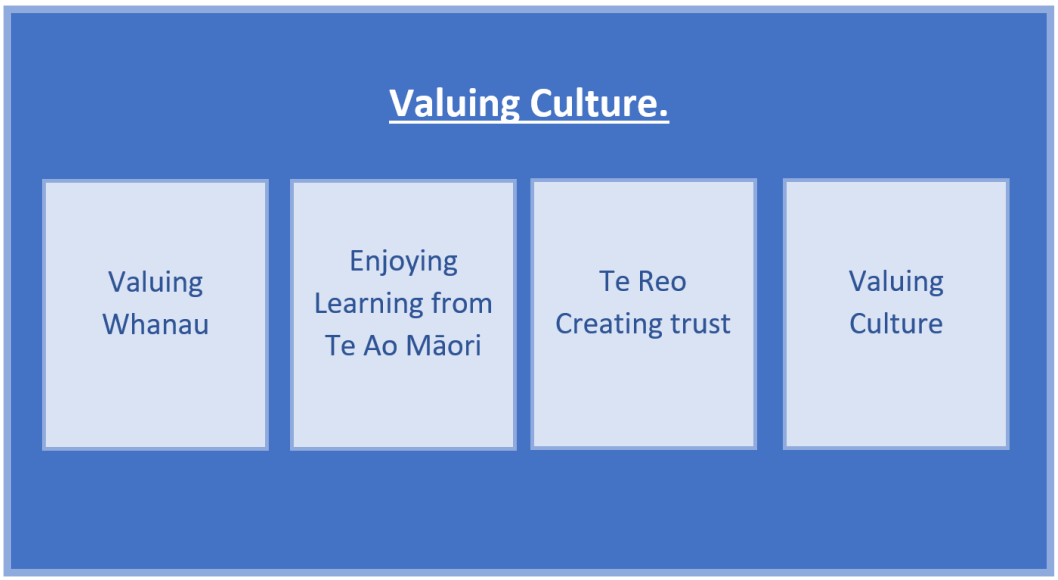

Figure 6. The codes underlying the category 'Valuing Culture'.

The graduates discussed culture from multiple perspectives; in relation to meeting specific needs, in trying to advocate, in learning, and in exploring new skills such as use of language and tikanga. The majority of graduates spoke from a place of curiosity, open mindedness, and willingness to try. There was fear verbalised. Fear of getting it wrong or making a mistake, but these came from a place of wanting to get it right and valuing culture as well.

> *Q: I didn't feel quite comfortable because I don't want to make a mistake, and I don't want to do something wrong*
> *Researcher: what were you afraid of?*
> *Q: Doing something culturally insensitive without realising it.* (Q. p.7)

Graduates representing all participating ethnicities talked about culture in ways that valued other people's cultures, not just their own. Nurses spoke of their understanding of cultural safety becoming more simplified the more they knew. You have to ask because you can't assume – this is actually a simpler outcome than the expectation that they know or understand all cultures in order to meet need.

4.5.1 Enjoying learning from te ao Māori

Te ao Māori translates as the Māori world and is used in this code to make it clear that it is not just having Māori content, learning frameworks, values, or facilitators, but also including content that may have come from Māori classmates. It was the ability to have visibility of the Māori world through others that was described in empowering and fulfilling ways. The code was constructed from the content of people of all ethnicities participating in this study except the participant who self-identified as New Zealand European. Interestingly those who had come to Aotearoa New Zealand as immigrants themselves had the strongest themes of finding empowerment from having more than one way of learning being shared in the programme.

> *"Having one teacher I feel like that is the only way. Having more than one teacher shows that there's lots of ways of being a nurse. Lots of the time the Māori teacher spoke what I felt." (J. p.4)*

Part of this appeared to be that having visibility of te ao Māori and Māori ways of being and working gave them enough visibility to recognise similarities with their own culture if born overseas, or second-generation New Zealander, and explore what they shared with indigenous New Zealanders.

> *"Getting to realise the culture here, and how things are done [by Māori], it's been able to allow me to open up more, and feel like I am part of the culture… I can connect in a way and find similarities, and that I don't feel that because I'm from a different country that's differentiating me from New Zealand."* (D. p.2)

Participants shared their understanding that nursing itself is not monocultural and can be practised in many ways. This was described in empowering ways to allow them to bring their own culture to their nursing practice.

> *"When I came in this programme, I got to know everybody's opinion and knowing that every thinking and way of thinking is different and it's not just one way of right or wrong but it can be many ideas and it doesn't have to be right or wrong, they can be always more thoughts and ideas, beliefs, and values, and that's all ok."* (J. p.2)

> *"I think when we got together in our study groups and meetings, you could see when we would do discussions on health and values and all of those, you could see that because of the bicultural range of people* [facilitators of class were both Māori and non-Māori*] that everyone had a different opinion*

> *that they could draw on from their backgrounds, not only from what they had experienced in the hospital."* (I. p.2)

Graduates spoke of the bicultural programme empowering them to uphold their own culture to better meet the needs of their patients.

> *"Yeah, having lots of ways of believing and understanding and the chance to talk about our boundaries… I feel stronger in my culture for this chance to process it with others. I am more holistic than some teachers I had before." (L. p.4)*

The NETP programme helped graduates come to the understanding that nursing has many ways of being practiced and described how they started out by trying to fit in and be like their preceptor. One participant identified that she felt the difference in study days run by a tertiary education organisation; those days only had Pākehā facilitators.

> *"There wasn't like that [bicultural programme] in the university, we had a study day then we went home, there was no different style of teaching – it was just one way, and we all did it."* (I. p.7)

Some nurses who felt value in the bicultural programme described feeling 'at home' with it, or recognised that having a Māori voice in the room was a new experience for them. Having it as a new experience did not create a barrier to learning or enjoyment.

> *"It [bicultural programme] felt like my comfort zone. I've grown up like that. Like at school there was often classes with a Māori teacher, it's just very normal, and then it was good because we do stuff together."* (S. p.5)

> *"I come from a DHB that doesn't have very many Māori people. The training programme which I went in through had some Māori focus, but a lot of it was separated, for whatever reason, I don't know. I thought it was good that it was not so separated. I really enjoyed learning things from a Māori perspective, as well."* (Q. p.4)

> *"I really love how we normally get a Māori person in, there, saying their perspective, because it's all very well like hearing it from a European perspective, but when Māori actually come in and say why, and the reasons, it's much easier to understand and put into practice, you know, what they have been telling us."* (A. p.2)

Even if it did not feel like familiar territory, it was clear from discussions that exposure to this new way of working did not feel like a threat from those who shared content coded as *'Enjoying learning from te ao Māori'*, even when previous experience had made people feel uncomfortable or scared to try:

> *"It [bicultural programme] didn't feel like a threat at all, I felt good about it. We talked a little bit about it in nursing school, but obviously where we live now there is a lot of Māori people, and from doing this programme I feel like… Like I would never have EVER spoken any te reo ever when I was at home because I was too scared, I wasn't around that. Now I have no problem using te reo at work, saying kia ora to people, that sort of stuff. Part of this programme made it more comfortable to try. I don't know - you taught it in a Māori worldview, whereas we didn't have that so much at home. I really enjoyed it."* (Q. p.5)

Receiving a Pākehā centric undergraduate nursing curriculum, or having been isolated from other cultures, meant that the bicultural classroom was an adjustment and new environment but this was not necessarily a barrier: Several participants reflected on the fact that their NETP year was a new experience hearing from Māori people about te ao Māori.

> *"Yeah, it was really taught through a Pākehā lens. In class we had to learn it but it was not taught from the Māori perspective at all. Like, for example, I found out that Māori were really good entrepreneurs and built their own stuff and this one guy went to Australia and did all this cool stuff... and you know… and I didn't know that. They didn't teach us that, they just taught us "we came here, and we took over and bob's your uncle" [laughs]. It was like that. You know? I suppose my education was a really white education. And I didn't realise that at the time, it was only later."* (Q. p.8)

Several graduates raised overseas also identified that Aotearoa New Zealand is, in one graduate's own words a *"white dominated country"* (K. p.4)

> *"Māori need to be put at the forefront. And I think, I get frustrated because it feels like the Pākehā, or New Zealand European culture is still quite dominant within nursing and how a lot of nursing is run. So for me personally I don't think I would want any more of my culture being put to the forefront"* (M. p.15)

Those who expressed concern and were aware of the fact they had been isolated from cultures different to their own went on to share stories of valuing culture and connecting and meeting need.

> *"Even as an outsider from New Zealand, Māori culture is a whole new thing because you think 'oh I am going to New Zealand', and I was imagining white kiwis around. "I am going to a foreign land and everyone is going to be white". So then when I came here, then I found out that there is something called Māori, so we are not well aware of that."* (T. p.8)

Those who did not explicitly share insight, but whose isolation from other cultures was evident in their descriptions, did not go on to share any codes of valuing culture in others or connecting with patients.

4.5.2 Valuing whanau

Whanau is used in the context of understanding the needs of the wider family group (whanau) rather than only the patient, or even the patient and their support person. Graduates were able to share that they understood the need for wider family support, not only for the patient but supporting the care they receive by assisting the 'team' with information and insights into needs.

> *"You don't just care for the patient; you care for the family as well."* (B. p.6)

The relationship between nurses and whanau was described in reciprocal ways, with participants not only talking about how whanau helped inform and assist with care, but how they as nurses can 'take a load off the family as well" (C. p.6).

> *"Even if you are busy, taking the time to talk to family, cause often they make up a person's culture or play a big part in it as well." (A. p.5)*

The *Valuing whanau* code was constructed not only from positive stories and ideas, but from challenges. There were discussions of visitors being asked to leave due to time constraints or the number of people visiting, and the ethical conflict graduates felt at being part of a system separating patients from their support network. In one story a graduate shared that they had been part of care where the whanau was asked to leave, and had learning out of that where they would work differently next time.

> *"On reflection I wish that the coordinator hadn't asked them to leave - The patient passed away, not long after. So on reflection I think it would be good to kind of make more, like, you know, be thinking*

about that family culture, and understanding that the family need to be there, and making allowances for that." (H. p.4)

4.5.3 Te reo creating trust

Te reo Māori is the indigenous language of Aotearoa New Zealand. This code was a focused code construct that encompassed the open codes of 'respect through pronunciation', 'using te reo', and 'connecting through language'.

The code was developed out of content from three out of the four focus groups and in each example the graduates shared their use of te reo in relation to the connection it made to the patients and families they work with. These stories were shared by those of Pākehā or international backgrounds as well as Māori.

"I think it's cool as a nurse to go to a patient who is Māori and speak te reo, they appreciate it – especially when they know you aren't Māori – they are very appreciative." (S. p.6)

Graduates who described using te reo all spoke as non-fluent speakers, or those just starting to learn. There was no one who described using te reo who shared that they had fluency. Graduates who identified as Māori also spoke of using te reo as something they were increasing in confidence in, not as something they took for granted or used easily yet:

"I feel that I'm a bit more confident now that at using certain language of cultures, and being able to connect on just that small thing of being able to share that common ground of te reo". (D. p.4)

Participants were linking the use of language with the importance of pronunciation and putting the effort in to try to get it right:

"If you go up to a person and say like, kia ora [pronounced correctly] they really appreciate it." (Q. p.5)

This was especially discussed in relation to pronouncing names in particular. Graduates not only discussed trying to pronounce names correctly, but recognising and sharing that if they did, they received reward type behaviour such as positive feedback from the patient or whanau, or the patient opening up to them:

"Even pronouncing someone's name right makes a huge difference."
[all others make audible noises of agreement and nod] (F. p.5)

Pronunciation and using te reo correctly was linked with a therapeutic relationship both explicitly and implicitly in participant stories, and graduates linked learning in a classroom with growing confidence in practice:

> *"The bicultural study really helps me have a better therapeutic relationship; for example, I get a Māori patient and I greeted her with a Māori word, just simple words, but she was so happy for that.* (E. p.4*)*

Of interest was that there was a code that was constructed of 'patients won't tell me', which came out of graduates sharing that some patients would not connect with them. However, those who described use of te reo and careful pronunciation of names did not have this code out of their content other than as the starting point in stories that had an explicit connection between showing their respect for someone's identity and culture through pronunciation and language use, and patients beginning to trust them, either in the moment or over time during their care:

> *"I've noticed when I say someone's name correctly, they will talk with me and be a bit more open to answering questions." [the other seven participants nod in agreement] (*F. p.8)

In contrast, a graduate who had no codes of connection, use of te reo, or getting to know patients shared that:

> *"[I ask] any special needs they might have, or things they might want while they are here. [pauses] Most say no."* (O. p.6)

And that was where that story ended; no continuation of patients opening up once she got to know them as others had shared.

4.5.4 Wanting to learn from Māori colleagues

A code was constructed from participants who discussed their interest and curiosity in their Māori colleagues' perspectives on nursing, racism in healthcare, and the needs of Māori patients:

> *"There are some of us who don't identify as Māori but still know a bit of the language and the culture and stuff so I guess it would have been interesting to know from being taught Māori*

> *experience of nursing, even for us being a bit of how we could handle it a bit better." (R. p.6)*

All those who had the code of wanting to learn from Māori colleagues were Pākehā or Aotearoa New Zealand European. Those who were more recent Aotearoa New Zealand immigrants did not have this arising in their conversations. In fact, when asked what they thought of the Māori students having one day apart from them there was a genuine lack of curiosity.

The code of wanting to learn from Māori colleagues came from multiple conversations; some graduates wanted to talk and learn from reflecting with Māori colleagues, some wanted their insights into Māori culture. But the strongest thing participants wanted to know from their Māori colleagues was what they themselves were experiencing as Māori nurses:

> *"I would like to hear more about* Māori *Māori culture but then again that's from my personal journey, that's what I want to do personally because you can see when they come through the health system that there is such massive discrepancies." (M. p.15).*

It seemed to be that from those who had the specific code of wanting to learn about Māori experience of racism, that actually, the reason why remained about them. They were concerned that they themselves were being talked about, and the expectation that Māori colleagues should be able to speak to them about it themselves:

> *"If there was something that needed to be said, couldn't it be said in front of all of us? And if it was a matter of cultural sensitivity, it would be learning for us to have that said in front of us because we don't know what happened when they went… We don't know what was discussed or anything, so… " (O. p.6)*

Interestingly, the group who had the most codes leading to the category of wanting to learn from Māori colleagues was the same group who had codes of 'what about me', 'It's not fair', and 'it feels like us and them'. They spoke of what went on in the Māori class through second hand accounts and were comfortable sharing that they themselves had no Māori peers they had actually spoken to about this. In fact, they had not actually heard from any Māori graduates at all about their programme; highlighting that their lack of time with Māori nurses was not unique to the classroom, or graduate programme, but also socially. This was unique to other groups who spoke of their knowledge of what the Māori class did from first person information from friends and peers.

4.6 CONNECTION

Connection was not constructed as a category until 2021, very late in my work. In my memos I explored the fact that during theoretical coding I could 'see' connection occurring, but content describing connection was already enmeshed under various other codes and categories, including the category 'Meeting need':

> *"I can see connection occurring in a variety of stories and within content of codes. I have realised I need to work backward and look specifically at those who have codes of 'meeting need'. Do those who meet need all have connection? – is connection a condition of meeting need? Should this be a standalone category rather than just something that occurs within meeting need and valuing culture"* (Memo, 16 April 2021).

Eventually I realised that connection must be described as a category. Excluding it because it was already described within other categories did not share the importance of connection. Figure 7 below shares the codes that underlie the category *Connection.*

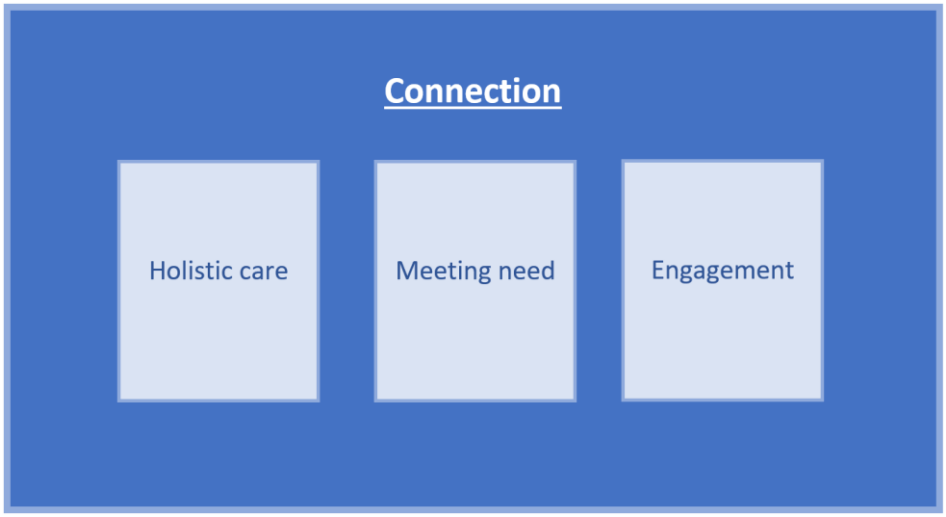

Figure 7. The codes underlying the category *Connection.*

Interestingly, connection as a code was one of the first constructed, with early content of the first focus group talking almost exclusively about connection. In fact, as the focus group facilitator I commented:

> *"So far, there's been a bit of a theme of connecting; so connecting because of the language you are using, or connecting because you are actually asking people what they need, you know, pronouncing names correctly and things like that. Is that a fair statement of what is coming*

> *up so far?" [Everyone nods, with four or so people saying 'yes' or 'yep'.]* (Focus group 1. p.5)

And yet, because connection was so intertwined into the other codes and categories, it took me time to realise it needed to be a category in itself. Connection and stories showing connection with patients and their whanau were found in almost all groups. There was one unique group who did not, and that will be explored in Section 4.8 – Barriers to moving through the categories.

Connection was described almost as a tool by some, rather than the outcome of other interventions:

> *"I think it's very vital to have those relationships so you can build that therapeutic relationship. It impacts their family and friends as well."* (B. p. 8)

This was interesting because it was also described as the outcome of care in pronunciation, or getting to know patients in a more holistic way. But B had a clear visibility that connecting in itself was a tool. Many had a clear view that without connection you would be limited in your ability to carry out the ideal care plan for that person. They saw connection as a requirement, and it was also described by graduates within a therapeutic relationship:

> *"I think the reason culture has come up so much is that in order to carry out your best sort of care, you need to kind of have some form of therapeutic relationship with the person and a person's culture makes up a big part of who they are, you know?"* (A. p.8)

Connection was also seen as something occurring early on in greeting and respecting a patient and their whanau. Graduates saw connection occurring on arrival ideally, and as part of relationship building. They were describing connection as that first link of trust that occurs between patient and nurse, the platform for the relationship.

> *"I think it's really helped me to be able to build that relationship with our patients which is amazing. [smiling] Yeah. Because when they go, that's what they think about. As a nurse you are with your patients, like, 99% of the day, so, I think it really helps them too."* (B. p.3)

Graduates described patient and family appreciation in several ways. Some in forms of direct feedback, or a change in pain or comfort in direct relation to care given. Some in the ways that patients chose to open up and share of themselves where they may not have previously.

"You can just see them, they like, THRIVE". (S. p.6)

Participants also spoke of actual feedback and specific thanks given. Much of the feedback was given on the discharge of a patient. This would mean that if a member of staff was not meeting need, they may not know so until the point of discharge, which by then is too late:

"And on her discharge, she gave me like a great, tight hug, I was feeling so good. [smiles] (E. p.4)

Some nurses described the opening up of patients and reciprocal sharing as 'a therapeutic relationship' showing they understood connection was part of their role, and there was a nursing framework for it:

"A therapeutic relationship is really important to us, and obviously that kind of thing makes a big difference." (H. p.7)

Participants were clear that they could tell when patients or whanau were engaging authentically, and saw that as recognition that they were beginning to meet needs:

"They light up a bit more and they will talk with me." (F. p.8)

It took me over a year as a researcher to process the content and codes of four focus groups well enough to reach an understanding that connection is a vehicle to meeting patient need.

I will leave the final word on connection to Participant A from Focus Group 1. Within the first 30 minutes of our first focus group they outlined:

"If you are not aware of their culture then it's hard to form a relationship. It's more of like a nurse-patient relationship rather than, like, a working together relationship. And I think that's more what nursing is, it's not just like we are the nurse and they are the patient – we are working together for their health, we are working in partnership with them." (A. p.8)

4.7 CONDITIONS

No graduates shared stories of connecting without also having shared how they valued culture in others. In order for graduates to be able to value culture in others they needed to have explored their sense of self:

"That is something I like about this programme, I can say what I feel as a new grad, I can speak. In many study days, we have activities, for example in the first study day we had to explore our strengths and values, so I absolutely loved that because I got to explore myself, but I also got to look at others strengths and values and their uniqueness, so that was great – it's ok to be yourself. In the end that's the thing." (J. p.7)

The conditions for graduates to be able to connect were:

- The ability to spend time with patients and share ideas.
- A level of nursing competence and physical dexterity that allowed them to focus on the individual they care for rather than just the task they are doing with that patient.
- To value their patients' culture.

"It's just really challenging because when you are in a busy ward you just are seeing so many different people and different cultures all the time… I guess when you are not a nurse you don't really get necessarily exposed to all that kind of different [cultures]. Yeah." (H. p.7)

For graduates to be able to value culture beyond their own, the conditions were:

- Time to explore and learn.
- A safe space to reflect on new experiences and beliefs and learn from others.
- To have a clear understanding of their ability to prioritise a patient's needs and have insight into their own limitations or prejudices.
- Experience of putting an emphasis on other people's cultures in a positive way (if they have not had this previously) as part of formal education. For some graduates this had occurred in life, or in school or undergraduate programme. For others, the NETP was their first experience of emphasising other cultures in a positive way:

"I think it was nice that fear wasn't something to be ashamed of talking about. It was nice to get it out in the open and to have the educators be so acknowledging." (O. p.8).

"It's just like 'ahhhh [exhalation of relief], so you have days like that too!' so it was just quite reassuring". (M. p.9)

The conditions necessary for graduates to be able to explore their own self were:

- A non-judgemental class group to reflect with.
- Safe leadership from those who would not judge or punish.
- The ability to share of themselves, with others, in a safe space.
- Self-empathy, and the ability to understand they are on a journey to improve.

> *"It was a group contract for the sort of environment to respect other people and the values we wanted as a group, we wrote them ourselves - it felt for me, that was a better environment to share my ideas. I'm not usually someone who feels comfortable sharing in a big group and that made it feel comfortable. I really appreciated that we took the time to do that." (Q. p.10)*

4.7.1 Barriers to moving through the categories

There were several clear barriers as demonstrated by NGRN stories in this study.

- Feeling defensive or challenged in a way that made a learning space unsafe meant that they didn't progress from focusing on themselves to valuing culture in others.
- Time pressure and area culture causing graduates to prioritise safety and visible tasks over communication and holistic care.
- Perception of limitations in staffing, decreased learning opportunities, or chances to debrief after clinical experiences.

Feeling defensive or challenged: Codes were developed of 'It's not fair' and 'What about my culture'. As discussed in 4.4.3, there were tones of persecution related to their own identity as Christians. This may have formed a barrier to their ability to find a safe space to explore culture if they felt on the defensive. For example, P and O discussed that they heard various things about the Māori nursing class. None of the things they heard were from a Māori nurse. Which infers that not only were they isolated in their community but they also were not linking in socially or professionally with those who identify as Māori in the graduate programme.

> ***P:** I do not mean this in any way to be offensive, but it… it… feels like there's so much, um, emphasis on the Māori culture that we almost miss our culture. Like, a European culture, or Pākehā culture. Like it feels like... 'cause I remember one session was split, and it felt like, well, there was*

the Māori group, and then there was just 'Everyone Else' [gestures widely] mixed in, and… yeah…

***O:** And didn't they get a free lunch you said? [implying they had discussed this before together as this wasn't discussed yet in the focus group]*

***P:** Well I HEARD they got a lunch.*

***O:** And we didn't get lunch.* (P & O. p.6)

Those who had not shared stories of valuing others' culture had no examples of connecting with patients. For example, O specifically outlined that when she offered the opportunity to discuss cultural needs with her patients they declined to share. She was making the offer, she knew to ask, but without connection the patients were not sharing with her enough for her to meet need.

"I think asking if there's anything for cultural safety, like, asking everyone if there's anything we can do to make them feel more at home when they are here. Um, any special needs they might have, or things they might want while they are here - most say no." (O. p.6)

Time pressure and area culture: The graduates identified that the pressure to get tasks completed in a timely way was a priority when orientating, and lead to feeling pressured to be highly task-focused.

"*I think when I first started, I was really focused on the tasks, and not getting things wrong. And now I have gone through NETP [9 months into programme] it's made me focus more on the person."* (F. p.5)

The awareness of this was illuminating since it is something nurse educators and leaders are trying to avoid, and yet these graduates were sharing that they also do not wish to work in that way. It is not unconscious - they are aware - and there were codes of pressure, resentment, and working to change interlinked with that 'task based' code.

"Some nurses are more task oriented, or tell you to be more task oriented [murmurs of agreement from the other eight participants] We KNOW the importance of taking the time out to sit and talk to the patient even though we might not get it." (D. p.9)

"I think when we get really busy, we get focused on the physical wellbeing of the patient but actually their cultural wellbeing is so connected to their mental health, which is so connected to their whole health. And it's

> *important to them [the patient], and it makes such a big difference to their overall health and wellbeing."* (H. p.4)

Perception of limited staff support: Lower than ideal staffing levels were raised by participants as making the nursing role more time-pressured and task-focused, but also meaning they themselves felt significant anxiety about being in a more isolated position on the floor with less support nearby:

> *"I find it quite difficult when we are short staffed and maybe only have four staff on and a senior nurse has to go to do for dinner and the other one is out doing a [role that takes them out of the clinical area] and that just leaves me and another new grad or junior nurse - and it's like wow, we have got two patients who are high acuity and it's a bit nerve wracking."* (S. p.4)

> *"I've never done anything that is unsafe but it is a stressful situation, there is a lot of responsibility put on new grad nurses due to staffing."* (Q. p.5)

Lower levels of experienced staff also meant that nurses cannot be released for learning opportunities so, even where a graduate is motivated to learn and someone is willing to teach or debrief, if it takes a nurse off the floor this would not happen.

> *"I felt quite stuck a lot of the time. I have a really, really supportive environment, but I just find a lot of times that it's things out of our control and we just don't have enough staff for some things. Or you want to do a learning thing but again you don't have enough resources to take another nurse off from the floor to go do it."* (R. p.3)

A safe space to explore ideas is one of the conditions, and if nurses are unable to leave the floor to learn at times, that is limited.

4.8 Conclusion

Nursing graduates in their first year of practice participating in a bicultural NETP programme in Aotearoa New Zealand were able to share stories and examples of developing their self-awareness, valuing cultures, and connecting with patients. Three key categories of '*Exploration of self*', '*Valuing culture'*, and *'Connecting'* were developed. It was apparent from the theoretical coding and inductive logic that these categories were interlinked and each led to the next, as phases. Firstly, NGRNs explore their sense of self, their identities and culture, how that impacts on them and their families, and how they would or have been impacted in healthcare. Once graduates have a strong sense of self identity, they move on to explore

others' cultural identities and needs and, for most, this leads to valuing culture in others. This valuing of culture, when it becomes an active process, occurring with patients and their families, leads to connection with patients. This theory is described as '*Valuing culture to connect with patient need'.* NGRNs required reflection and having developed beyond their sense of self to have the ability to value others' culture.

The connection was iterative, with graduates needing to find ways to show patients that they valued their culture and cultural needs, and sometimes needing to do this over time to build up trust. This analysis showed that if conditions were not met, graduates did not share insight or examples to the next category. Without cultural connection these nurses were either not meeting patient need, or did not receive the feedback of having done so.

In order to value culture NGRNs needed to have been able to explore their own culture and understanding of the world, and have had the ability to reflect and learn from their experiences, as well as having reached the developmental stage of moving beyond basic orientation and into functional independent practice. In order to then proceed to connecting with patients, time and nursing competence was required. Nurses who did not yet have the dexterity or skill to undertake tasks fluidly could not maintain a therapeutic conversation while trying to still 'task', and those earlier on in their year who were still sharing stories of skills-based challenges had not progressed to connection yet. The bicultural graduate programme classroom time was shared by all groups as being a significant key to finding understanding through reflection and sharing. It was particularly empoweringly described by those not born in Aotearoa New Zealand. The act of having more than one voice facilitating learning, and having two cultures leading discussions empowered them to uphold their own culture and align their nursing with their culture rather than put it to the side to try to assimilate with the task-focused nursing culture they were seeing it in practice.

Not all participants developed beyond understanding themselves. Graduates gave insight into the causes of not progressing through these developments and skills. Key barriers were: task-based practice; feelings of persecution, or defence of own culture; and the clinical environment not meeting the needs for a safe learning space through lower staffing or staff skill levels.

5 CHAPTER 5 – DISCUSSION

5.1 INTRODUCTION

This discussion chapter focuses on the study outcomes, the defined theory, and underpinning literature that supports and strengthens the impact of the findings. Chapter Four explained the theory "*Valuing Culture to Connect with Patient Need*", and shared that the categories of '*Exploration of self', Valuing culture*', and '*Connection'* are interlinked and each is reliant on the previous as a progression. There is an overall context of a safe, non-judgemental learning environment required for NGRNs to move and develop through these categories, and there are specific conditions required as follows; opportunity for reflection, safety, time, and nursing competence (Benner, 1984). This study provided insight into what NGRNs feel they need, but also their understanding and experiences at different stages of the NETP programme.

Firstly this chapter will demonstrate the quality of the study against credibility, originality, resonance, and usefulness, as outlined by Charmaz (2014) as requirements for a robust constructivist grounded theory. Secondly, this chapter proposes three key messages which share the relationships between categories and implications. Thirdly, the challenges in practice are outlined, with discussion of how they may support other research findings. Lastly, this chapter will complete this thesis with a conclusion and recommendations for further research, policy, and education.

5.2 QUALITY

Rigor of method is key when determining the value of research and it has been accepted that within qualitative paradigms, the ontology informs the epistemology. The relativist ontological position of grounded theory places the value on the meaning being constructed (Mills et al., 2006a).

Credibility in this study was demonstrated through transparency of the research process. Full methods are shared, along with segments of memos, and evidence from the participants in the data segments presented. Where possible, in vivo codes were used – meaning codes themselves were the voices of the participants.

Charmaz (2014) suggested that familiarity with data is a requirement of insight into participant experience, and therefore a requirement of making empirical observations. Analytical method was demonstrated in Chapter Three, explaining codes, comparisons, and development of the theoretical categories constructed. Individual quotes are used intensively throughout Chapter Four. Transparency and insight into the study population is shared in the

participant profiles. Oversight of this study was maintained with my academic supervisor throughout.

With regards to originality, the literature review pointed towards an abundance of deficit focused studies in international research on NGRNs, with findings that reported challenges and reasons for leaving nursing. The originality of this research is that the unit of analysis was a bicultural NETP programme. There are no other NETP programmes delivering a bicultural model throughout Aotearoa New Zealand.

Resonance is a concept relating to how robustly the experience of these nurses has been portrayed, and the ability of this report to highlight meaning from their data (K. Charmaz, 2014). I have co-constructed the theory and explained it by using quotes and stories from the participants. Sharing the participants' voices verbatim in quotes shows that graduates are at different stages in reaching the final category of '*Connection'.*

Usefulness is summarised as 'a grounded theory that conceptualises and conveys what is meaningful about a substantive area' (K. Charmaz, 2014, p. 338). The expectation of this study was that findings would contribute to further knowledge in nursing and how to support NGRN development, and would provide insight into the current phenomenon. The theoretical categories clearly identify three distinct steps whereupon NGRNs form self-awareness, understanding and valuing of other cultures, and then connection with their patients. From this, a potential substantive theory of '*Valuing culture to connect with patient need'* was constructed. The ability to connect and meet need increases nursing work readiness. Internationally, the focus on nursing retention is highlighted with concerns about high turnover (Çamveren et al., 2020; Fasbender, Van der Heijden, & Grimshaw, 2019; Han, Kim, Lee, & Lim, 2019; Walker et al., 2018). There is discussion that the millennial nursing workforce's 'lack of loyalty' is a reasonable reaction to the current work environment (Koppel, Deline, & Virkstis, 2017, p. 363). Work readiness has a positive impact on both intentions to stay nursing, and job satisfaction, and NGSPs increase work readiness (Çamveren et al., 2020; Kim & Yeo, 2021; Rush et al., 2019). If NGSPs can find additional ways to increase skill, holistic care, and work readiness, this may increase NGRN retention.

5.3 THE INTERNATIONAL GRADUATE EXPERIENCE

Graduate nurses newly entering the workforce are experiencing a complex environment (Dyess, 2009; Murray et al., 2019b). Graduates entering the nursing role experience shock, which is widely reported as a challenging process (Graf et al., 2020; Hampton et al., 2021; Kim & Yeo, 2021; Montgomery, Harshman, Kennedy, Richards, & Shaw, 2020). This shock has been described both historically as reality shock (Kramer, 1974), and more recently as

transition shock (Duchscher, 2009), and it remains a focus of NGRN research (Hampton et al., 2021; Kim & Yeo, 2021). In addition, this research highlighted the eye-opening experience of NGRNs leaving the shelter of their local communities and stepping into the wider range of people outside their culture that they are caring for in clinical settings. This specific personal culture shock can encourage personal growth (Stone et al., 2014), but was reported to be an added stressor due to fear of making a mistake or not meeting patient cultural needs (Barnes, 2013; Barton, 2008)

Newly graduated nurses are a high-risk group of the workforce, with higher levels of nursing turnover (Han et al., 2019; Kim & Yeo, 2021; Tyndall, Scott, Jones, & Cook, 2019), reported stress (Jarden et al., 2021; L. J. Labrague & McEnroe-Petitte, 2018) and a risk of clinical depression (Melnyk, Hrabe, & Szalacba, 2013).

Added to these challenges, there are historic attitudes and prejudices from more experienced staff that NGRNs are unsafe (Johnstone & Kanitsaki, 2006), however, a literature review of medication errors prior to the formalisation of NGSPs actually showed that they were no more likely to make an error than more experienced nurses, who remained certain and confident in spite of being incorrect (O'Shea, 1999). The expectation from teams already established is that graduates should be work-ready on arrival (Hawkins et al., 2019a) and there is inevitably criticism when they are not, although it has been well established that undergraduate programmes do not make a work-ready candidate (Gellerstedt, Moquist, Roos, Karin, & Craftman, 2019) and graduates often feel overburdened and out of depth (Hawkins et al., 2019a; Rush et al., 2019).

Fitting into the culture of the work environment, and socialisation into the nursing team, are factors in transition success (Dyess, 2009; Lea & Cruickshank, 2015; Malouf & West, 2011). The new graduates want to fit in and belong (Hampton et al., 2021; Hunter & Cook, 2018), with there being risk to them not feeling safe to speak up and ask for help (Malouf & West, 2011). Integration to the team reduces that risk (Chung et al., 2021; Cunnington & Calleja, 2018; D'Ambra & Andrews, 2014; Devey Burry, Stacey, Backman, Donia, & Lalonde, 2020). In the Aotearoa New Zealand context, Māori NGRNs experience additional challenges with racism and disengaged staff who are unable to support their use of Māori health models (Foxall, Forrest, & Meyer, 2017). There are no protective mechanisms for Māori new graduates in practice to prevent experiences that echo the internationally reported nurse experience of racism and discrimination in the healthcare setting (Harris et al., 2012; Hunter & Cook, 2020b; Kidd, Came, Herbert, & McCreanor, 2020; Simmons et al., 2008).

Graduates find handover stressful (Lim & Pajarillo, 2016; Rose & Newman, 2016) and felt pressure to hand over in the right way. The SBARR framework assisted with strengthening

their handover confidence (Chung et al., 2021). It is acknowledged that this stress is not disproportionate, as handover is a time of risk, with higher numbers of errors occurring when staff are transitioning between shifts (Cross, Considine, & Currey, 2019; Gardiner, Marshall, & Gillespie, 2015). The period of a graduate entering the workforce is also a time of higher risk, with an increase in medical errors which is seen at times when new nurses or rotations of doctors or allied health workforce move into an area (Murray et al., 2019b).

It has been highlighted that NGRNs are very task-focused, and nursing leadership is aware of the lack of clinical competence and critical thinking that occurs when nurses approach their work in this way (Doughty et al., 2018), but this fits with developmental expectations. New graduate nurses being task focused aligns with Benner's novice to expert model (Benner, 1984). The participants of this thesis have a determined focus to provide what they describe as holistic care. They could fluently describe different influences seen negatively that pressure them to be further task-focused and less holistic. This insight was not found in wider research but the task-based focus was seen in Australian research that identified graduate nurses focused on task completion and time pressures rather than holistic care or safety (Murray et al., 2019b).

In the context of this highly complex and challenging work environment, the majority of Aotearoa New Zealand trained nurses with Aotearoa New Zealand residency or citizenship are working under a NETP or NESP new graduate RN support programme with 1677 graduates in 2019. All NETP programmes are based on theoretical nursing frameworks (Health Workforce Directorate, 2018) as recommended by literature (Graf et al., 2020). In addition to working within the understanding of reality shock and transition shock (Duchscher, 2009; Kramer, 1974), the Waikato DHB NETP programme has a focus on the transition between novice to advanced beginner (Benner, 1984). From 2018, Waikato DHB's NETP programme also followed the framework of a bicultural programme (Sheehan & Jansen, 2006) in the attempt to better meet the need of all nurses to improve outcomes for Māori (Brockie et al., 2021; Hunter & Cook, 2020b; Hunter, Roberts, Foster, & Jones, 2021; J. Roberts, 2021) and to ensure a stronger support focus for Māori nurses, due to the expectations based on clinical need for tikanga knowledge and Māori nursing knowledge (Graham & Masters-Awatere, 2020; Hunter & Cook, 2020a; Kidd et al., 2020; Ministry of Health, 2019a).

5.4 A BRIEF OVERVIEW OF THE KEY FINDINGS OF GRADUATE NURSE EXPERIENCE

The categories developed in this study demonstrate that nurses must first develop their sense of self before having the ability to explore their understanding of other cultures. That understanding and value in other cultures allows nurses to then create connection with their patients to meet need.

Graduates discussed trying to prioritise patient cultural need, and to upskill themselves to be able to deliver this. It was a clear priority for the majority of participants. Ethno-cultural empathy is a term used to describe the ability to empathise with those from a different culture (Kleiman, 2009). It is recognised that healthcare professionals need to be competent at recognising both differences and similarities in cultural need, and ensuring it is integrated into their practice (Singh, King-Shier, & Sinclair, 2018). Participants talked about what is required to safely explore culture, their own identities as nurses, and people of their culture, and to find ways to work with a wide range of people safely. Compassion helps create a link to others (Schwartz & Bardi, 2001). There are questions as to whether compassion alone overcomes a lack of culturally centred care, as much compassion related research is in Western settings (Sinclair et al., 2016). 'It is through empathy that we come to know the other as a whole person rather than as an object' (Kleiman, 2009, p. 51). Empathy requires understanding and insight.

Through participants data the category of *'Connection'* was constructed by understanding that valuing culture is a part of connection with patients (Degrie et al., 2017; Hunter et al., 2021; Levack et al., 2016). Nurses' shared stories of successful and unsuccessful attempts to connect with patients to meet need, and the unsuccessful stories of not connecting with patients, were helpful to the development of the theory, showing the challenges and barriers. Not connecting increased the risk of not meeting the patient's need, as patients chose not to share with that particular nurse what exactly they required (Cook et al., 2014; Levack et al., 2016).

The participants shared openly of their challenges and local pressures. These ranged from those normalised in nursing culture such as lower staffing (Regan et al., 2017; Walker et al., 2018), and those nurses whose practice is out-of-date so that well-meaning advice leads to inaccurate information for new nurses (O'Shea, 1999). New graduate nurses shared experiences of prejudice, team members unwilling to teach, and toxic behaviours. Prejudice is an issue in healthcare with staff experiencing it both as targets of that behaviour (Chang & Cho, 2016; Foxall et al., 2017) and as bystanders (Hoffman, Trawalter, Axt, & Oliver, 2016; Huria, Cuddy, Lacey, & Pitama, 2014). In both positions they felt pain and harm as a result.

Graduates reported that sometimes their requests for opportunities to learn, or be taught, were declined or ignored. Some nurses did not have the time or inclination to support a new graduate, and on busy shifts the support disappeared when graduates were no longer rostered on the same shifts as their delegated preceptor (Regan et al., 2017).

Bullying was not described in this research using that word, however through stories of exclusion, deliberate patterns of critique without a clear learning outcome, and graduates unwilling to interact with certain nurses, a picture was painted of bullying behaviours (Evans, Boxer, & Sanber, 2008; Tabakakis et al., 2019).

This chapter has broken the central thesis into three key messages and the next section explores these, elaborating on the wider implications and research that links in.

5.5 DISCUSSION OF KEY MESSAGES OF THIS THESIS

New graduate nurses first develop their sense of self, before moving on to the ability to explore and value other cultures. Valuing culture was a required step to connection with patients. This is illustrated in Chapter Four. This development towards the ability to connect with patients is supported by Carper's ways of knowing, where personal knowing precedes ethical knowing (Carper, 1978); the personal comes first, and is the starting point for knowledge.

This thesis is outlined through three key statements which are expanded upon in the following sections.

- Exploration of self is a condition of nursing development.
- To value others culture, NGRNs need insight into their selves, time to reflect, and a safe space.
- To connect with patients, NGRNs need to value culture, and need time with patients and competence of practice.

5.5.1 Exploration of self is a condition of nursing development

Graduates described self-awareness in many ways, both current and retrospective. All groups spoke of the leap in awareness of their own cultures, and how they had grown and developed their understanding of the wider world beyond their own families and communities as a result of becoming nurses. The work setting provided a wider world than the one they had seen before. Ricoeur (1984), known for his writing around what develops a 'capable

human being', described that personal narrative is the construction we use to make sense of the world, and what we describe as common sense is actually shared values around behaviour, which can occur because people have experience speaking aloud in sharing values with each other. Without reflection on actions, that narrative may not evolve. Study days were a safe space to learn, reflect with peers on actions, and understand the reasoning and impulses behind what they had done (McKenna & Newton, 2008). It is recognised internationally that time away from the clinical area with their peer group is valued by new graduates (Doughty et al., 2018; Henderson et al., 2015; McKenna & Newton, 2008).

Self-awareness included awareness of their identity and responsibilities as nurses (Ranjbar, Joolaee, Vedadhir, Abbaszadeh, & Bernstein, 2017). Graduates experienced fear of their nursing responsibilities, and risks associated with those responsibilities. Graduates were not only afraid of what they were experiencing as nurses, but also anticipating worse outcomes or conditions based on the stories they were hearing or the ways they had seen other nurses' experiences on their shifts (Hawkins et al., 2019a; Regan et al., 2017). Their identity as nurses was different from person to person, specialty to specialty as professional identity is developed through experience in the clinical area, and each of them had very different experiences (Fagermoen, 1997). Professional values raised were also quite different between specialties, and they showed that their professional values were following the way they were being developed in their area (Aydın et al., 2021). For example, those working in perioperative areas were focused on integrity and transparency, those in long-term conditions spoke of walking alongside and communication.

Nurses showed awareness of their own prejudices or judgements they had held of others, and did so freely and without shame; discussing old beliefs as something they had shed as part of their clinical skills development (Oliver, Shenkman, Diewald, & Smeltzer, 2021). Each group seemed to have a culture that being on a journey to understand and do things well was acceptable, and that sharing old mistakes or previous flawed understanding was socially acceptable and supported by each other (Nicolaides & Poell, 2020). Graduates grew in empathy for themselves as they progressed and had the opportunity to sit with uncomfortable situations and reflect on them (Rinaldi et al., 2019), with those towards the end of their programme speaking of themselves as if they were almost a different person from a year ago.

Nurses found value in reflecting on how their culture was clashing with professional culture or clinical department culture, and discussed ways to uphold values and best practice. Those who were born outside Aotearoa New Zealand had unique strengths as they had already experienced making the adjustment to fit into a new culture (Brunton, Cook,

Kuzemski, Brownie, & Thirlwall, 2019). They also described additional social burden in speaking up to nurses more senior or older than them, stemming from cultural beliefs around respect for older colleagues (Andrews, 2017; B. Jenkins & Huntington, 2016). Graduates born outside Aotearoa New Zealand found their values and nursing practice better aligned with the Māori facilitators of the bicultural programme.

Many nurses spoke clearly and fluently of their own culture, and their awareness of how that did or did not align with nursing culture (Alkaabi & Wong, 2020; Çamveren et al., 2020; Feltrin et al., 2019; King et al., 2021). A clash in nursing versus personal culture was shared more from those who identified as ethnicities other than Pākehā or New Zealand European (Barton, 2008; Bell, 2007; Hartin et al., 2018). Some nurses felt safe in the classroom setting but reflected that their own identities did not seem to be as valued. The simple act of moving the centre of focus away from their identity was a threat to some nurses, who all identified as Pākehā or New Zealand European (Bell, 2007; Margaret, 2002; Nairn, 2002).

These nurses provided insight that a feeling of safety is required to be able to safely reflect on your own beliefs and understanding of the world. Threat does not have to be explicit to be real, and decentralising majority voices can be a new experience that feels uncomfortable for some in the group (Craig & Richeson, 2014; Isom Scott & Stevens Andersen, 2020). For those who are a part of dominant culture, the simple act of your culture not being centred may be seen as a threat (Ranzijn & McConnochie, 2013). Nurses who felt excluded or unvalued were unable to elaborate on which parts of their identity felt undervalued or not able to be shared, beyond religion. This may mean that they did not explore their self-identity and culture more widely, or it may be that they chose not to share it.

5.5.2 To value others culture, NGRNs need insight into their selves, time to reflect, and a safe space.

To achieve the ability to value other cultures, nurses need to develop insight into their own self and culture, have time to reflect, and a safe space to do so. It was helpful that the dominant culture was no longer centralised which allowed nurses to feel comfortable to explore their own culture, and share this with others (J. Roberts, 2021). Having classroom facilitators who were Māori and from non-Māori ethnic groups allowed more than one way of nursing and facilitating learning to be on display (Barnes, 2013; Hepi, 2008; D. Jones & Creed, 2011; Sheehan & Jansen, 2006), leading to a more approachable way of learning tikanga best practice in an oratory fashion, through stories, shared experience, and whakatauki – proverbs.

Nurses shared insights and reflected on changes in thinking, new learning, and understanding of their own beliefs and their work environment and culture (Graf et al., 2020; Oliver, Shenkman, Diewald, & Smeltzer, 2021; Pai et al., 2020). Nurses enjoyed hearing from the wide variety of cultural beliefs of their classmates. Out of this they developed learning about how to engage in a safe conversation with patients to share of themselves and ask questions in ways that allowed the patient to feel safe to share their own culture and cultural needs (Lau, Ang, Samarasekera, & Shorey, 2020; Levack et al., 2016). For many this learning was about not assuming people's needs, but taking the time to find out (Hughes, 2021).

Graduates described safe spaces in different ways, and all included a space away from the work setting – the clinical area of work was not seen as an environment suitable for reflection (Nicolaides & Poell, 2020). The graduates outlined specific strengths of their classroom as a safe space; setting their own ground rules, lack of shaming, empathy from others, time away from the clinical area, and supportive class facilitation.

The previous section established that some nurses found the bicultural classroom to be a challenging space for their learning with a code of 'what about me' as they felt their culture was not a priority. It would be fair to assume that, based on their feedback, a study day where those who identified as Māori or Pacific Islander were in a different classroom space, working through the same learning outcomes through an indigenous lens would be better for them as this meant that the ratio of Pākehā in this group's classroom was higher. However, the group were not comfortable that day either. Nurses voiced strong concerns that they were being talked about in the other classroom, and that the Māori and Pacifica group were receiving something different or better (A. Jones & Jenkins, 2008; Smith, 2012). It appears that neither a bicultural classroom, nor a separate Māori stream is agreeable to this group, and it remains an opportunity for future research.

In Western societies, whiteness is seen as the norm or default, and race and culture is something attributed to others (Dyer, 2005; Sue, 2006). The threat of no longer being centred appears to have been enough to stifle the ability to open the mind to new ideas or other ways of being. There is visibility that Pākehā can find the decentralisation of their way of doing things as a threat and that Pākehā students have been seemingly willing to learn of other cultures but wish to do so on their own terms (A. Jones, 2001). In spite of decades of focus on cultural safety it appears that there are still problematic attitudes to race and culture in nursing (Graham & Masters-Awatere, 2020) and this is occurring even in those new to the workforce.

5.5.3 To connect with patients, NGRNs need to value culture, time with patients, and competence of practice.

Nurses showed passion for connecting with patients. Connecting was seen in differing ways: bedside feedback from family was highly valued; physical contact such as a hug on discharge or after a particularly intense time was noted and prized. Nurses described that the patient's whanau would share insight into need being met as it had not in the past (Halldorsdottir, 2008). Shared humour and light-heartedness was described in relation to connection (van der Krogt, Coombs, & Rook, 2020), and graduates were proud to share better outcomes as well as patients demanding different care from other nurses, citing that the change was as a result of a nurse connecting and identifying a need previously unmet.

Graduates all spoke of the difficulty of working holistically and connecting with patients in their first three months, and many early on in their NETP year said that although they wanted to take the time to get to know patients that there simply was not the time (Murray et al., 2019b). The term 'Care Rationing' has been used to describe nurses failing to meet care needs due to 'Inadequate time, staffing, or skill mix' (Schubert, Clarke, Glass, Schaffert-witvleit, & De geest, 2009, p. 885). Graduates further through their NETP year spoke of their first 6 months reflecting on how they had felt pressure to keep up the pace, and how this task-based focus pushed them away from time at the bedside (Doughty et al., 2018; Pai et al., 2020).

Connection started at the initial interaction and pronunciation of names and taking the time to get to know a patient's family was a prominent trend seen in three focus groups. It is relevant that these graduates experienced this modelled in the bicultural NETP programme where time was taken each study day to reconnect with names, background, and current updates on what they were experiencing. Culturally appropriate engagement (Hunter & Cook, 2020a) and building of relationships is pivotal in te ao Māori, the Māori world, and Māori patients in particular place high value on the process of whanaungatanga; meaningful connection (Cook et al., 2014). Māori have been shown to have been discouraged to engage with healthcare if that connection is absent (Levack et al., 2016).

Graduates developed greater skill in assessment and understanding as the year progressed (Innes & Calleja, 2018; King et al., 2021; Montgomery et al., 2020) and also increased in their physical skills and manual dexterity. Being able to do a task easily or without full concentration frees up a nurse to be able to truly listen to what a patient is saying when they are with them. There was also a clear message that once graduates became less linear/task based and more assessment based and needs lead, they were more efficient in their interventions and felt less out of control of their workload (Winters & Neville, 2012). More

than one group discussed the fact that taking time to get to know a patient's individual needs actually saved them time later, and holistic care felt safer (Graham & Masters-Awatere, 2020; Murray, Sundin, & Cope, 2019a). Latent curve growth analysis shared that there is a positive relationship between nursing competence and professional socialisation (Pai et al., 2020) and it is of interest that this study shows that holistic and cultural care also follows that trend.

Graduates who had been unable to participate fully in valuing culture struggled to connect with clients who were outside their own culture (Bell, 2007). Patients declined to engage in discussion about their specific needs (Levack et al., 2016). Other graduates without fear of persecution spoke of connecting and learning more about their patients, and then patients sharing needs; or doing this in an iterative fashion, getting to know a patient more and more and be able to learn and understand the patient's cultural needs for their care. Patients did not necessarily trust nurses on first meeting, and needed the time to get to know them.

This is opportunity for further research; this persecution blocking a nurse's ability to connect and learn of other cultures may not be unique to NGRNs (Bell, 2007). These nurses are unaware of their fear being anything different to other nurses, and held their feelings of persecution and missing out as something understandable and fair. Without insight and awareness into how that attitude may impact on patients, there may be clinical risk.

5.6 THE CHALLENGES IN PRACTICE FOR NGRNS

Challenges identified by graduates have been split into four sections for ease of review.

5.6.1 Lack of insight into cultural need from non-NETP team members.

Graduates feel pressure from nurses and nursing leaders to prioritise visible outcomes such as medications, wound dressings, or documentation (Jarden et al., 2021; Kelly & Ahern, 2009). There was little or no prompting for the NGRNs to ask about cultural support, culturally safe practice, or the cultural needs of patients by most preceptors. Unfortunately, in spite of up-to-date standards and expectations of cultural safety, racial bias is still occurring in nursing (Graham & Masters-Awatere, 2020). Nurses are ideally placed to uphold the needs of Māori patients (Brockie et al., 2021) who are disproportionately represented in the inpatient setting (Christey, Amey, Campbell, & Smith, 2020; Scott et al., 2018), however, there are limited numbers of Māori nurse educators to meet need (J. Roberts, 2021; Simmons et al., 2008). The graduates valued the classroom and programme access to Māori nurses to mentor and facilitate learning. However the clinical areas have a lack of care tailored to indigenous need (D. Wilson, McKinney, C., Rapata-Hanning, M. , 2011). Some graduates had trained in undergraduate programmes that were designed to uphold and

prioritise Māori knowledge and frameworks, but once graduates started work as nurses, they found the clinical areas did not have sufficient insight or knowledge to value this. The graduate programme was seen as a safe space but it was in contrast with the clinical areas which are Eurocentric, normalising white experience and othering those who do not align within that (J. Roberts, 2021).

5.6.2 Pressure to task

Graduates feel pressure to keep on top of key tasks, and pressure to not hand anything over to the next shift (Chung et al., 2021). New graduates will follow role models attitudes and work ethic, and if a team appears very task-focused, graduates will follow that lead (Hunter & Cook, 2018). If nurses are under time or staffing pressure, they may have routinised their day, or skip cares, which can lead to not viewing or meeting individual patient need (L. Labrague & Santos, 2020; Vinckx, Bossuyt, & Dierckx de Casterlé, 2018). In addition, time pressured nurses will prioritise tasks with visible outcomes or measures such as medications and observations (Cross et al., 2019; Murray et al., 2019a). Graduates showed no insight that more experienced nurses were also under pressure and might not be working in their own ideal way (Vinckx et al., 2018). With regards to their own self-empathy, they had this only in retrospect, in the moment they shared feeling stressed and anxious about their perceived incompetence or lack of preparedness (L. J. Labrague & McEnroe-Petitte, 2018). Graduates were painfully aware that as new staff they take longer to complete their expected nursing role tasks, but no participants shared any insight into why that might be. It was just stated as the reality they were in; part of being a new graduate is taking longer. The reality of a new workforce is that they cannot take anything for granted – for example NGRNs needed to look up each medication and often needed to check things with another nurse – this leads to slower care delivery (Halpin, 2017). Pressure to complete key sign-offs to a specific schedule was part of the challenge – for example evening medication rounds at a set time regardless of the sleep pattern or individual needs of patients. The culture of the wards was part of it, but the anticipatory fear added to this.

5.6.3 Stress and fear

Not only were graduates anxious or stressed while working (Malouf & West, 2011), but they also experienced anticipatory fear (Hawkins et al., 2019a), and anxiety of what might happen if things went wrong (Mellor & Greenhill, 2014), and the awareness they could do harm (Henderson et al., 2015; Rush et al., 2013). Death, and dying patients are a part of the job, but there is emotional distress caused by this (Puente-Fernández et al., 2020; Zheng et al., 2016). The responsibility of being a registered nurse was described in terms of a weight by some, and is echoed in literature with apprehension, anxiety, and stress reported from workload, risk of error, and high patient acuity (L. J. Labrague & McEnroe-Petitte, 2018), and

the theory-practice gap contributing to this (Ebrahimi, Hassankhani, Negarandeh, & Gillespie, 2016; Mellor & Greenhill, 2014; Parker, Giles, Lantry, & McMillan, 2014). There was also cultural fear described by participants; a fear of getting it wrong (Almutairi, Adlan, & Nasim, 2017; Degrie et al., 2017; Repo, Vahlberg, Salminen, Papadopoulos, & Leino-Kilpi, 2017). Saying the wrong thing or misunderstanding and causing insult or hurt was a real concern for some participants, although none described it as a barrier to interaction as it has been described in the literature (Barnes, 2013). Māori nurses experience an additional fatigue that their emotional labour is not recognised or valued by non-Māori nurses, but is needed by their Māori clients, and used to negotiate institutional and personal racism (Hunter & Cook, 2020b).

5.6.4 The clinical environment and staff

Graduates shared stories of trying to establish who they could or could not trust, and although they did not discuss or identify specific negative team dynamics they clearly differentiated between more recently trained nurses, those in leadership, and those there for more than 5 years without a senior role. Graduates described that nurses who were senior and skilled but without a leadership title would be less willing to teach, help, or communicate effectively in the style of the receiver. It is worth considering that nurses who feel role conflict, frustration, or increased workload pressures were showing more risk of burnout related negative behaviours (Frankenberger, Roberts, Hutchins, & Froh, 2021; La & Yun, 2019). There is no option in Aotearoa New Zealand to be in a clinically skilled role without the expectation of teaching and leading, regardless of title or pay grade.

Professional identity and moral development occurs through interaction with other professionals (Deppoliti, 2008) and space and time for this to occur is required (Lea & Cruickshank, 2015). Staffing is a clinical safety issue, and without the ability to step away from patient care, learning is difficult to prioritise. This lack of private space available does remove the opportunity for a discrete teachable moment, or ability to safely reflect prior to leaving shift.

Both staffing and skills shortages were described in all groups, with some talking about short staffing and less people to divide the workload among (Doughty, Sinnema, McKillop, & Dixon, 2021). Others specified that there were days when, although they had the right number of nurses, they felt they were mostly all new to the specialty or less experienced. There was recognition that simply having the right number of nurses is not enough; if a nurse is a higher level but doesn't have local area experience, NGRNs can feel less supported (Ostini & Bonner, 2012; Winters & Neville, 2012). Graduates also discussed in groups that

staffing is generally set at a level for the best-case scenario and for those in departments where nurses work across areas, or where patient transfer may be required, if a senior nurse leaves with/for their patient, the NGRNs can suddenly feel very alone. A lack of support can hinder graduate confidence and developing competence (Hussein et al., 2017). Graduates will tend to adopt a trial-and-error approach to clinical challenges if left without sufficient oversight, and so this leads to increased risk of error or harm (Mellor & Greenhill, 2014; Spector et al., 2015). Graduates seem more focused on staffing as a controllable issue than any other nursing challenge, since rationing of care occurs with lower staff levels (Schubert et al., 2009), and their focus on this aligns with research showing that improved staffing levels are a key retention tool for the junior workforce in nursing (Kenny et al., 2016). District Health Boards with rural sites will find that NGRNs may be in charge and delegation roles earlier in their career due to smaller teams, and need to keep this in mind (Lea & Cruickshank, 2007).

5.7 Opportunities for future research

There is opportunity for further research on those nurses who had not progressed with the rest of their class to connect well with patients. How do nurse educators safely move those embedded in a dominant culture away from their comfort zone to increase their sensitivity to other cultures without raising defence mechanisms or a fear response?

This study included participants of Māori descent. The researcher is Pākehā. The Māori participants were not the primary focus, nor was the research done in kaupapa Māori methodology. There is high value in a Māori led and focused research on the experiences of Māori graduates in a bicultural NETP programme to ensure that their specific learning and outcomes are visible.

Graduates born outside Aotearoa New Zealand found value in the bicultural classroom. Having more than one way of nursing, and the time to reflect on conflicts between dominant medical culture and personal culture, was seen as empowering to them in advancing their practice. This is an opportunity for future research focusing specifically on this group and their learning needs and outcomes.

5.8 Strengths and Limitations.

The main strength of this research is that it is an insight into a bicultural NETP programme in Aotearoa New Zealand. As at the time of this research this is the only bicultural NETP programme this research holds opportunity for learning not found elsewhere.

Limitations of this research include that it is a small study of only 19 Participants. Other researchers may have provided different constructions from this research. Covid disruption meant that there was a six-month time-lapse between completing the last focus group and returning to analysis and coding. This disconnection may have impacted on continuity of this research.

5.9 CONCLUSION

Graduates experiencing their first year of practice within the support network of a bicultural NETP programme develop the ability to connect with patients by first exploring their own identity, then opening up to value other cultures. This development occurs under the conditions of a safe and non-judgemental learning environment, and the conditions to step through the stages are reflection, and appropriate development, time, and competence.

The new graduate year is one of self-awakening, growth, and awareness of a wider world. Graduates use self-reflection on their own identity and shared stories of their culture as an entry to then extend into appreciation of other cultures. A bicultural programme with the dominant culture decentralised and indigenous experience prioritised provided strengths for learning. Māori and non-Māori nurses shared that they found it helpful to explore nursing from different perspectives. For those born outside Aotearoa New Zealand, seeing multiple ways of being a nurse was empowering. A space to hear of other ways of nursing, or bringing individual culture into practice for the benefit of patients, gave nurses role models of nursing that were not the same template as those they had seen before. For some though, the opportunity to learn in a bicultural classroom had felt like a threat and this decentralising of Pākehā culture was enough of a challenge to their identity that it may have been a barrier to learning.

Nursing connection occurs iteratively, with NGRNs sharing of themselves as part of connecting with patients. Graduates shared and showed interest in their patients to find out more about them, appreciating what was unique to them, and ensuring they prioritised individual need. That connection through culture met patient need. Barriers to connection were developmental as well as grounded in the clinical environment which remains complex and diverse across specialty areas, however, key aspects were across most specialties, and related to stress, staffing, workload pressures, and other nurses not understanding the value of best practice tikanga or cultural care.

In conclusion, the latest entrants to the nursing workforce are bringing with them a broader understanding of nursing care - beyond the physical and mental - into the cultural, and with them they are raising patient and family expectations. Graduate programmes need to be

providing the space, time, and facilitation to allow graduates to reflect on themselves, and the world they are experiencing. Clinical areas should be staffed to a level that would ensure team wellbeing, protect against burnout, and support new graduate nursing development. Graduates are optimistic, have strong belief in what nursing should be, and are enthusiastic about working in a holistic way. These strengths they bring to the workforce should be upheld and encouraged by managers and educators, while they also seek to keep them safe in practice.

5.10 Reflection.

The process of ethical consideration of the impact of this research felt like an academic process initially, learning about the possible pitfalls and risks from books and academic mentors. Like most new researchers, I assumed I knew what I would experience and that it would follow a clear and planned pathway. Interestingly, the impact of this research on myself did arise in a very real way at the stage where I ran a focus group. Within the focus groups, controversial themes arose and strong opinions were voiced by participants that ran in direct conflict to my nursing values, as well as my personal belief system. There was no harmful action or behaviour disclosed, but codes of judgment and centring the self over others felt hurtful to both listen to in the moment, and transcribe later. I found that I could work for only 30 minutes transcribing before needing a break and a walk outside to process. I found it challenging to follow ideal practice as an interviewer and just listen and let them talk without challenging them when these themes arose. Having processed the idea that I might personally feel compromised or challenged by the research, it was a straightforward matter to engage confidential support from an appropriate academic mentor to support my processing of this challenge, and I was very grateful to have considered it ahead of time. I have no doubt this could have either compromised my process, or derailed my research had I not been prepared.

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7 APPENDIX

A. PARTICIPANT INFORMATION SHEET

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

New graduate nurses' experiences within a bicultural NGRN programme.

Participant information sheet: Focus Group.

Tēnā koe, my name is Lisette Ingram, and I work as a nurse educator for graduate programmes. As part of my Masters Thesis at Massey University I am carrying out a research project exploring new graduate nurses' experiences of their first year of practice when participating in a bi-cultural NETP programme. I would like to invite you to participate in this project. Your participation is voluntary, and you can decline to participate. My role as a nurse educator is completely separate to my role as a researcher.

Project Description and purpose:

I would like to know your experiences and opinions of your new graduate RN year so far, as you have completed orientation, settled into your clinical area, and begun your study days running under the new bicultural model. If you participate in this study you will be participating in a focus group with a group of your NETP colleagues.

How was I identified and why am I being invited to participate in this research?

You have been identified and invited to participate in this research because you are a new graduate nurse employed by Waikato DHB in 2019. All graduates in the NETP program who started in 2019 have been invited to participate.

Procedure:

The focus group will be carried out by myself. It will take place in a meeting room away from your clinical work area, or an alternative location of your choice, and will last approximately 45 minutes to an hour. The focus group will be digitally recorded and later transcribed (written out) for analysis by myself. Those transcripts will be analyzed, and some quotes from the information may be used in presentations, reports or publications.

Information from this study will be used to complete a Master's thesis, and may be used to contribute to published work. Your information will be anonymized, and no information will be identifiable to a participant.

Your participation or non-participation will have no impact on your grades, academic relationships or employment with Waikato DHB.

Right to Withdraw from Participation

You will be free to withdraw from the study and / or focus group at any time. If you withdraw from the focus group, the information you have contributed up to that point cannot be deleted.

A copy of the research report will be sent to participants upon request.

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

How will your privacy be protected?

To protect your confidentiality, no real names will be used in the transcriptions. No identifiable information will be requested or transcribed, such as birthdates or addresses. You may refuse to answer any questions and are free to leave the group discussion without having to give a reason. Because there will be other participants contributing at the same time, the recording device cannot be turned off during the discussion and the information you have contributed up to that point cannot be deleted.

Because of the nature of group discussions, what you say during the focus group will be known to other participants in the focus group and therefore cannot be confidential. All participants will be asked to complete a confidentiality form and each member of the focus group will be asked to respect one another's privacy, not to talk about the group discussion to others, and to agree that everything that is said in the focus group remains confidential to the people involved. You will never be identified as one of the research participants by the researcher. Your personal information will never be related to any of the study findings. The risks of participating in this study are minimal.

The digital tapes will be transcribed by me (Lisette), and then destroyed. Transcripts will be kept in a locked cabinet for six years in case they are required for future publication purposes, after which they will be professionally destroyed and computer files deleted.

Consent forms will be stored separately from all other transcripts and research data.

How do I agree to participate in this research?

Please inform Lisette Ingram, and if you have any questions or wish to know any further information, you may also contact Karen Hoare.

Lisette Ingram RN, Educator Waikato DHB Lisette.ingram@waikatodhb.health.nz	Dr Karen Hoare PhD Associate Professor Massey University k.j.hoare@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/57. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz

B. PARTICIPANT CONSENT FORM.

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

New Graduate experiences of practice.

This form will be held for six years.

Researcher:
Lisette Ingram
RN, Educator
Waikato DHB
Lisette.ingram@waikatodhb.health.nz

- I have read the NGRN experiences of practice participant information sheet. I understand the nature of the research and why I have been selected. I have had the opportunity to ask questions and they have been answered to my satisfaction. I understand I can ask further questions at any time.
- I understand that my responses will be recorded and transcribed. I also understand that as this is a focus group, recording will not be stopped, but I may withdraw at any time.
- I understand my employment, and participation in the Waikato DHB NETP program will not be affected through participation or non-participation in this project.
- I understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.
- I understand all the information I provide will be kept confidential to the extent permitted by law, and I will not be identified in any report or publication resulting from this research.

Note: There are limits on confidentiality as there are no formal sanctions on other group participants from disclosing your involvement, identity or what you say to others in the focus group. There are risks in taking part in focus group research and taking part assumes that you are willing to assume those risks.

- I understand that I am able to request the findings of the study.
- I understand that study data will be kept for six years, after which time it will be destroyed.
- I agree to take part in this focus group.

I _____hereby consent to take part in this study.

Signature: _____ **Date:** _____

To receive a copy of the research on completion, please share your email address below.

_____

C. Ethics Approval, Human ethics committee, Massey University.

Date: 09 October 2019

Dear Lisette Ingram

Re: Ethics Notification - **SOA 19/57** - **New graduate nurses' experiences in their first year of practice.**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Southern A Committee** at their meeting held on **Wednesday, 9 October,**

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

D. HEALTH AND DISABILITY ETHICS COMMITTEE WAIVER

Health and Disability Ethics Committees

Health and Disability Ethics Committees
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
6011
0800 4 ETHICS
hdecs@moh.govt.nz

9 August 2019

Ms Lisette Ingram
Waikato DHB
Lisettesplace@gmail.com

Dear Ms Ingram,

Study title:	New Graduate Nurses' experience in their first year of practice

Thank you for emailing HDEC a completed scope of review form on 09 August 2019. The Secretariat has assessed the information provided in your form and supporting documents against the Standard Operating Procedures.

Your study will not require submission to HDEC as, on the basis of the information you have submitted, it does not appear to be within the scope of HDEC review. This scope is described in section three of the Standard Operating Procedures for Health and Disability Ethics Committees.

Your study meets the student-led research exemption criteria described below. Your scope of review form described an observational research project for the attainment of a Master's degree.

For the avoidance of doubt a study conducted wholly or principally for the purposes of an educational qualification requires HDEC review only if it:

- is an intervention study, or
- is not conducted at or below a Master's level.

If you consider that our advice on your project being out of scope is in incorrect please contact us as soon as possible giving reasons for this.

This letter does not constitute ethical approval or endorsement for the activity described in your application, but may be used as evidence that HDEC review is not required for it.

Please note, your locality may have additional ethical review policies, please check with your locality. If your study involves a DHB, you must contact the DHB's research office before you begin. If your study involves a university or polytechnic, you must contact its institutional ethics committee before you begin.

Please don't hesitate to contact us for further information.

Yours sincerely,

Matthew Poulsen
Assistant Advisor
Health and Disability Ethics Committees
hdecs@moh.govt.nz

E. WAIKATO DHB ETHICS APPROVAL

Management and resource sign-offs.

Management and Resource Sign-offs

This study does not require HDEC review.

Locality Review – *the undersigned agree to the following statements:*

- The study protocol and methodology are ethical and scientifically sound.
- This researcher has identified that this study does not require Health & Disability Ethics Committee (HDEC) review.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Cultural consultations have occurred or will be undertaken as appropriate
- Appropriate confidentiality provisions have been planned for.
- Appropriate arrangements are in place to notify other relevant local health or social care staff about the study, and for making available any extra support that might be required by participants, where relevant.
- Conducting this research will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that the results of the study will be disseminated and where practical and appropriate the findings of the study will be translated into evidence based care.

Queries about this research must be made to the Primary Contact person listed.

Dept/Service/ Org	Role	Name (print clearly)	Signature	Date signed
Nursing & Midwifery	Deputy Chief Nurse	Cheryl Atherfold	C Atherfold	1/8/19
Nursing & Midwifery	Chief Nursing & Midwifery Officer	Sue Hayward	S Hayward	1/8/19
~~Te Puna Oranga~~	~~Māori Research Review Cttee~~	~~Nina Scott~~		

F. WAIKATO DHB CLINICAL AND SUPPORT SERVICES SIGN-OFFS.

Clinical Support Services Sign-offs

CROSS OUT/ADD SIGN-OFFS APPLICABLE TO THIS PROJECT

SIGNATORIES DECLARATION: We agree that appropriate resources are available in our service to support this project

Clinical Support Service	Name (print clearly)	Signature	Date signed
~~DHB Pharmacy~~	~~Rajan Ragupathy OR Alice Chang~~		
~~DHB Pharmacy~~	~~Marinda van Staden OR Jan Goddard~~		
~~Laboratory~~	~~Kay Stockman~~		
~~Radiology~~	~~Glenn Coltman~~		
~~Medical Records~~	~~Marilyn Hunt~~		

Please return to the Research Office (via Sarah Brodnax, 13 Ohaupo Road) along with required documents as identified in the checklist for final approval.

Office use only:
Quality & Patient Safety, Waikato DHB

Signature: 

Date: 5/8/19

Name: Mo Neville
Director
Quality & Patient Safety

Position: