The impact of the presence of the first level practitioners in wards and the changing role of the nurse unit managers

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University of Wollongong

1992

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"THE IMPACT OF THE PRESENCE OF THE FIRST LEVEL PRACTITIONERS IN WARDS AND THE CHANGING ROLE OF THE NURSE UNIT MANAGERS"

A thesis submitted in fulfilment of the requirements of the award of the degree

MASTER OF NURSING (HONOURS)

from

The University of Wollongong

by

TRUDY PODMORE R.N., C.M., B.ED.

DEPARTMENT OF NURSING

1992
Acknowledgments

The assistance, guidance and encouragement given by:

Dr Felix Yuen and Mr Jock Crawford during the planning, researching and preparation phases and Mrs Irene Stein and Mrs Robyn Veitch during the reviewing phases of this thesis is gratefully acknowledged. Also gratefully acknowledged is the support and draft readings by Mrs Margo Nancarrow and Mrs Dianne Henderson. Especially noted is the encouragement and long suffering of my three daughters who have on many occasions had to do without their mother so that this project could be completed.
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Abstract

Nursing was the last of the health professions to move to tertiary education. This did not occur however without much distress for Nursing Unit Managers who were concerned about their changing role in relation to the arrival of the First Level Practitioners. This exploratory study was conducted over a six month period in 1990 within the Lower Hunter Valley and analyses the perceptions of Nursing Unit Managers, First Level Practitioners and Directors of Nursing of such impact. Specific areas focussed upon in the study were the roles of supervisor, facilitator, teacher and coordinator.

Information was obtained by interviewing Directors of Nursing about the integration of the First Level Practitioners and the degree of involvement of the Nursing Unit Managers. Following this, Nursing Unit Managers and First Level Practitioners were informally interviewed and were requested to complete a questionnaire which explored their perceptions of the involvement of the Nursing Unit Managers in the integration process of the First Level Practitioners into the clinical teams. Nursing Unit Managers were also asked to identify whether they felt that their role had altered since 1987 and to identify which specific areas of the role have altered and what had caused the changes.
Results identified differences between perceptions of Nursing Unit Managers and First Level Practitioners concerning integration processes of the new practitioners and the degree of involvement of the Nursing Unit Managers in these processes. Nursing Unit Managers suggested that the roles of facilitator, teacher and coordinator had altered since 1987 and that these changes were directly due to the presence of the First Level Practitioners in nursing teams.
CHAPTER ONE

INTRODUCTION

During the past decade various studies have been conducted exploring roles and the workload of the ward/charge sister\(^1\) (Pembury 1980, Orton 1980, Allen 1982, Benner 1982, Runciman 1983 and Duffield 1991). Despite these research activities, no studies appear to have investigated the relationship between the Nursing Unit Manager (NUM)\(^2\), the education of the student nurse and his/her integration into the ward team or on the consequential effects upon the role of the nursing unit manager.

Historically, nurses learned their skills under the medical model of practice. This model promoted a mechanistic view of people and curing. Prevention was not the aim of care. Educational needs of nurses were dictated by service needs with the emphasis being placed upon obedience to doctors' orders. In recent times however, nurses have begun assuming more responsibility and accountability for their roles and nursing actions as

\(^{1}\)Charge sister in this study refers to a registered nurse who had been appointed as the most senior nurse in authority in a ward or unit within a hospital setting for the purpose of managing and supervising the unit. The term was used until 1983 when the charge nurse role was altered and divided into the roles of Nursing Unit Manager and Clinical Nurse Consultant.

\(^{2}\)Nursing Unit Manager (NUM) is the registered nurse within a ward or unit in a hospital setting who has been appointed at level II or III for the purpose of management of the unit. This registered nurse is considered to be a first line manager or in some cases an Assistant Director of Nursing. The term has only been used since 1983 following the alteration of the Charge Nurse role.
the expectations on the part of society have altered following changes and availability of health care services (Bates & Lapsley, 1985).

We live in an age of comparative affluence directed in part by changing health policies, modern disorders such as stress related diseases, disability and an ageing population. This has implications for social, organisational and educational structures. Change can also be influenced by the political will of governments and economic changes in the environment. During the 1970s and 1980s, the emphasis in health care management was placed upon care versus costs and accountability. In the Lower Hunter Valley in New South Wales (NSW) as in other areas of the state such as Sydney, a need arose for more skilled nurses who possessed a depth of knowledge which extended further than achievement of technical skills (McClelland 1968).

Traditional health care services such as Schedule Two and Schedule Five hospitals and community nursing services were restructured. This affected the type of care services being offered at institutional level as many clients who had formerly been residents were moved out into community housing. The impact for nursing was an increased coordinator role for the middle managers (NUM's). Little money was channelled into community nursing where ageing and disabled or chronically ill were now to be found as a result of implementing reports such as the Richmond (1983) and Olsen Reports (1981). These reports precipitated the transfer of many long term clients into the community and changed the approach to health care delivery from traditional, institutional based care to community care services.
Wallace (1982) and Andreoli & Musser (1983) suggest that as a result of these changes, new approaches to care were developed in an attempt to provide for the needs of the patients. This extended the nurse role to health promotion and disease prevention at community level.

Social change has occurred as a result of advances in medical technology. Transfer of services has polarised the distribution of community services. This has effectively isolated some groups of disadvantaged from the very services they require to maintain an adequate level of health care services. When funding to hospitals is cut, administrators in the public sector have to limit the number of hours for which nurses and medical practitioners are available, which in turn forces doctors to perform fewer operations and reduces the need for nursing hours. This limits the types of nursing and/or health care services available within communities. Bates and Lapsley (1985), suggest that doctors no longer have the same power as they did in the 1960's. The introduction of funding controls of hospitals by governments has eroded the doctors' power and as a result, they have been forced in recent years to restrict their activities due in some cases to limited access to facilities.

Perhaps the clearest indication of this power shift was the series of disputes between doctors and governments in 1984 on issues of access to hospital appointments and costs. At the same time the Government removed nurse training from the hospitals. The dispute was escalated by what Bates and Lapsley (1985) identify as a rash move by the Government. This led to the medical practitioners almost unanimously withdrawing their labour from hospitals over the issues relating to the Medibank principles.
The culmination of this was that the Governments have increased their control over medical activities. Both doctors and patients in the public systems experience access barriers such as decreased services, decreased hospital beds and increased costs put in their way to prevent unnecessary medical services being delivered. Since that time, hospitals have introduced various quality assurance programmes aimed at ensuring that people are not admitted unnecessarily to hospital, do not stay too long or do not receive unnecessary operations or tests (Bates & Lapsley 1985). As a result, an altered role for hospital care emerged.

The NUM was seen to be a crucial figure in health care delivery in terms of coordinating and maintaining cost effective services. Nursing service as it existed at that time changed in terms of training and education as until that time, nursing students had been the apprentices. The knowledge base of nursing has increased with the development of theories of practice by nurses such as Orem (1980), Rogers (1970), and Watson (1979) to name but a few. This theoretical development is well documented in nursing journals (Roy 1980, McGrath 1984, Russell 1988 and Fitzpatrick & Whall 1990). Application of theory, clinical research and other specialty techniques by nurses has brought about improvement in methods of curing and caring for patient/clients in a variety of settings with many and varied health breakdown processes.

The role of the nurse practitioners changed from task assignment to management of care with the difference being that an attempt was made to include patients in the planning of their care. This was not only evident in
their job descriptions but in dealing with patient interrelationships, staff organisation and funding constraints as well.

In NSW change in nursing has been slow with few watersheds. It would appear that Committee of Inquiry reports such as The Matron's Committees (1960) the New South Wales Registration Committees (1975), Nurses Representation Committee (NORC) (1975), which indicated the need for improved education for nurses have been ignored. Change, as always has been in the hands of a few innovative leaders within the profession who have initiated advancement by searching for opportunities and resources, experimenting, modelling, by setting an example and establishing new values. However, their impacts were limited by low levels of acceptance by both the profession and Government bodies of the day as evidenced by the fact that change took so long to be initiated.

Health organisations are dynamically undergoing change, reassessing and evaluating the need for further change (Swansburg 1990). Nursing leaders need to modify their ideas, values and functions. Leaders can become "lost" or "swamped" in the role of manager as they assume the mantle of leadership at unit level instead of the traditional headship to which organisational authority previously appointed them. This means that the role of the NUM must be clearly defined and realistic boundaries need to be set to assist these people to function effectively within the organisation.

Leadership is a learned management skill, which must be developed in order to run an effective nursing team which provides quality and safe nursing care to the patient/client. The formation of such a team however
becomes more difficult when those dealing with the uncertainties of change (such as unknown future, job security, perceived opportunity for promotion) are unsure how far reaching the change is going to be. This was the situation in which NUMs found themselves following the transfer of nursing education to tertiary institutions in 1984. This transfer meant that those in current practice were unsure of the impact of such a transfer upon their own professional practice (Cowan 1984, Baird 1987).

NUMs manage complex equipment, monitor performance, solve problems and supervise staff. They also teach staff, keep the patient comfortable and maintain the efficacy of treatment whilst performing the roles required of a first level manager (Foster 1981, American Organization of Nurse Executives (AONE) 1992). This expectation requires them to be a facilitator, supervisor, teacher and co-ordinator at all levels to ensure that the expectations of both clients and nursing management are fulfilled. This multifaceted role demands increased skills that include people skills such as supporting, mentoring, generating enthusiasm, communication, problem solving skills, technical skills and manipulating physical resources skills such as equipment, personnel and finances. Historically, most NUMs had not been educated for this position. They were promoted through the system and were conventional managers that is managers who instruct and direct. This raises two questions. The first is how should the NUM be educated and the second is who should provide their educational process in order to prepare them for the currently existing system (Irurita 1988).

One of the major factors which influenced the nursing profession and nursing care practices in NSW was the transfer of nurse education from the
hospital based method to that of tertiary education in 1985. This transfer, resulting from the acceptance of the Sax Report (1979) eventuated in a change in educational values from training for service to educating and development of the practitioner. This in turn affected the cost and mix of nursing staff in hospitals. This change also impacted upon the role of the NUM. For these managers, a major impact of this change was seen in the structure of the nursing team. The student, who in the past had increased responsibility according to the length of training and experience, disappeared as part of the ward nursing teams. Student nurses were replaced by enrolled and registered nurses thus affecting the mix of expertise and experience levels of the nursing team (Partridge 1984). In addition, the arrival of the newly registered college educated nurse with reduced clinical experience has again altered the level of expertise. These beginning practitioners do not have the equivalent extent of clinical or hands on experience which NUMs have relied upon in the past from a newly registered nurse.

Traditionally, trained registered nurses had spent at least three (3) years performing tasks in the wards and improving their psychomotor skills. In many cases, these nurses had worked with the NUMs before they registered and were already familiar with the policies of the wards. More importantly, they were familiar with the unspoken expectations of NUMs in terms of procedures and doctor preferred methods of caring for their patients.
The emergence of the college educated nurse who begins as a First Level Practitioner\(^3\) has spawned new problems. One of the most obvious differences is that the First Level Practitioner is a registered nurse who has a different knowledge and skill base to the traditionally trained nurses of the past. According to some graduates (Brun 1988), there appears to be an emphasis on cognitive and affective skills with some discontinuity in their learning related to clinical skills during the period of their education.

Due to the comprehensive nature of the nursing courses in NSW students undertake clinical experiences in both hospitals, and community settings. This means that college educated nurse graduates, having experienced clinical practice in these settings, are entering the workforce with a more comprehensive knowledge base, but with clinical experiences which have been in wider settings for shorter periods of time. Bircumshaw (1989) states that in the United States of America, these nurses required much support from the ward teams during the early phases of their integration. This in turn has the potential to place a heavier load upon the NUMs.

Clinical placements throughout the undergraduate nursing programmes are important. The types of placements available for clinical learning experiences have a strong influence on a nurse's development. As these nursing students are supernumerary, it is the clinical teacher who ultimately decides just what the students will experience or observe during their practicum. For the traditionally trained nurses, a majority of facets of care come together during the three year training period. As a result of

\(^3\)First level Practitioners are registered nurses who have successfully completed a nursing course offered by a tertiary institution and have been registered for less than twelve months.
daily involvement in the nursing processes, these students graduated with confidence in their clinical abilities at most levels of decision making due to their daily involvement in the processes. This differs for the college educated First Level Practitioner who has not experienced an equivalent amount of time in clinical settings to confidently develop as many skills by the time he/she graduates.

Currently, because of the need for large numbers of clinical teachers, institutions may employ clinical teachers who lack formal teaching qualifications or experience but may have specific clinical expertise. This has the potential to compound nursing student (and therefore graduate) skill deficiencies unless these clinical teachers are given specific support and guidance. As not all hospitals have specific staff members or programmes to fulfil this teaching need, the degree of involvement in the area of teaching/facilitation required of the NUM may increase when the First Level Practitioner arrives in the ward.

Many hospitals have planned to overcome these identified problems by introducing buddy systems or by appointing preceptors. NUMs still appear to bear the brunt of this educational change. This is evidenced by increased time spent on supervision, team coordination and overall safety responsibilities to the staff and to clients. No doubt it can be argued that this is part of the role of a manager and that such activities would appear to be part of the job description. Such issues have the

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4Preceptor refers to a registered nurse who is working within a ward or unit and is responsible for assisting staff develop and consolidate safe effective practice (NSW College of Nursing, 1985).
potential to change the NUMs perception that their role would be one of management rather than one of education, leading to a need for increased senior management support.

1. The Problem

The traditional role of the Ward Sister/Charge Sister based upon service experience (Irurita 1988) has always been regarded as a pivotal role in that it combined clinical nursing and some management. This role involved responsibility for planning, organising and coordinating resources and maintaining the effectiveness of the ward or unit. Naturally the strengths of the Charge Sisters lay in the clinical skills developed during training based upon the medical (cure) model and refined during their careers. Little if any training in management, teaching or social skills was given or thought necessary. Workloads were unpredictable and control of the workload was sometimes designed by medical staff who initiated orders for treatment, sometimes by both medical and nursing staff and/or by the nursing staff based upon task procedures and policies coupled to strong hierarchical organisational structure.

Running the ward (including organising patients and care workload, staff control and decision making, all of which are components of the management function) was at best unpredictable. As also were the behaviour, attitudes and approaches of the Ward Sister/Charge Sister and the nursing staff. The central difficulty for the NUM would seem to be one of role ambiguity as no specific preparation was given for the role.
Coupled with this was the fact that the hospital ward/unit was both a nursing and an administrative unit with the work of the NUM being poorly defined, even without the presence of the First Level Practitioners. In the current climate of change, this may even impact upon organisational structure within the care delivery system as a result of poor role delineations and mistaken expectations by staff at all levels.

A model was developed by this researcher which describes the many dynamic interactive facets of the NUM role. The various facets of the roles interact continually without specific delineations and thus provide diffusion or overlap of the roles (see Figure 1.1). This has the potential to cause role ambiguity and role conflict for the NUMs in the current climate of change.

Roles of The Nursing Unit Manager.
Figure 1.1
Prior to the undertaking of this study, NUMs in the Lower Hunter Valley had frequently informally stated to this researcher that since the arrival of the new First Level Practitioners, their role focus has altered. Many have attributed this changed role focus directly to the presence of the First Level Practitioners. It is difficult to determine whether such a change is purely due to the presence of graduate nurses in clinical practice for the first time in NSW. Another perspective might be that the change is due to changes in the structure and emphasis of health care services placed by society, or is influenced by politically driven impacts on the health care organisation and systems over the same period of time.

It may also be that the expectations of NUMs concerning the new college graduates have been inappropriate as a result of inadequate communication between the tertiary institutions and the NUMs on their behalf. This may have led to inadequate preparation of the NUMs for their educator role. The operationalisation of the transfer of nursing education may also have resulted in unclear expectations by NUMs of the graduate nurses' abilities. It therefore becomes necessary to investigate whether the arrival of the new graduate has in fact altered the NUMs role focus. No current research evidence relating to this aspect of nursing appears to be available at this time.

A common reaction to the transfer of nursing education has been the normal reaction to any change, that is a fear of the unknown (Cowan 1984). Many questions arose. Amongst these questions were; would these new nurses be paid a higher wage? Would all registered nurses who were hospital trained have to rush and gain higher educational qualifications or
be passed over in the race for promotion? Who was going to have to teach the new graduates how to become "real nurses" (Cowan 1984, p 11)? Such concerns further precipitated the staff feelings of uncertainty and anxiety.

Since 1987, many hospitals have chosen to aid in the integration of the First Level Practitioner by introducing preceptors (Baker 1990). This has occurred mainly in the metropolitan regions where nursing staff numbers and finance could be positively manipulated. Correctly implemented and monitored, preceptor programmes which were designed to ease the transition period for the new practitioners, are highly valued by the NUMs because they take over the support and clinical education of the graduates. However, as with many ideas in nursing, these programmes may flounder through variability in the availability and quality of interested staff. Workloads, finance and costs in some hospitals have rendered these programmes ineffective. Some hospitals, in the Lower Hunter Area Health Region had area health boards who allocated specific funds per student for the purposes of integration programmes for the new graduates (Hunter Area Health Service 1989, p 1).

In the Lower Hunter Valley, the instigation of preceptor programmes has been limited resulting in inconsistent support for the NUM in their efforts to integrate the college graduates. The problem is further compounded for NUM in those hospitals without preceptor programmes as such preceptor responsibility is often undertaken by the NUM with limited support and guidance from senior nursing managements.
In summary, the clamour for change in nursing has mostly been based on the multiplicity of roles and highly specialised nature of the work. The ideology of linking service and education increased in the sixties and finally resulted in the transfer of nurse education from hospitals into the tertiary education sector. This move was designed by Federal Government to professionalise nursing - thus maintaining the existing opportunities for education and training of nurses and leading to progressive improvement in that process (Sax Report 1979).

By understanding the responses to change, NUMs are able to plan and respond appropriately. The normal human response to change in a climate of uncertainty is resistance and resentment with feelings of anxiety, inconvenience and altered lifestyles (Lewin 1951, Swansburg 1990). Nursing administrators therefore need to create conditions which are going to be favourable for the acceptance of change. These conditions need to include the smooth integration of the new college graduate nurse entering clinical practice.

2. Purpose of the Study

This study investigates, within the Lower Hunter Valley, the impact of tertiary educated First Level Practitioners on the role of the NUM. Attitudes relating to four role areas (care delivery, patient safety, teaching and management) were sought from NUMs and First Level Practitioners working in unit teams. This was undertaken in an attempt to identify whether a role change was perceived to have occurred for the NUM as a
result of the change to tertiary educational preparation of the registered nurse.

3. **Aims of the Study**

1. To identify the traditional role of the Ward Sister/Charge Sister by means of a review of literature.

2. To determine whether changes which occurred as a result of creating the role of the NUM in 1983, were identified prior to 1984 when nurse education was moved from hospitals to tertiary institutions.

3. To survey perceptions of NUMs to changes in their roles related to having First Level Practitioners as members of the unit team.

4. To examine integration practices employed by hospitals for the First Level Practitioners and their impact upon the role of the NUMs.

5. To investigate perceptions of First Level Practitioners of their integration into unit teams and their expectations of the part played in this process by the NUM.
6. To compare the perceptions of the NUM and the First Level Practitioners about the integration processes for the First Level Practitioners.

4. **Research Questions**

The research attempts to answer the following research questions:

1. Has the role focus of the NUM changed as a result of the First Level Practitioner becoming a part of the nursing team? If so, how has it changed and in which direction?

2. Do NUMs and First Level Practitioners perceive that hospital integration policies are effective in the integration of the First Level Practitioner as part of the clinical nursing team?

3. Are support mechanisms in place to help the NUM meet the issues created by the introduction of the First Level Practitioner?

4. Are the expectations of NUMs and First Level Practitioners similar or different regarding the performance ability of the First Level Practitioners?
5. Hypotheses

The study attempts to test the following hypotheses:

1. The role focus of the NUM has altered since 1987 as a result of the presence of the First Level Practitioners in the unit nursing team.

2. There is no difference between the integration programmes for First Level Practitioners conducted by the major Lower Hunter Valley Hospitals.

3. Nursing administration has continued to adequately support the NUM since the First Level Practitioners became part of the ward nursing teams in 1987.

4. All nursing staff have held realistic expectations about the performance abilities of the First Level Practitioners since 1987.

In this study, variables used in the research for the purpose of examining the changing role or role foci of the NUM were facilitator\textsuperscript{5}, coordinator\textsuperscript{6}, teacher\textsuperscript{7}, supervisor\textsuperscript{8}. These are the role areas identified in an unpublished

\textsuperscript{5}Facilitator refers to the NUM's subrole of acting as overseer and prime mover to ensure progress, stability, to influence the behaviour of nursing staff in the unit in their efforts towards goal setting and achievement of organizational goals in terms of client management and staff development.

\textsuperscript{6}Coordinator refers to the NUMs subrole of linking activities within the ward or unit designed to continually stimulate a dynamic situation in which the patients receive optimal care and support aimed at facilitating their return to optimal health. This is achieved by supplying information to those in both the wards and in key positions within the organization with relevant information to meet organizational objectives.

\textsuperscript{7}Teacher in this study refers to the NUMs subrole which requires them to provide information and/or demonstrations - either formally or by role modelling. This enables other members of staff or clients to make informed decisions, perform appropriate interventions or provide others with relevant information within the ward or unit.
study of NUMs undertaken by Sharkey and Buckley (1989) in the Hunter Valley as being most at risk of change when First Level Practitioners become part of nursing teams.

6. **Significance of the Study**

This research will be significant in that the following outcomes will be obtained. The research will:

* further knowledge of the interaction between NUM and the First Level Practitioners.

* highlight areas which can expand unit managers' understanding and acceptance of the different roles of the First Level Practitioner. As a result, this has the potential to improve graduates' effectiveness within the unit team and reduce role conflict situations.

* provide insight and information to the researcher which can be utilised to improve teaching and therefore the preparation of future students for the work environment.

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8 Supervisor in this study refers to the NUMs subrole which includes behaviours which delegate authority, provide encouragement, supports personal relationships and ensure detailed work or performance. It is more directly involved with monitoring of patient care, staff performance levels and overseeing specific tasks within the wards.
CHAPTER TWO

CENTRAL THEORETICAL CONSIDERATIONS OF THE STUDY

The change process is usually underpinned by major issues, regardless of which aspect of life it affects (for example, management, nursing or society as a whole). As a natural consequence of major change many changes will occur. Financial forward planning, goal selection, profit making, cost effectiveness and ongoing staff development are some examples of the results of change (Swansburg 1990). Change Theory and Role Theory have been used as the major considerations for this study.

2.1. Change Theory

According to Partridge (1985) the phenomenon of change has been analysed using various models such as sociological psychology, systems/organizational theory. There exists a need for strategies which foster understanding, internalization and use of change process. Green (1983) suggests that the change process insists upon "particular understandings,
attitudes and behaviours from the nurse change agents for its successful use" (p 16). To this end change theory is explored in this part of the study.

According to Lewin's (1951) Force Field Theory, the change process involves opposing forces which first push the system towards change (driving forces). The opposing forces which act to pull the system away from change are known as restraining forces. If the leader is accurately assessing these forces and attempting to implement change, a thorough knowledge is required of the target system (the recipients of the change), the environment (particular history and circumstances involved in the change) of the change, the characteristics of the change and the potential human responses to the change. Lewin asserts that when restraining forces are stronger than the driving forces, leaders need to use normative or power-coercive change strategies to reduce these forces and to increase the driving forces to effect the desired change. Lewin (cited in Swansburg 1990) further asserts that the process of change consists of three facets; unfreezing (the learner ready to possess new skills), changing (attitudes are altered as a result of identification or internalization of new knowledge) and refreezing (attitudes are accepted and integrated into one's personality).

Change in society as a whole is reflected in relationships between people and within organisations (Schein 1985). Within the health sector this is shown by those relationships between doctors, patients, nurses and other allied health professionals within hospital organisations in terms of care
relationships and care delivery at various organisational levels for example the shifting of power bases.

Marriner (1982), Swansburg (1990) and Green (1983) comment that change and innovation are two ongoing processes which create a new state in nursing. Koerner et al (1991) also state that the profession of nursing must redesign its role and responsibility if it is to "meet society's mandate in the emerging reality of the twenty first century" (p 20). The implication of this is that if managers do not adopt, or at least display a willingness to participate in change, then decreased efficiency and stagnation will be the outcomes for the organisation. They further suggest that change may be accomplished by removing or transferring personnel, modifying duties of particular individuals (as has been the case in nursing), recruiting outside talent or undergoing reorganisation to make job requirements congruent with personnel capabilities. In part this is known as job redesign.

Reorganization of services within an organization may be achieved using job redesign for certain individuals within a system. In 1983 in NSW this occurred for the charge sisters when their role was split into two functions NUM and Clinical Nurse Consultant (CNC). This introduced a middle manager role into the hospital system at ward level (Duffield 1992).

Job redesign alters the basic relationships between a person and what they do in a job. It offers the opportunity to break away from previously held limitations of the job and to move towards internal motivation that leads the individual to do the work because it interests, challenges and rewards them for a job well done. In addition, job redesign directly changes behaviour
and the behaviour tends to stay changed (Douglass 1987). Thirdly, job redesign offers numerous opportunities for initiating other organisational changes such as increasing profitability, changes in structure, adjustments in work practice situations and job relations.

Using Lewin's model of change (1951), the arrival of the new First Level Practitioners in NSW in 1987 would have resulted in a series of driving forces which would promote a number of changes, including: perceived advantages of having registered staff, administrative support for the change, improved quality of nursing care and staff ability to cope with change. Restraining forces in this situation could be identified as being the lack of staff participation in the transfer of nursing education and little or no staff knowledge of the new education system. Feelings of potential threat to security by giving up old, well-practised routines and rituals and resistance to new models of practice as it becomes necessary to change behaviour to suit the profile of the newly registered nurse also acted as restraining forces.

Swansburg (1990) suggests that the Reddin (1971) model of change is one which would be useful for NUMs. Reddin suggests seven techniques by which change can be accomplished. These are diagnosis, mutual setting of objectives, group emphasis, maximum information, discussions of implementation, use of ceremony and ritual, and resistance interpretation (cited in Swansburg 1990, p 238-9). The first three actions are designed to allow the nurse to influence the direction of the change whilst the remaining four are designed to reinforce group involvement in the processes of the change.
Change agents do not necessarily always use relevant change theories and strategies such as those suggested by Lippitt, Watson & Westley (1958); and Elfrey (1982). The NUMs were not the initiators of the change in the transfer of nursing education and were not included in any of the decision making processes until the change was announced in 1983 at the same time as their Charge Nurse role was being split. As a result, resistance to the change would have been a common response according to Swansburg (1990). In many cases such resistance may have been based on a perceived threat to the status quo of their practice or the timing of the change or to their individual security as registered nurses caught up in a situation over which they felt that they had no control.

Some may have felt that their value as individuals and managers were being threatened. Marquis and Huston (1992) state that appropriate strategies for change in this situation should have included strategies to lessen the perceptions of exclusion and powerlessness, reduced self esteem and sense of security. Such strategies would have included the managers in the change and provided them with appropriate information to plan constructively for their part within the process. In 1993, Westmoreland suggested that such perceptions included the basic beliefs and attitudes of individuals motivation levels regarding work and the environment in a situation of "repeatedly trying to portray to nursing executives what they were experiencing at the time" (p 62).

In a situation such as occurred for nursing in 1984, (when student nurses were no longer accepted for hospital training and were replaced by
enrolled and registered nurses in the wards), NUMs should have been given the opportunity to gather data about their work, discuss, analyse and use the knowledge gained to effect the changes in which they were directly involved. Swansburg (1990) suggests that the implementation of nursing management systems can refine much of the freezing and unfreezing processes. However this appears not to have been the case in this instance in the lower Hunter Valley.

2.2 Role Theory

An understanding of role theory can help nurses to comprehend that hospitals need to slot people into categories which have predictable role expectations to ensure continued efficient functioning of the organisation. Traditionally, role theory evolved around the concepts of position and functional role in a social relationship where people are seen as occupying a variety of positions concurrently within society and systems and/or organisations (Swansburg 1990).

Conway (1974), suggests that role theory represents a collection of concepts and hypothetical formulations which predict how people will perform under a given set of circumstances. The concept of role theory evolved in the late 1920's and early 1930's from anthropology, sociology and psychology and has been evaluated extensively by writers such as Neiman and Hughes (1951), Gross, Mason and McEachern (1959), Banton (1965), Rizzo, House and Lirtzman (1970), Strong (1979) and Burke and Scalzi (1988).
According to these writers, within an organisational context, role is defined as a set of expectations applied to the incumbent of a particular position by others both within and beyond the boundaries of the organisation. The concept of role theory has been clarified by the creation of more definitive concepts such as role behaviour, role playing, role stress, role expectations and role ambiguity (Hardy 1978).

According to Goffman (1966), there are few concepts more commonly used than role. It has been suggested by Gerrish (1989), that the term "role" may be used in three ways. These are the expectations of others, expectations of self in terms of how one should behave and/or the actual behaviour which is experienced (p 199). This suggests that expectations and reality at times may not be congruent, a concept which can readily be applied to the NUMs in 1987 when the First Level Practitioners became part of the ward establishment. Allen (1982) confirms this by suggesting that the role prescription of the NUM may not be understood by others. Given the unsettled and uncertain climate at the time, the same could be said of the First Level Practitioners.

Hardy (1978), states that role stress is a general concept which encompasses those conditions which lead to vague, difficult or impossible to meet expectations. Role stress will occur regardless of whether the stressor is positive or negative. Sullivan and Decker (1985), suggest that stress overload for health care personnel falls into four categories of task based stress, role based stress, institution based stress and person based stress (cited in Marquis and Huston 1992 p 416-7).
Within the concept of role stress lie the two subconcepts of role conflict and role ambiguity. These are described by Rizzo, House and Lirtzman (1970) as conflicts between an individual's standards and the defined role behaviour expectations. Andersen (1983), noted that role conflict may be experienced by nurses at two levels. Firstly this occurs within their own body of roles. This may be between the subroles of clinician and educator or manager and secondly, the conflict may exist between the manager's own specific roles and those of others, for example, the First Level Practitioners and/or the medical staff. Cederberg (1986), supports this by stating that the transition from clinician to manager can result in role confusion and conflict, whilst Duffield (1991) suggests that this arises because first line managers must be credible with both co-workers and the management.

NUMs may also experience role ambiguity or role strain. According to Gerrish (1989) this involves lack of clarity concerning role expectations and performance behaviours. She suggests that this occurs when an individual does not have the right kind of information at their disposal which they need to perform their job properly. People differ in their tolerance levels with some requiring more structure and support in their jobs than others. This may lead directly to role conflict for the role holder.

Marquis and Huston (1992), identify that role overload, leading to role conflict and ambiguity will occur for health personnel who are experiencing multiple roles. This is especially so if they are new roles.
being experienced without clear job descriptions and clearly communicated role expectations.

According to Strong (1979) all social life has a ceremonial aspect which may be seen as being artfully constructed (which may be so routine as to pass unnoticed by us in a given situation). When situations or systems are repeated, well-developed roles emerge and actions are divided into manageable clusters of acts which can be compatibly and competently performed by a single person within the system (Strong 1979). In addition, role differentiation occurs so that different people within the system perform different roles. Strong (1979) further suggests that historically, role frames are shaped by political dispute and changing circumstances, a situation that has been paralleled in nursing up to the present time.

Results of studies (Rizzo et al 1970; Johnson & Graen 1973 and Caplan & Jones 1975) into the effects of role ambiguity indicate that lack of clarity about performance expectations is associated with a greater concern with performance, lower job satisfaction, unfavourable attitudes toward role senders, increased tension and anxiety, depression, resentment and increased job turnover.

When a person joins an organisation (such as a hospital) they will work through a series of stages in the process of role acquisition. According to Swansburg (1990), these include:

1. The Anticipatory Stage (forming expectations and adapting them);
2. The Formal Phase (objectives agreed upon, tasks identified work relationships are defined, codes of behaviour discussed, legal and psychological contracts established);

3. Learning workmates' expectations (through non verbal cues, usually adopted without evaluation); and

4. Acquisition (occurs later when held expectations become realistic, the entry stress is over and the person feels comfortable.)

As Christman (1979) argued:

"The social structure and consequently the roles in which people find themselves often better predicates their behaviour than their psychological traits or their training. Organisational arrangements powerfully influence role behaviour. These may encourage or inhibit progressive activities of the staff, foster or discourage co-operation among various roles, promote or retard continuity or disrupt communications" (Christman, 1979 p 4).

Such a description has implications for the NUMs as well as the First Level Practitioners in the ward/unit areas. As a result, nursing administrators need to come to terms with not perpetuating roles for the sake of the role, for if they are not facilitating or enabling care they become non-roles. Nurse theorists in the United States such as Orem (1956), King (1965), Rogers (1970), Levine (1976), Schlotfeld (1977), Benner (1982), Roy (1980), and Parse (1987), have developed a number of care and role models for nursing which centred around the needs of the
clients and significant other people involved in their lives. These models advocated a stronger professional role for the nurse in terms of clinical decision making, health promotion behaviours and quality of care but have not looked to the health seeking behaviours required by the NUM. Schlotfeld (1977), defines health seeking behaviours as representing a range of acquired physiological and psychological, social, cultural, institutional, philosophical and spiritual behaviours which are necessary in maintaining optimal health. These may be used to compensate for an individual's inability to cope with a given situation (cited in Fitzpatrick & Whall, 1989, p 244)

For the purposes of this study, Schlotfeld's health seeking model (1977) has been modified and adapted in order to identify those factors which impacted upon the NUM role since 1987. The modified model is summarised in Table 2.1. This model was originally developed to provide a basic conceptual framework for structuring nursing science and proposing nursing research questions. Schlotfeld's model is chosen for this study for its strength of logical adequacy. It describes the knowledge development and transmission required for client health in a well-organised format. Two main difficulties with the model have been described Glazer and Pressler (1990). In their analysis, the terminology needs to be studied for clarity and groups within the model are only broadly described in relation to health assets (cited in Fitzpatrick and Whall 1990, p 249). Despite this, the model adapts well to the purposes of this current study. The adaptation provides a means to demonstrate the relationships between the situational factors facing the NUMs and appropriate goal setting and
coping mechanisms introduced by the managers to more appropriately fulfil their roles in a time of change.

<table>
<thead>
<tr>
<th>CLIENT</th>
<th>HEALTH SEEKING BEHAVIOURS</th>
<th>INTERVENING FACTORS</th>
<th>GOALS</th>
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<tbody>
<tr>
<td>NUM</td>
<td>*Role focus areas-</td>
<td>*situational factors *perceptual factors *coping resources e.g. -changed society needs -transfer of nursing education -presence of First Level Practitioners -perceptions/ expectations -role conflict</td>
<td>*Maintain role identity -initiate/maintain relationships with others -maintain role -distress in manageable limits</td>
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<td>*facilitator</td>
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<td>*coping mechanisms</td>
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Table 2.1

In nursing practice today, the delivery of health care by professionals depends upon the enactment of a number of roles. Individuals occupying these roles hold expectations for their own role performance as well as having expectations of the roles of others in the same setting.

According to Hinshaw (1975), jobs fraught with conflict, rapid change, role ambiguity and unrealistically high performance standards are sources
of role stress. This concept transfers easily to the NUM in NSW at the time of the transition of the new practitioners from tertiary institutions. For the NUM, incongruence in role expectation can create conflict among individuals occupying health care roles and retard their ability to function together effectively (Foley, 1984).

Roles, methods of working and techniques are ever changing. Traditional roles are being swept away by the 'tide of change' imposed by nurses, doctors, politicians and society alike. The role of the NUM has many facets (refer to chapter 1). These roles require nurses to initiate care and implement care and management plans at a standard of excellence, promote a professional image within the community and organise co-ordinate and integrate services for patients, the public, nursing staff and paramedical staff.

Frustration is often an unfortunate experience for the NUM as for a manager in any comparable organisation. Any number of situations have the potential to go awry at any given time. These include shortages of staff, unhelpful medical staff, unsympathetic senior administrative staff and personal home problems. Problems such as role conflict and role failure emerge when the unit manager experiences incompatible expectations from one or more persons/situations in their environment (Wright 1993 p 130).

NUMs besieged by multiple expectations and responsibilities relating to different role areas may experience role overload. This may present as role failure when encountering a continuously intensely busy work pace or low staff establishments coupled with feelings of hopelessness in an
unimproving situation. Even before the arrival of the First Level Practitioners into clinical practice, NUMs often battled with the need for role clarification and often failing support from senior nursing administration. Situationally this arose as a result of little formal preparation for the managerial role which they had assumed.

At the time of the transfer, NUMs were given little education as to what performance levels to expect from the First Level Practitioners. This had an effect upon the unspoken expectations of all the current staff in the wards, as performance of clinical skills had in the past always been the criteria for assessment of staff performance. Perhaps the NUM expected this criteria to continue despite the changed approach to nurse preparation due to lack of information. Mistaken or unspoken expectations led to some personal anxiety on the part of many registered nurses as First Level Practitioners were structured into their unit nursing teams.

2.3 Summary of Chapter

This chapter explored the relationship of the concepts of change and role theory to the role of the NUM as it currently exists in the health system in NSW today. Change was identified as being reflected in relationships between people and within organisations. This is evident in relationships between health care givers in society, especially in the delivery of nursing care.
Marriner (1979), suggested that change and innovations are two ongoing processes which create a new state in nursing. If NUMs do not adapt to or at least become willing to participate in the change process, then decreased efficiency and reduced outcomes of care will result. The model adapted for this study (Schlotfeld 1977) evaluates the relationships between the NUM role, the situational factors in the health care delivery system and the mechanisms adopted by these managers to cope within a situation which at times they are powerless to alter.

The many faceted role of the NUM may lead to frustration if the managerial roles are not clearly delineated for these people. Without role clarity, role ambiguity and conflict may impair the nurse manager's ability to perform as effectively as they would wish in the role. Nursing like all other aspects of society is subjected to change which may be explained by exploring role theories and relating these to the findings. In nursing over the last few years the aspects of low control by nurses over their profession have been especially evident in relation to the transfer of nursing education. With this transfer have come unplanned reactions of powerlessness and feelings of fear on the part of some NUM (Sharkey and Buckley 1989). This, in turn, has had the effect of creating role conflicts and ambiguities for these people at a time when they require above all, role definition and stability in order to appropriately oversee the transition of First Level Practitioners into nursing teams.
CHAPTER THREE

REVIEW OF LITERATURE

There is a paucity of literature in New South Wales and indeed nationally dealing with the post-transfer period of nursing education from hospital schools of nursing into the tertiary education sector. No serious study appears to have been made of the impact of the transfer or of the subsequent effects of the presence of the First Level Practitioner on the role of the NUM. According to Foster (1981), Florence Nightingale's talent lay "not so much in soothing people's fevered brows, but in management, in planning, organising, directing and demanding that people do things regularly and consistently" (p 16) in order to provide quality health care for patients. It is necessary therefore to explore the available information to develop understanding of those factors leading to the current situation faced by NUMs.
Figure 3.1
Model of Concepts of Role Function as determined by Political Will, Organisations, Changing Controls and Practices of Nursing Between the 1960's and the 1990's
3.1 Precursors to Educational Change

The implications of the changed education processes for nurses may be more fully understood if the political influences are noted as they affected the educative processes of nursing up to 1984 when the transfer to tertiary based education occurred throughout NSW (see Figure 3.1). As the conceptual map demonstrates, the affluence experienced within Australia during the sixties precipitated a series of events including the women's liberation movement of the sixties, shifting populations, government demands for higher efficiency within the health care sector and advances in technology which in turn led to longer life expectancies for trauma victims and the elderly (Foley 1984).

Russell (1988, p 38), identifies that from the 1960s nurses generally had become discouraged with prevailing wages and conditions. This was clearly demonstrated by an ever increasing militancy over industrial issues. During this period, rapid social and technological changes occurred and the role of the nurse became increasingly complex. Russell further suggests that hospitals also became more complex in organisation and operation and the need for nurses to develop managerial and educational skills increased rapidly as a result.

Policies of the Whitlam Government in 1972 made more funds available for social issues such as health and education (Russell 1988, p 41). The changing role of women also affected nursing in that increasing numbers of women with tertiary qualifications meant that more married nurses remained in employment changing the face of
nursing practice in that more married women were employed in the wards and the availability of jobs for newly graduated nurses decreased. This according to Russell (1988), was partly stimulated by inflation, unemployment and improved working conditions for nurses.

A consequence of this was a restructuring of the health services and conflicts between interested parties (that is Governments and health agencies) which ultimately affected the skills base required by nursing staff in order to provide the most appropriate services to the community. The changed emphasis of nursing education in NSW throughout the seventies and eighties and restructured health portfolios by the Government of the day meant that the outcome was a total refashioning of nursing education in 1985 (Russell 1988).

In Australia, nursing was the last of the health professions to move to tertiary education (Andersen 1984). At the time of the transfer to tertiary institutions many nurses expressed concerns in nursing journals such as 'The Lamp', 'Image' (Gardner & McCoppen 1989, Ecton & Fralie 1987, Droes, Kramer & Hatton 1992, Cavanagh 1992) and the media about issues such as changing organizational structure, their own career pathways and how the new nursing students would survive financially. In particular they expressed strong dissatisfaction about the fact that once more politicians and non-nurses were deciding the fate of nursing for the future (Rice, Sydney Morning Herald 25 Nov 1983, p 18).

One of the precursors of educational change in nursing in NSW was the Chittock Report (1968). This report specifically identified the
need for change in nursing education and suggested that an interim syllabus (not made compulsory until 1976) be introduced. This report provided an opportunity for nurses to examine more critically nursing education and the profession. This year also saw the New South Wales Minister for Health (Dr Jago) set up the Regional Hospitals Advisory Council with fifteen committee members serving to determine the needs of the hospitals (and nursing) at the time (Russell 1988 p 42).

A reflection of the regional nursing educational system of that time has been documented by Watson (1989) in the Lower Hunter Region in NSW. This paper well displayed all the characteristics of regional schools throughout NSW and is a valuable source document. In 1970, only four out of eleven hospitals had appointed educators with teaching qualifications with the other seven hospitals sending their students to these hospitals for lectures. Poor communication existed between these hospitals. This led to difficulties in planning and education of nurses.

Watson (1989) states that in 1971, the Regional Nursing Committee supported the establishment of a Regional school of nursing and identified the need for teachers with full teacher training. It was not until 1976 that the first registered nurse with nursing education qualifications was appointed as nurse education officer. She was the first in the Lower Hunter Valley.

In 1974, the Nurses' Organisational Representative Committee (NORC) was formed to facilitate discussion between the Nurses' Association, the Matron’s Institute of New South Wales and the
Australian Capital Territory, the New South Wales College of Nursing and The Royal Australian Nurses Federation. This was the first time that these organisations had combined to more effectively state the nursing case for improved opportunities for educational change (Watson 1987, p 1).

As a result in 1977, the New South Wales Government adopted a policy of early transfer of responsibility for education. The assumption of overall control of nurse education was to be by the Minister of Education rather than the Minister of Health and the transfer was to be a gradual process. It was suggested that there be a "plurality of opportunities which should be undertaken for nurse registration" (Parry 1984, p 14). According to McGrath (1984), this referred to a need to upgrade the standard of training and establish contractual arrangements between hospitals and/or groups or schools.

The Sax Report (1979) provided a major impact upon nursing education. This report suggested that the professional functions of nurses would be enhanced if nursing were to be transferred to tertiary education systems. This report was perhaps the most influential factor in the justification by the Government of the transfer of nursing education to the tertiary sector in 1985.

Since this time, nursing education has been under constant review by nurses, journalists and politicians alike with deficits relating to accommodation, costs and student numbers being documented frequently. Deficits were identified as including students being required to work in areas for which they had not been prepared (that is in intensive care); disintegration of the relationship between theory
and practice; inadequate service release time for lecture attendance and service needs taking precedence over educational needs (Rice, Sydney Morning Herald 8 Nov. 1983). As student nurses at this time were hospital employees, it was virtually impossible to overcome all of these deficits. In addition, some student nurses were isolated from educational facilities and the lack of congruence between programmes and health service needs was also a major problem (Watson 1989).

Whilst there was an intention on the part of nursing committees as well as the Government to upgrade nursing education there were also many obstacles. For example, according to Quinn and Smith (1987) in the 1980s, the increasing cost of health care had alerted individual consumers as well as health providers to the need for improved services. Such concerns were confirmed in 1982 in an Interdepartmental Committee study for the Implementation of Government Policy on Nursing Education. Also confirmed was the fact that hospital based programmes were very expensive to conduct - a point which had been identified by nurses for many years. It was suggested at the time that to upgrade the system as it existed would have incurred even greater costs (involving staff salaries, related block release costs, student release costs).

During 1984, political activity by nurses throughout NSW relating to nursing education increased. Goals in nursing targets were published (Education 2000) and task forces were established to examine the consequences for nursing should such changes be made (McGrath 1984). In 1984, the New South Wales Nurses Association presented a discussion document which expressed the Association's views concerning the impending transfer. Major points noted included:
i) Members demanded more information as they had been excluded from the state planning group;

ii) Information was requested about the number of nurse educators in the system and appointment of senior positions within Colleges of Advanced Education;

iii) Information was required regarding which industrial award nurse educators in Colleges would be employed under;

iv) Information was requested as to the implications for nurse educators who remained within the hospital system whilst hospital courses were completed; and

v) Information was requested about the future role for registered nurses who trained within hospitals (Moatt 1984).

At a seminar conducted by the New South Wales College of Nursing, Parry (1984), the chairman of the Higher Education Board, addressed nurses and foreshadowed the aims of the government which were;

"* to improve the quality of nurse education by overcoming the existing shortcomings in the system at the time;

* to establish an efficient, trained stable workforce; and

* to improve hospital efficiency and contain escalating health costs" (p 6).

According to Parry (1984), this would be achieved through the establishment of a standing committee to deal with industrial and employment matters. He stated that the transfer would be total to achieve the most cost efficient transition and to avoid the administrative and industrial turmoil of parallel and competing programmes. In retrospect, this may be seen as a management
oriented philosophy rather than a care philosophy as it dealt more with resources and costs than with care outcomes and the needs of those in charge in terms of education, involvement and support.

These activities culminated with the target date for the transfer being 1985 being set by the Government in 1984 giving a lead time of approximately six months for courses to be written and suitably qualified staff to be appointed ready for the first intake of students in February 1985 (Andersen 1984).

In 1985, Lublin performed an evaluative assignment for the Commonwealth Tertiary Education Commission to discuss reports which the commission had funded. She noted that these reports attempted to evaluate the differences in performance between hospital and college graduates and suggested that often, the conclusions of these reports (that there was no significant difference in performance between the two groups) were invalid owing to methodological flaws.

Quinn and Smith (1987) made a valid observation. They agreed with Parry's statement that nursing education required upgrading but they suggested that with the increasing cost of the health care environment it is likely that a reduced amount or quality of care will be available. They suggested that nurses can no longer be certain that wage increases will come from reducing profits or raising rates, as in many cases a surplus of nurses no longer exists. As a result of these changes, (Quinn and Smith 1987, p 135) further state that nursing administrators too, face an uncertain future as demands for higher wages may be met by the hiring of fewer nurses, or the substitution of less qualified personnel to provide nursing services.
At the time just prior to the transfer in 1984, general suspicion existed amongst traditionally hospital trained practitioners that young recruits from tertiary education systems with their nursing diploma/degree would come with theoretical knowledge and unrealistic ideas about what to do, but with little practical experience. It was felt that this would lead to a need to be kept under control and given much support as the new college graduates would experience culture shock (Cowan 1984).

These authors did not suggest however, the knowledge which the NUMs would need to acquire about the profile of the graduate and how it would affect their own role performance ability. Little was known at this stage by the NUMs about the skill/knowledge base that these new career graduates were bringing with them (in terms of educational processes and standards). Consideration must here be given to the fact that each tertiary education system is primarily responsible to itself and secondarily responsible to the nursing profession and its registering bodies and that nursing education had a low status compared to some other aspects of true education (i.e. teaching) as it was traditionally seen.

3.2 The First Level Practitioner

Following successful completion of studies, the First Level Practitioner graduates from a tertiary institution after having obtained a nursing diploma/degree and begins clinical practice as a registered nurse. The first twelve months post graduation is a time of consolidation for these newly registered nurses who are meant to work in a situation of support and ongoing education (Buckenham
and McGrath 1982, Brereton 1984, Carty & Bednash 1984, Baker 1990, Butts & Whitmer 1992). The nurse is a beginning practitioner and is not expected to take charge positions or function in areas where clinical decisions involve unpredictable outcomes or where there are multiple problems presenting, until judged by virtue of increased length of experience or additional qualifications to have developed appropriate competency. It was "anticipated that the new graduate would have access to, or work under the direction of, more experienced professional nurses" (Department of Health Circular, 10 June 1986, p 1).

In studies undertaken during the last decades, Benner (1982), and Dear & Keen (1982), identified significant differences between traditionally hospital based trained nurses and tertiary educated nurses. Such differences were concentrated mainly on the psychomotor or procedure orientated skills. Their comparisons suggested that differences existed between times taken to perform skills and the ability to perform procedures within the two groups.

Roell (1981), Slater (1984) and Smillie (1987) supported these findings and also found that whilst graduates had a sound theoretical base, some students may never have observed many of the practical skills prior to their registration. This deficit was seen by NUMs as being a critical factor relating to the performance of the role of registered nurses. This reflects what can be considered to be the major areas of concern for most writers who explored the roles of the NUM and as a result influenced the direction of this study. All respondents considered that the junior registered nurses were well prepared but different priority was given to various role aspects such
prepared but different priority was given to various role aspects such as communication and building a sound theory base for practice as opposed to specific mastery of all technical skills at an advanced level.

Later, McGrath and Princeton (1987) confirmed this lack of clinical expertise and suggested that their survey provided evidence that preceptor programme objectives relating to the transition of new graduates from student to registered nurse were being met - with the exception of the area of preparation for charge nurse responsibility. These authors suggested that in times of high patient activity, many unit staff experienced frustration due to the new graduates' lack of practical competence. This resulted in increased stress levels leading to the NUM having to deal with staff discontent at many levels. Effects upon the quality of patient care were not measured in this study. McCloskey and McCain (1987) later concurred and suggested that directors of nursing believed it unrealistic to expect that new practitioners, who would be highly skilled for all settings, would emerge from the new educational system.

Whilst psychomotor skills are only one of the criteria for evaluation in the educatory process, it is one that is highly rated by the NUM as being a determinant of "safe practice" (Stanton, Haughey and Malizia 1988). These authors surveyed the perceptions of nurse educators and administrators about essential skills for the entry level graduates to determine whether differences between the two groups existed. They found that results were limited to the extent that only one component (psychomotor skills) was examined. Overall, there was high concordance concerning essential entry skills. Their study
attempted to replicate the 1982 study by Sweeney and Regan but their findings were inconsistent with the 1982 study. This was attributed to the differences in sample sizes and the subjectivity of responses. They suggested that assessment skills may have low priority and that competency may be viewed in terms of how many treatments are needed rather than how the need for and response to them is assessed.

In their paper "Educating for Reality Shock", Bell, Stein-Parbury and White (1987) identified the concept of expectations as a major issue in the integration processes of the graduates - both for the already practising registered nurses as well as the graduates. These authors found that whilst the graduates had little difficulty in adjusting from student to worker, adjusting to a new environment, organisation and in particular adjusting to the hierarchical structure, unit team and nursing practice proved to be most difficult.

Birscumshaw (1989), undertook a study of senior nurses' attitudes to new graduates in order to show that new graduates would take longer than traditionally trained nurses to adapt to their new roles. Whilst her study explored the perceptions of senior nurses, it focussed specifically on the roles of the new graduates as opposed to their impact upon the roles of already practising nurses and consisted of a sample of only twenty eight respondents. Respondents in the study suggested that newly qualified nurses need more time to consolidate their training than did the traditionally trained nurses.

In Bircumshaw's (1989) study, the majority of practising nurses felt that new graduates functioned differently from traditionally trained
nurses and that they should fill mainly research, teaching and management positions. Her report also suggested that the new graduates would be less confident than the traditionally trained nurses were they to be placed into similar care giving positions. Implications of these findings are that the perceptions of senior registered nurses would be likely to influence the positions offered to the graduates as well as the extent to which the graduates would be able to utilise their skills and knowledge.

Conclusions reached by Bircumshaw (1989) were reflected in a short unpublished study by Sharkey and Buckley (1989) conducted in the Hunter Region which focussed on the changes foreseen by a number of NUMs should a significant number of the unit team be First Level Practitioners.

In 1988 Brun, speaking from the viewpoint of a new graduate, stated that within the educational system, little preparation is given to learning about the reality of the bureaucratic hospital system. He stated that whilst he expected to perform tasks the way he felt suited the particular situation, such expectations were soon shattered when he was told he had to perform to the set hospital procedure. This situation has implications for the safety of clients and safe practices by the new practitioners as they try to fit into the system in which they find themselves and are unable to use those skills with which they have been provided.

In some cases for the graduates, this has meant relearning both skills and attitudes which at times has engendered an internal conflict situation. What Brun was experiencing and was unprepared for,
were the rules and process controls within the hospital bureaucratic system; in other words, the real life work situation. The implicit question Brun poses is whether the new professional practitioners have sufficient if any discretion within a nurse management philosophy of "the more control the better" (Brun 1988, p 2). A differing of values as such deals a blow to the expectations of the First Level Practitioner and places extra demands on the knowledge and skills of the NUM in integrating these new practitioners into her/his unit team.

Such a situation also impinges upon the philosophy of educational institutions which - in line with current trends in nursing practice journals - promote problem solving using principles as they relate to given situations in various practice settings.

3.3 The Nursing Unit Manager

Drucker (1990) states that management denotes a function as well as a person who discharges that function, and that hospitals have management functions in common with other organisations. As nursing is a profession in a state of change, the role changes of the NUM cannot be fully understood without reference to the changes occurring within the health service as a whole. According to Manning, Parker and Kendig (1991) the following are relevant considerations:

i) changes in the mode of finance - with the greatest political impact coming from private insurances to various Medibanks;
ii) the rapid growth of public spending on health care in the
seventies;

iii) in the eighties, the average length of stay in hospital decreased with rises in the domiciliary care services without increases in finances.

According to Manning Parker and Kendig (1991), there existed a suspicion on the part of the community that the greater proportion of health care resources was being spent on intensive care which in turn produced many bio ethical debates about life support systems. This was relevant for the politics of health funding as well as for nurses in general; and

iv) Bed rationing meant that patients were in hospital less time but were more acutely ill requiring highly trained operators and nurses.

Developments more specific for the NUM were as earlier stated, the transfer of nursing education as well as the negotiation of new career structures accompanied by increases in rates of pay linked in some cases to post basic training; a shorter working week and removal of non-nursing duties from nursing work. At the same time according to Manning, Parker & Kendig (1991), a shortage of nurses existed in NSW. However, these trends were also reflected in other employment areas for skilled workers at this time.

Changing demographic profiles and value systems of both nurses and their patients were affecting role interpretations and modifying patterns of response for the NUMs (Davis and George 1988, pp 182-200). Duffield (1992) suggests that high technology generates compelling demands for more highly educated nurses with wider spans of interest and capacities and greater tolerance of stress whilst
coping at the same time with complex assessments and treatments and more complex psychosocial problems. She further states that perhaps the most significant change in nursing has been the relocation of nursing education to the tertiary sector as the assimilation of the First Level Practitioners into the work force demands NUM who can mentor their transition in the early days of their practice.

In 1982, the New South Wales Government succeeded in closing some major hospitals in Sydney despite public relations campaigns, marches and threatened strikes. Bates and Lapsley (1985), suggest that the closures succeeded in spite of the best efforts of specialists, nurses and the public, thus heralding a change in the status of the Australian Medical Association and the health care system.

In 1983, the Royal Australian Nurses Federation established a national committee to co-ordinate the development of an improved career structure which aimed to give nurses a wider career choice (Gagen 1984). Several states established various levels for nurses for example in management, education and clinical arenas. The charge nurse function was split into two equal classifications. These were the NUM and CNC positions - on the grounds that one person could not adequately fulfil requirements of management, patient care and teaching (Silver 1986, p 45).

According to Gardner and McCoppen (1989), nurses have not easily achieved their new career structure. These authors state that in the workplace, most nurses occupy a subordinate role within the hierachical organisation. Nursing as a whole is subordinated within a hierarchy of health care occupations dominated by medicine. The
medical relationship is really a collaborative one disguised by power disparities. They suggest that this places the NUM in a strong position to respond to the new consumer movement in health care by assuming a higher role in policy making. The reality for the NUM however at this time was that they did not possess the requisite skills in most cases to assert this power.

Grant and Lapsley (1986) suggest that a situation such as this occurs because it is only in the last few years that managers have become key people in the health care arena - considerably later than has occurred in other industrial areas. There are now substantially more first line managers than middle and senior managers and they encounter staff members, patients and visitors more frequently. According to Duffield (1992), their influence on the nursing division's operations and image is pervasive even though their span of control is limited. As early as 1941, Burnham suggested that managers would have key positions within systems. As managers are people in charge of making decisions about resources and costs, their power is increasing whilst that of the doctors in the same area has been decreasing (Grant & Lapsley 1986, p 209).

In 1991, Weaver, Byrnes, Dibella and Hughes undertook a study which explored First Line Managers' skills, perceptions and performances. They determined that the roles which organisations envision for managers may not necessarily match their performance capacity or their reported inclinations and priorities. For both superiors and subordinates, significant role ambiguity makes attitudes, habits and priorities less reliable and predictable. These authors concluded that consistent managerial practice would prevent
concluded that specifying skills in position descriptions has become essential to stabilise nursing departments expectations, to improve future recruitment and guide career development.

As the number of educated people in any community increases, the community as a whole has little hesitation in challenging the health care providers. Interested community groups demanded that health care be arbitrated. This was due to rising costs of health care which were reflected in taxations and the Medicare levy. As a result, Governments have increased their interference in checking the health care services being provided. Grant and Lapsley (1986) suggest that this places the onus on the NUM to be more cost effective at a time when staff establishments are being lowered and services are being rationalised. Large scale policies have arisen out of new capacities in health care delivery including concepts such as national priorities and needs. Coupled with the transfer of nursing education, these factors impinge on the ability of the NUM to retain control of their roles in such a climate of change (Grant and Lapsley 1986, p 228).

Moloney (1979), Mooney & Schnackel (1988), Foster (1981), stated that managers set the tone of the work environment, justify budgets, interpret management policy goals and correlate information whilst acting as a connecting link between departments. Organizations are extremely vulnerable to forces and factors in the external environment and changes and trends in governments and society have had increasing impacts on organizational systems. Specifically, changes such as increased government and legal regulation reduce the role of the manager in terms of autonomy and role satisfaction (Burack and Mathys 1983).
In 1991, Duffield undertook a study to determine the role competencies required by NUMs in public and private sectors. These competencies were divided into three broad areas of structuring the environment, assisting staff members and care delivery. Her study revealed that influential experts in both management and education positions expect these people to possess a very broad range of expertise. However, all too often these people are chosen for their excellence in personal practice rather than their abilities to shape the practice environment and influence peers', public, subordinates' and superiors' behaviour.

Morland (1989), believes that managers in any organisation utilise resources, influence human action and facilitate changes in order to accomplish organisational goals. He states that this is achieved when they recruit, organise and motivate people and monitor the effectiveness of goal achievement of the organisation. He believes that they need to develop useful information and be able to allocate resources (decision making). That is to use the services of the organisation as effectively as possible. He further states that delegating authority establishes a clear relationship with subordinates and in turn motivates rather than controls staff.

These criteria do not strictly apply for the NUM, however there are many similarities. In 1985 Guthrie, Mauer, Zawackie & Couger who compared the motivational levels of industry managers and Nursing Managers. Their results indicated that the means for Nursing Managers consistently exceeded those of managers of other
organisations with the need for achievement being higher for NUMs. There were significant differences between the areas of skill variety and task identity, autonomy and general satisfaction with supervisor and pay satisfaction. Guthrie et al (1985) state that the higher skill variety scores may reflect the fact that clinical skills continue to be used by NUMs daily along with management skills unlike managers in other organizations.

These authors identify that the complexity of management decisions in hospitals as well as the NUM's direct involvement in patient care offers a stimulating environment to exercise these skills in the day to day routine. This type of involvement would not normally be available for other types of managers. NUMs demonstrated considerable freedom to act in their own areas of expertise and make independent judgements and decisions. This is especially important when compared to managers in other organizations.

Sharkey and Buckley (1989) state that role conflict and overload have become a reality for the NUM in the existing climate. Such a situation impinges upon the philosophy of educational institutions which, in line with current trends in nursing practice prepare practitioners, promote problem solving using principles which relate to various practice settings. For the NUM these principles are valid only as long as roles and expectations are clearly defined.

Research in nursing which systematically identifies sources of role stress pertaining specifically to NUMs in the Australian context is limited. Writers such as Simmons (1968), Kramer (1968), Arndt and Laeger (1970) Bachand (1974) and Hardy and Conway (1978)
examined role conflict; lack of congruence, lack of time to carry out role obligations, inconsistent role demands and expectations. Each of these writers found role conflict to be a significant problem for staff.

Similarly, studies by Drory (1981), Hingley, Cooper & Harris (1986), Ecton (1987), Gilmore (1987) relating to role stress among production foremen has some implications for the NUM in a climate of change. Drory (1981) used the scale devised by Rizzo, House and Lirtzmann (1970) which measured role conflict using eight items. Role ambiguity was conceptualised as lack of clarity of role expectations and degree of certainty regarding performance outcomes (p 146). Results displayed a similar pattern of relationships between conflict and ambiguity with correlation between conflict and job attitude becoming significantly higher for managers. Results of the study suggest that managers should seek means to reduce sources of role conflict and ambiguity as they relate to their jobs at first line management level.

Unfortunately, there has been little documentation of this in relation to the transfer of nursing education to tertiary institutions. Even with the utilisation of time management and delegation skills, a need remains for further role clarification for the NUM. Managers interviewed by Sharkey and Buckley (1989) included NUM from two orthopaedic units, four medical units and four surgical units. The experience of these unit managers ranged from three months to 25 years; 90% of the unit managers were classified as level II and 10 % were level III. This however had no impact upon the results.

Sharkey and Buckley (1989), interviewed fifteen unit managers who
1. increased time spent delivering direct care themselves;
2. increased time spent monitoring staff care activities;
3. increased time spent teaching staff;
4. increased time spent co-ordinating patient safety; and
5. decreased time spent managing Sharkey and Buckley 1989, p 10).

This study hypothesised that major changes would occur in the role of the NUM should a proportion of graduate nurses make up the NUM's team in the clinical area.

The majority of the participants in the study by Sharkey and Buckley (1989) study perceived that their roles would change in those areas directly concerned with patient care and education. Participants stated that they would have to re-allocate their time and therefore shift their subrole responsibilities. Key role areas to be affected were seen as being; supervising, monitoring of patient care, teaching and managing - three of the variables chosen for this study (Sharkey and Buckley 1989, pp 18-22). Only ten percent perceived that their managerial role would continue as before, most felt that they would have to set this role aside in order to integrate the new First Level Practitioners into their units.

Writers such as McGrath and Princeton (1987), Bell, Stein-Parbury and White (1987), McCloskey (1987), and Slater (1984) who explored the transition from student to practitioner have given various detailed methods by which this may be achieved - along with the merits and demerits of each method. Bell, Stein-Parbury and White (1987 p 37) identified various reactions and anxieties which are to be felt by both experienced and inexperienced practitioners. In
recent times, the profession of nursing has had much publicity as to its various problems which have led to staff shortages, burnout and dissatisfaction in the workplace (Fox 1987). Areas of dissatisfaction - according to Morris and Wang 1990 - can be broadly identified under the following headings:

a. "Intrinsic work factors (based on Herzberg's 1968 two-factor Hygiene - motivation theory which included both extrinsic i.e dealing with workplace and conditions of work environment and intrinsic work factors which dealt with perceptions of the workers);

b. industrial award problems; and

c. management/administration conflict" (p 3).

From the foregoing list, intrinsic factors and management/industrial conflict would be the most likely antagonists for the NUM at this time of uncertainty for, as Acorn (1988) and Morris & Wang (1990) stated, these would provide major aspects of dissatisfaction and conflict in the workplace thereby leading to further role conflict and stress.

Meleis (1985), confirmed this and stressed the importance of role clarification. She states that if role conceptions are incongruent with the experienced role reality, the reduced possibility for optimal development of skills leads to reality shock. Acorn (1991), also supported this whilst suggesting that social support leads to a mediating process. She also states that it is important to identify at which levels the role conflict and role ambiguity become adverse or dysfunctional as not every individual responds to stressors uniformly.
For the NUM experiencing role deprivation due to fragmentation of their roles and perhaps inadequate preparation about the abilities of the new graduates, the consequences according to Kramer (1974) may be role ambiguity and job dissatisfaction. Rizzo, House and Lirtzman (1970) confirm this, and indicate that role conflict and ambiguity reduce trust, liking, communications and employee effectiveness within the organisation.
Influencing Variables on NUM Role

Figure 3.2
Model of Nurse Training in an Historical Context
3.4 Curriculum Implications of the Transfer

One of the major curriculum implications of the transfer of nursing education to tertiary institutions is professional development and personal growth of the students. A number of variables which influenced this may be seen in the conceptual map (see Figure 3.2). Partridge (1984) saw this as being one of the positive outcomes of the transfer of nursing education away from the hospitals. This factor provides - by virtue of the hidden curriculum, an opportunity for personal growth and development in many unexpected areas for students in terms of the broader spectrum of courses being offered across the campus.

Partridge (1984) discussed the implications of the transfer in terms of curriculum planning for nursing courses. He saw the basic aim as being, the "preparation of graduates to be practitioners and therefore clinical practice needs must be addressed" (p 14). He also suggested in 1984 that "the heterogeneity of the student today and the diversity of extracurricular activities exposes the student to a wide range of issues which would rarely be experienced in the hospital setting" (p 13).

Partridge (1984), states that this also however means that graduates exposure to some relevant clinical/educational experiences is very minimal in some instances leaving them to increase their independent learning requirements. For some students, this proves most difficult as many are unprepared for and inexperienced in this approach to formal learning.
At the same time, writers such as McGrath (1984) published their concerns for nursing should nursing education be removed from hospitals. She stated that there are certain implications of the transfer. She believed that教育ationally it should facilitate the upgrading of nursing to true professional status. In addition the new educational system would cost less than the current system. It was foreseen that the savings would be large enough to cover the costs of college based education.

However, concerns were expressed by McGrath (1984) as to the availability of sufficient numbers of staff who could competently replace the students once they were removed from the clinical areas in 1987. Societal implications foreseen by McGrath related to the changed status of the student. No longer would they be salaried but would, according to their financial status - be eligible for financial support from the Tertiary Education Assistance Scheme (TEAS - now known as AUSTUDY). For school leavers this would mean decreased job opportunity with a proportional increase in tertiary institution opportunities.

McGrath (1984), further suggested that if the number of college places was to be determined by state needs for registered nurses, a situation would arise whereby graduates would not be confident of obtaining a job as "too many nurses would be available for the amount of positions" (p 14). McGrath's statement has been fulfilled in part but only in some areas of the state. Industrial implications which occurred as predicted by McGrath related to the reorganisation of nursing services when students were phased out of the system and
replaced with the new team structure of registered nurses and enrolled nurses.

Work by Barr and Desnoyer (1989) and Saylor (1990) complemented McGrath's (1984) concern in considering the possible effects of changes in the unit team mix, that is, having an all professionally trained team, albeit with different base levels of skills/knowledge. Specifically they focussed on career development for nurses. They developed a functional model which they believed would assist NUMs assess skill levels of staff nurses; incorporate staff development and provide systematic progression for staff nurses in the continuing education processes. Such a change they felt, would place an increased demand on the NUM to integrate the various dimensions of the management role at the expense of their clinical/hands on approach with which the majority of the NUM were more familiar and practised.

The response to the transfer of nursing education in the Hunter Valley mirrored that of nurses statewide, even though committees such as NORC and the College of Nursing of NSW had been recommending a transfer since 1969. Major concerns related to adequate staffing, suitable qualifications for educators but no problems were foreseen relating to the NUM roles (Watson 1989).

In her study of the history of nursing education, Russell (1988), reflected upon the change for nursing in terms of history and the resultant implications for nursing today. She noted that some twelve colleges of advanced education and one university were offering the Diploma (Applied Science Nursing) courses. She further stated that
by 1984 the final intakes of hospital trainees had been completed and that "sadly these schools of nursing with long and proud histories of 100 years or more would cease to exist" (p 4). This fulfilled the plan as proposed by Sax (1978) and thus changed the face of nursing in NSW.

3.5 Impact on the Roles of the NUM

The concept of role deals with thoughts and behaviours of individuals in given positions and emphasises the influence of societal demands and standards. Numerous studies have explored the dimensions of role as sources of stress at work and have aided in the understanding of the relationship of job characteristics and worker behaviour (Kahn, et al 1964; House & Rizzo 1972; Drory 1981 and Duffield 1991). As earlier stated by Christman (1979) roles played by individuals may either thwart or help an individual develop identity and self esteem. This concept has had particular impact upon the role of the NUM in that role prescriptions (and job designs) for the occupant of a particular status not only specify how an individual is to behave but implicitly specify the behaviours of persons in related positions toward the occupant of that status (Brim, cited in Hardy & Conway 1983, p 35).

Levine (1976), states that in all health settings, there are both technical and professional roles to be fulfilled. She argues as did Bachand (1974) that situations continue to arise wherein new threats to nurses arise in the form of new technologies and she wonders if this will affect the quality of health care delivery. According to Levine's study, confusion in the roles of workers, both professional
and technical, has been a result of changes in health care and that given these changes, the education of nurses must change also.

In 1970, Schein used an open system framework and determined that leaders, in this case managers, must be able to diagnose situations and select appropriate strategies from a large repertoire of skills in order to be effective. He concurs with Kramer's views and further suggests that roles are social prescriptions for behaviour (or an alternative definition might be the actual rather than prescribed behaviour of a person occupying a particular position within a group). He determined that leaders/managers must be able to diagnose situations and select appropriate strategies from a large repertoire of skills in order to be effective (Schein 1970).

Luft who studied roles in group processes suggests that one of the interesting problems regarding roles is to identify the principles underlying change in the role of a member of a group. He also suggested that it is possible to learn how each member of a group sees the other members and themself at different stages in the life of the group (1970, p 34). The sociometric questionnaires Luft (1970) suggests may have relevance to future studies concerning the roles of NUMs as they and the First Level Practitioners become a more established group within the hospital setting.

Kelly (1982) suggests that a knowledge of role could increase the nurses' understanding of the structure of organisations of which they are a part. Foley (1984) however believes that role theory encompasses the concept of role and the patterns of social interaction between members of an organisation. She identifies that whenever
there are large numbers of individuals entering the nurse role (as in the case of the First Level Practitioners) who have been influenced by major changes in society and who find their perception of the nurse role consequently differs from that of the organisation, then the organisation as a whole must be affected.

One of the major changes which Kelly examined was the move away from the traditional traits of the nurse role which she states are "obedience, self sacrifice, patience and conscientiousness" towards the promotion of more positive qualities such as "self reliance, power, leadership and creativity" (1982, p 42). She suggests that the hospital as an organisation requires certain standard behaviours for any given role to ensure that a predictable continuous flow of services results. The implication of this is that conflict will occur when the expectations of the organisation differ from those of the nurses.

In conclusion she states that resolution lies in nurses unifying to enhance their professional status through improved and continuing education and by developing and clarifying a defined role as a distinct body within the health profession.

Matterson (1986), examined the role of personal job related needs and certain organisational characteristics which would affect job satisfaction in a sample of 259 laboratory professionals. The findings indicated that organisational practices or characteristics relating to formalisation, chain of command, coordination, planing and adaptability are significantly related to overall satisfaction. However, they suggested that administrators experienced higher levels of self
actualisation, esteem and autonomy than non administrators and that this was dependent upon the size of the hospital.

According to Hollander (1979), leadership effectiveness requires the use of problem solving, maintenance of group cohesiveness, communication skills, competence, fairness, dependability, creativity and identification with the group (cited in Hardy & Conway 1983, p 36). Of these qualities, the last has been the most difficult for the unit manager to achieve, given that many NUM are still unsure of the abilities of the First Level Practitioners and just which skills they possess. Hollander recognised that leaders and followers are interdependent with both contributing to the relationship which in this case is the effective functioning of the ward.

Pembury identified ward charge sisters as being the people who set the tone of the unit, ensure the highest quality of care delivery, communicate with other members of the health team, allocate resources, make decisions, orientate staff, evaluate their own and other staff performances and counsel with staff, patients and relatives each day (1980 pp 52-53). She suggested that the ward sister occupies a complex role but had little managerial authority (p 55).

Likewise, Foster (1981) states that NUM are concerned with the responsibilities associated with setting the tone of the environment, ensuring that care delivery is of the highest degree, communicating with other members of the health care team, allocating resources within the confines of the ward by justifying budgets, decision making, orienting and evaluating their own as well as others performances. Following the same trend, Singleton & Naill (1984) and Strassen (1989) offer the following suggestion for the problem
"... with clear expectations, adequate time management, relevant policies and procedures and scientifically based staffing, nurses should be able to accomplish, document and receive awards for professional practice" (cited in Sharkey & Buckley 1989, p 11).

Watson (1989) states that as a separate body, NUM did not exist until 1983. Prior to this time, they were known as Charge Nurses and operated under a different role structure altogether. In 1983 it was acknowledged that these nurses fulfilled a role equivalent to that of a first line manager and the title of the role was altered to more appropriately reflect the role - to that of NUM. Many of these nurses were anxious about their future ability to gain senior positions in competition with college graduate nurses (Cowan 1984, p 10). Watson further suggested that Directors of Nursing at this time, expressed concern that if insufficient efforts were made to provide some form of acceptable access for them these people would be lost from the system.

A relationship may exist between the above findings and those of Silver (1986) and Scalzi (1988) who examined problems within the role of the NUM. Areas of conflict were identified as being role ambiguity, role conflict and role stress. Silver (1986), Adams (1988) suggested that there are too many roles for the charge nurse to execute effectively and stated that as a result of such a situation, NUM will act as a manager of resources or care but will not adequately fulfil both roles (p 42).

In a similar vein, Pilkington and Wood (1986) investigated job satisfaction as it existed for a group of registered nurses in a large teaching hospital in NSW. Specifically, they examined role
ambiguity and role conflict using scales constructed by Rizzo, House and Lirtzman (1970). Contrary to their expectations, the prevalence of role ambiguity appeared to be higher than the prevalence of role conflict. They sought perceptions from full time workers and part time workers. They did not identify NUMs as a specific group in the study. However, they did identify that if role ambiguity was present then job satisfaction would decrease. This concept provides an underpinning for the current study.

These findings concur with the findings of Sharkey and Buckley (1989) who state that structured programmes for First Level Practitioners should be reviewed; that NUMs should be involved in strategic planning measures; and that rostering patterns should be revised. Quality assurance programmes should be reviewed and the role of the NUM must be clearly defined by the nursing executive in consultation with middle level management and NUMs.

As may be seen from the above, while the role of the nurse manager was explored by various authors, at no time prior to the transfer was any attention specifically paid to how this transfer was to affect the roles of the very people responsible for integrating the new nurses into the system - the NUM. No studies appear to have been undertaken to address their current roles and how the arrival of the First Level Practitioners would be likely to affect them in their practice given that:

* many NUMs did not have any tertiary qualifications;
* these unit managers were concerned as to how their career pathways would be affected by the entry of the new group of nurses; and
they were and in many cases remain unfamiliar with the new curriculum which prepares the new graduates for their units.

In the Hunter Region, the job description of the Charge Nurse was stated in terms of four broad areas that is: communication, record keeping, general supervision of staff and patients, and team conferences (see Appendix I). Today, the job description of the current NUM is somewhat different. Hospital and nursing administrations have decentralised management functions and have acknowledged development of the unit managers role further into that of middle management which may be identified under the following headings; professional, administrative, clinical, personnel (see Appendix II).

As earlier stated, the Lewin Model of Change (1951) suggests that we should look for multiple causes of behaviour rather than single causes. Lewin studied the process of change intensely and came to two conclusions which have relevance for NUM today. These are:

1. individuals have long established attitudes and behaviours;
2. change frequently lasts a short time and returns to former behaviours (cited in Sharkey & Buckley 1989, p 7).

Few articles were discovered in the available literature which specifically addressed the changing roles of NUMs. Existing literature says little about the interaction between the content of changes in job redesign and the organisational context in which they are installed.

Douglass (1987) suggests that job redesign is one of the most effective strategies for planned organisational changes available to
management and has been used extensively in many countries (p 46). He further states that in the long term, it can result in organisations which rehumanise rather than dehumanise the people who work in them, in that people can experience the exhilaration that comes from doing well. This was seen as being a prime motivator for change within organisations and specifically within hospitals. However, no literature has been found to suggest that this was the case for nursing.

Foley (1984) identified that a new definition of the nurse role meant that change was almost inevitable and that said change would be resisted by nurses who favoured the traditional role. She further states that conflict will occur when role expectations of organisations differ from those that the nurse has for her/himself in role enactment. Fralic (1987) agreed with this and suggested that the scope of responsibility and control is far too important to be relegated to a poorly prepared manager.

According to Yura, Walsh & Ozimek (1980), In the United States of America the NUM role works well when all of the role dimensions (facilitator, supervisor, teacher, co ordinator) are being constructively implemented. This enables the NUM to act as overseer and prime mover ensuring progress and stability to achieve a state of optimal health for clients.

Studies by Smeltzer and Vicario (1988) and Schank (1988) discuss change processes and barriers to change in relation to changing roles of unit managers. These authors identify five role functions of the NUM as being hospital - related management functions, patient care management functions, direct patient care functions, professional growth functions and marketing functions. They found, as did
Weaver, Byrnes, Dibella & Hughes (1991) after completing a time and motion study that what the nurse manager perceived as their roles and what the study showed were their roles were not congruent. Even further removed were the perceptions of the nurse executives.

This concurs with the view held by Kramer (1968, 1974) who studied aspects of role expectations of nurses. In 1968, Kramer used a role conception instrument to investigate the extent that nurses' role conceptions are oriented towards professional service and bureaucratic ideologies. In addition, in her study, how the nurse views the role conception as inconsistent with the way they are able to implement their role is measured and a deprivation score is obtained. A significant difference between the means (p>0.01) in the total deprivation scores suggests that the degree to which conflict is perceived to exist by the nurses will affect their performance ability.

In 1974 Kramer postulated the concept of reality shock in order to highlight the discrepancies between norms, values and behavioural expectations existing in the educational setting of nurses and those of the workplace. She stated that basic professionalisation has been found to be inadequate in preparing students to move into the work force and that conflicting role expectations may come from ones own reference group. This as she suggested earlier in 1968, has been the case for the new graduates who may be confronted with conflicting expectations from peers in the clinical area. Role senders such as NUM may have conflicting expectations based on their knowledge of the traditional nurse preparation as opposed to current methods. Kramer further suggests that the anxiety condition arising in response to incompatibility between norms of the organisation and worker
norms is referred to as role strain. She indicates that role conflict has been found to relate to tension, role strain, job dissatisfaction and anxiety - all of which NUM were voicing in 1989 (Sharkey & Buckley 1989).

Kramer (1974) further suggests that graduates are unprepared to deal with the actualities of practice due to lack of anticipatory socialisation processes. Unfortunately the impact of the same processes upon the NUM dealing with the type of graduates is not addressed.

Kramer (1974) studied reality shock for some years and found some substantial differences between professional goals and ideals and organisational goals and expectations. These discrepancies include a mechanistic versus holistic orientation, the prioritising of efficiency over effectiveness, the way expectations are communicated and feedback given. According to Kramer, if efficiency is the goal of the NUM, the speed and the amount of work done by the graduate is rewarded rather than the quality of the work. This in turn creates conflicts for the new graduate who have been allowed to take as much time as needed to provide holistic care whilst they were students.

Tappen (1983), agrees with Kramer's view and states that further conflict arises when instructions given to the First Level Practitioners are brief. Many of the NUM expectations are left unspoken by the team leaders or the NUM. These new graduates (who are unaware of the unspoken expectations which are according to Tappen, part of the informal level of operations of any ward), may find that they have unknowingly left tasks undone, or are considered inept by co-workers who believe that they know the 'right way' to do things.
Prior to the emergence of the new graduates in 1987, many registered nurses (and especially NUM) expressed a feeling of powerlessness. According to Cowan (1984), rather than perceiving themselves as participating in change, they saw themselves as being swept along by it. She suggested that these nurses knew that from this time onwards, their work relationships and familiar world would have to change; regardless of what they felt or did about it. This in turn has further contributed to the conflicts already being faced by the NUMs throughout the state.

3.6 Summary of Chapter

The concept of role has been made more specific over time through the creation of more definitive concepts such as role behaviour, role expectations, role playing and role status. As stated by Brim 1981 (cited in Hardy & Conway 1983, p 35), role prescriptions specify how an individual is to behave as well as implicitly specifying the behaviours of persons in related positions toward the occupant of that status. This fact has implications of import for this study in the Hunter Region as one of the areas of concern expresses informally by NUM to the researcher on many occasions.

The literature reviewed has suggested that role stress or role conflict problems may be grouped into six general areas; role ambiguity, role conflict, role incongruity, role overload, role incompetence and role over qualification (Hardy M. 1974, p 81). For the NUM since 1984, these issues may have been highlighted or accentuated when the newly graduated registered nurse became part of the clinical nursing team.
According to writers such as Kramer (1968, 1974) and Hardy (1974) disagreements in role expectations are generally associated with lack of clarity in role expectations rather than conflicting role expectations. Singleton and Naill (1984), McGrath and Princeton (1987) supported this view as did and Sharkey and Buckley (1989).

The premises of Pembury (1980), Sharkey and Buckley (1989), and to a lesser extent Bircumshaw (1989) are accepted in this work. Areas of role focus have been shown to be important to the NUM in maintaining job satisfaction and role clarity. The major areas identified by the writers encountered have been; facilitator role, co-ordinator role, supervisor role and teacher role. These were the areas most frequently highlighted in the literature as having changed in terms of fulfilment and conflict production. The presence of the First Level Practitioner has been highlighted as the catalyst precipitating these changes as a result of the different approach to learning and different skill levels experienced and obtained by them.

Various perceptions of the integrative processes and outcomes have been identified through the literature by writers such as Benner (1982), Buckenham and McGrath (1982), McGrath (1984), Scalzi (1988), and Russell (1988) to name but a few. One such perception was that the lack of preparation of the NUM for the arrival of the First Level Practitioners led to unrealistic expectations on the part of these people, whilst minimal independent clinical practice of the First Level Practitioners, (Brun 1988) also had an impact upon expectations by all parties concerned.
CHAPTER FOUR
RESEARCH DESIGN

When collecting data through interview, observation or textual documents, the researcher must address issues of credibility, transferability, stability, accuracy and reproducibility. Comack (1984) suggests that inferences may be drawn by counting, noting patterns and themes, splitting variables, noting relationships between variables and then by linking these occurrences together in order to draw conclusions and make recommendations.

4.1 METHODOLOGICAL CONSIDERATIONS

Each of the above factors was influential in this design and utilisation of the survey tools for this purposes of this study. Exploring relationships and differences between phenomena is one aim of theory generating research and may be achieved by using a variety of exploratory research designs. Most commonly used are correlational and comparative surveys.

According to Woods and Catanzaro (1988), comparative surveys contrast the experiences of individuals. Groups are usually selected through sampling procedures so they resemble each other as much as possible but differ in regard to particular variables being studied. Ideally as in this case, groups being compared represent the populations of interest to the
Correlational descriptive surveys allow the investigator to assess the extent to which levels of one phenomenon correspond to levels of another. In this type of survey, a sample representing a cross section of a single population of interest is studied in order to provide a wide cross section of experience for the sample.

To achieve such aims in this study, both qualitative and quantitative methods were used. The study utilised multiple sources from data collection (Directors of Nursing, NUMs and First Level Practitioners) as well as both qualitative and quantitative methods of evaluation. Triangulation has been utilised for this study. Such an approach has been well documented by Leinenger (1985) and Duffy (1987). According to these researchers, triangulation is the use of multiple methods, theories, data and/or investigations in the study of common phenomena. The focus of triangulation is the world view, of subjects' values, beliefs, thoughts, feelings and general characteristics of the subjects is central. No attempt is made to control or manipulate the events or the individuals being studied.

The researcher further believes that this triangular approach has the unique quality of being an open system approach, that is all variables are interdependent, interrelated and interactive. This is because triangulation allows a dynamic approach to this research problem and provides the opportunity to reformulate the problem and revise the method as the research is being conducted.

Historically, qualitative methods have generally been utilised and
developed where there has been a clear need to confront the idiosyncrasy of individual instance (Woods & Catanzaro, 1988). At times they have also been used for the wrong reasons; for example, to supplement inadequately and poorly conducted quantitative work. However in this research, where qualitative methods are being used, they are used as means of exploration and to follow up issues where quantitative data cannot probe.

4.2 THE VARIABLES

In this particular study, the independent variable was the arrival of the First Level Practitioner in the clinical settings. These First Level Practitioners graduate with different skills from the traditionally trained registered nurse of the past and therefore require different integrative, (socialisation) processes and more one to one support from the NUMs. Whilst every attempt is made to integrate theory and practice during their three years, graduates emerge not having had the same amount of time to develop time management and technical skills as did their predecessors. Nor have they had adequate opportunity to assume responsibility for their actions. These are all major areas of expectations on the part of the NUMs.

The dependent variables for this study were the perceptions of the NUMs about their own important role issues including the teacher, supervisor, facilitator and coordinator roles. These were the areas which NUMs had identified as being most at risk of change due to the presence of the First Level Practitioners to ward teams (Sharkey & Buckley 1989).
4.3. THE SETTING

The research was conducted in the Lower Hunter Valley in NSW. Only those teaching hospitals which had regularly accepted First Level Practitioners since 1987 were included. Each hospital has fulfilled a teaching role for the undergraduate nursing students for clinical learning since the transfer of nursing education to the tertiary system. Two hospitals had more than 200 beds whilst the remaining three hospitals had less than 200 beds. Each hospital offered medical, surgical, orthopaedic, rehabilitation, gynaecology experiences for the First Level Practitioners and conducted a twelve month Integration Programme for the new graduates.

4.4 THE RESEARCH PROCESS

4.4.1 Interview With Directors of Nursing.

The purpose of these interviews was to determine levels of correlation of perceptions between Directors of Nursing (DONS) and NUMs on relevant issues. That determined the awareness of DONs as to the real part played by NUMs in the integration process.

Ethics clearance was obtained prior to the commencement of the study. Prior to the interview, each DON was sent a letter asking permission to conduct the research project in their hospital. Included in the letter was an explanation of the research, the forms to be used and a request for a formal interview. In order to reduce researcher bias, directors were asked to nominate NUMs who regularly integrated the First Level Practitioners well as the First
Level Practitioners to participate in the study.

The qualitative section of this study involved informally interviewing the NUMs and the First Level Practitioners in their workplaces. Participants names were selected using the list provided by the DONs at each of the five hospitals. Participants were asked to identify their major concerns about their expectations of the abilities of the new practitioners; the roles of the NUMs in the integration processes and the difficulties to be faced by the graduates. The interviews were audio taped. Following transcription of the interviews, the participants were once again visited to verify the outcomes of the interviews in order to establish content and face validity as well as the relevance of the researchers interpretations of the findings of this section of the study.

The DONs' interviews were undertaken using a structured questionnaire (see Appendix III) which covered areas related to the integration programmes for the First Level Practitioners, processes employed by hospital management for the programmes, the role of the NUM in the programmes, the programmes effectiveness of graduates in terms of cost, time, educational value and staff utilisation.

DONs were asked to identify whether their hospitals had a formal policy which dictated the number of graduates which could be placed into a ward at any one time for integration; who allocated the resources for the programme and how much money was allocated to the hospital for the graduate programmes. Questions were asked about the operationalisation of the integration programme, that is,
how long the graduates were buddied before they could work independently in the wards? Were their evaluation processes different to those used for the other registered nurses? Who was actually assigned to perform the integration and evaluation of the graduates?

Central to these issues was the reality of the perceptions of the NUMs of the abilities of the First Level Practitioners. Also explored was whether or not their expectations of the new graduates' abilities had been realistic and if not, what was different. NUMs who stated that their expectations had been realistic in 1987, were asked had their expectations changed since that time and in which areas had they changed. The researcher also asked whether or not the DONs had met with their NUMs prior to the arrival of the new graduates to discuss any specific difficulties which they and their staff had identified for the new graduates as well as the NUMs and how they had planned to overcome these difficulties.

Responses were recorded in writing at the time of interview by the researcher. This approach was chosen in this instance because of the forced sample of five DONs who had to be contacted.

4.4.2 Survey of NUMs and First Level Practitioners.

(i) Prior to the presentation of survey forms to the NUMs and First Level Practitioners, the researcher informally interviewed each participant individually for about ten to fifteen minutes in order to determine their perceptions as to the degree of involvement of the NUMs in the integration of the First Level Practitioners. Participants were asked to discuss what they felt were the most
important issues relating to the new graduates as they commenced nursing practice (in terms of expectations, abilities, difficulties).

(ii) Following the informal interviews, survey forms were issued to NUMs and First Level Practitioners at the five major hospitals included in the study. Only those managers who regularly had had the First Level Practitioners in their wards since 1987 were asked to participate. NUMs from specialty areas that is intensive care, maternity, coronary care and paediatrics were excluded from the study as the graduates do not work in these areas until they have completed twelve months experience.

4.5 THE SAMPLE

In an ideal situation, random sampling would be adopted as it ensures that everyone in a given population has an equal chance of being included in a particular study (Bogdan & Biken 1982; Woods & Catanzaro 1988 and Polit & Hungler 1989). Such sampling is representative, unbiased and generalizable. However, with the present study, the First Level Practitioner population in the Lower Hunter Valley was not large enough to use random sampling and may therefore, according to Morse (1991) have jeopardised the quality of the research. The sample for this study was a forced one for both NUMs and First Level Practitioners.

Only certain units within the hospitals selected have graduates allocated as part of their teams. This meant that these NUMs were automatically included in the study. Only 89 graduates were employed throughout the Lower Hunter Valley at the time of the research and it is recognised that
the findings may predispose to bias whereby there may be difference between the true but unknown value for the population and its estimate based on the data from the sample. An attempt was made to overcome this problem by surveying both larger and smaller teaching hospitals and using only those which regularly employ the graduates. In addition, each of the graduates working in the Lower Hunter Valley were contacted about participation in the study.

All participants were working full time. Sixty percent of graduates were still employed at their original hospital where they had commenced as a First Level Practitioner. Fifteen graduates did not participate in the study.

4.6 THE QUESTIONNAIRES

The tool utilised by Pembury in Glasgow in 1980 when she assessed the role of the ward sister was modified for the purposes of this study. In addition, Bircumshaw's (1988) tool for the survey of attitudes of senior nurses towards graduate nurses was also of value in the formation of the questionnaires. Whilst Bircumshaw's tool highlighted attitudes it was felt by this researcher that it did not extend far enough in highlighting specific areas of difference between the parties surveyed as well as not exploring the issues of how the role of senior nurses was influenced by the presence of graduate nurses.

Pembury's (1980) tool on the other hand assessed the role of the ward sister in terms of management skills and how the environment or system of care influenced the ward sister's work against a more complex organisational role. The questionnaire she used identified three major
tasks; firstly the identification, specification and organisation of nursing; secondly the delivery of nursing care; and thirdly the evaluation of that care (1980, p 51). Her findings were then classified according to the daily management cycle.

Pembury's (1980) questionnaire was not totally appropriate for the Hunter Valley study as it focussed mainly on work problems in terms of time management and how a particular day's activities are planned. However, some broad issues such as care delivery, management issues and facilitation were seen as being eminently related to the present study.

The present questionnaire was developed to measure the construct of perceptions of the NUMs and First Level Practitioners on the changing role of the NUM. The questionnaire focussed on the managers' role, dimensions of teaching, facilitating, supervising coordinating. The significance of these dimensions has not been well documented by other researchers previously and are elaborated further here.

The first role explored is that of teacher. As the person ultimately responsible for the outcomes of care in the unit, the NUM is responsible to see that all care given is of an excellent standard. Teaching and educating therefore will be a major responsibility of the NUM.

Teaching for the NUM will have many objectives. These are to enable the First Level Practitioners to reach average skills as quickly as possible, to reduce the time taken to learn new skills and thus reduce costs to the unit, to reduce waste or down time (that is, periods of time when staff shortages exist), to introduce or to standardise the methods of practice, to achieve, maintain or improve quality standards of staff performance and to
improve safety in the area for both clients and staff (Irurita 1988, Sharkey & Buckley 1989).

If no preceptor or clinical nurse specialist is employed in the unit, the role of both formal and informal teaching may need to be fulfilled by the NUM, thus reducing the time available for the NUM to devote to specific day to day management of the unit or ward.

The second role dimension of the NUM is that of facilitator. The NUM is the person responsible for providing resources in terms of physical (equipment), and education and personnel for the ongoing personal development of staff as well as the efficient functioning of the unit. This role also includes ensuring adequate access is available to information for clients and their significant others fulfilling the advocate role for clients and staff and ensuring that quality care is received by clients.

The third role area is coordinator of both care and safety activities. The NUM must have a conscious concern to achieve organisational objectives in all respects and to promote safety in every situation for both clients and staff in the ward situation. The NUM must ensure that staff are trained to detect hazards specific to that area whether they be unsafe practices or conditions. Rabey (1987), believes it requires the setting of standards for quality, quantity, cost, time or performance measuring outcomes. He states that this is necessary in order to achieve the organizational objectives of the hospitals. It also requires comparing these outcomes with set standards of the organisation and taking action to bring performances in line with objectives (or re-setting the standard) and managing change. The creation of awareness of all staff particularly new staff that safety is a continuing factor in all activities of the wards or units.
is equally important. This is particularly so for the First Level Practitioner who has had very little clinical experience upon which to base clinical decisions and thus this impacts upon the role of the NUM who is ultimately responsible for all activities in the ward.

The fourth role dimension identified by NUMs is that of supervisor. This requires the NUM to be involved in observing and evaluating the day to day activities of the nursing staff, ensuring that the roles of ancillary staff are appropriate to the needs of the unit and the clients, evaluating outcomes of care and appraisals of nursing staff. In order for quality outcomes of care and ongoing staff development to occur it is necessary that the NUM have adequate time to fulfil this role without becoming detrimental to other areas of role focus at the same time.

Each of the above role dimensions are reflected in the four scales of the questionnaires. Scale items representing a particular aspect of a dimension were derived from informal discussions held with NUMs previous to the current survey.

FORM 1 (DONs questionnaires) was delivered during a formal interview to the DONs, whilst FORM 2 (NUMs' Questionnaire) and FORM 3 (First Level Practitioners' Questionnaire) were delivered to respondents and collected by the researcher one week later. These consisted of sets of questions which required participants to select the response which corresponded to their answer and place the appropriate number in the box on the right side of the page. (see Appendices III, IV, V)

Data collected from FORMS 2 and 3 was compared in order to determine whether or not, the perceptions of the NUMs corresponded with those of
the graduates. The questionnaires were divided into broad areas (scales) based on the major areas of role responsibility most frequently identified in the review of literature as being the most influential and relevant. These were: teacher, facilitator, coordinator and supervisor as previously identified.

4.7 VALIDITY

Any credible research needs to be valid. As Green (1983) points out, validity is concerned with systematic error due to biased responses, improper calibration or the context of the study. This has implications for the study as invalid measurement may produce inaccurate generalisations to the population being studied.

David Kahn (1993) and Lipson (1989) suggest that testing for validity of qualitative responses revolves around three key relationships: the relationship of the researcher with the participants; the data and the reader. For example, how the elements of trust, mistrust, social attractiveness or in other words "what interpretations were the participants making of the researcher" (p 124). This has been referred to as the influence of the researcher. As many of the participants had previously known the researcher, the element of trust enhanced the encounter and all participants responded freely to the questions. Responses were coded and presented to a panel of registered nurses and graduates for the purpose of grouping categories. Following this, the responses gained were compared to those of Sharkey and Buckley (1989) and found to be similar in most (94%) areas of response. This information provided the basis for the preparation of the questionnaires which were to be administered to the
DONs, NUMs and First Level Practitioners.

The items for this study were derived from a factor analysis of results of informal open ended questioning of the NUMs and First Level Practitioners. These results were then carefully and systematically classified by the researcher. This suggested that the questionnaires had face validity. Further, the questionnaires had been examined by five (5) tertiary credentialled, experienced senior nurses. They all agreed on all items in each scale except the facilitator scale where there is 87% agreement. This assisted content validity.

4.8 RELIABILITY

Reliability is concerned with random error (Green & Lewis, 1986, Seamen 1987) and assesses the extent to which the data obtained reflects the real phenomenon rather than an extraneous circumstance. Krippendorf (1980) noted that reliability can rarely be established with qualitative data, as a standard was rarely available against which to establish accuracy. Statistical procedures such as simple percentages of agreement amongst respondents provide an argument co-efficient for canonical data and matrices. For quantitative data, reliability can be examined with the test and retest split half method. Split half analysis of the questionnaires with a small population sample revealed a correlation of 0.8, indicating a reasonable reliability of the survey tool.

In this study, reliability in terms of the researcher's position and no biased selection of participants was enhanced by having the DONs choose the names of all NUMs and graduates employed by them and selecting the
participants for the researcher. Windsor et al (1984) would suggest that survey research data can only be as good as the quality of the survey instruments. As the tool used for this research was developed specifically for this study, reliability as far as stability and reproductibility was evaluated by pre testing the instrument. According to Stacy (1987), the quality of data collected may be enhanced by improving instrument validity and reliability and pre testing survey instruments.

This was achieved by using the instrument evaluation tool developed by Stacy (1987). The tool comprised three evaluation guides to be presented to sample representatives from three specific categories. The first evaluation form was presented to colleagues experienced in the field of research. The second evaluation guide was presented to people randomly selected from the sample to be studied, whilst the third evaluation guide was presented to a sample from the group of people likely to be recipients of the findings of the research.

4.9 PRE-TESTING

Pre-testing of the questionnaires was undertaken prior to the major sampling. The questionnaires were given randomly to four respondents in each of the categories (ie. NUMs and First Level Practitioners) in order to assess for ambiguity of questions and correlation of responses. Questions which subjects identified as being ambiguous were restructured before administering the questionnaires again.

Results from this pre-testing suggested that the NUMs and First Level Practitioners had differing views as to the integration role and involvement
of the NUMs, indicating a need for further exploration of these issues. Pretesting also reviews unclear wordings of some questions which were subsequently clarified.

4.10 LIMITATIONS

The study was restricted to the Lower Hunter Valley as the majority of the First Level Practitioners from the local tertiary institute (now the University of Newcastle) are employed in this particular area. Only those hospitals which regularly offer employment to the graduates as First Level Practitioners were included.

Private hospitals were excluded from the study as they do not employ graduates until they have completed twelve months experience in a major public hospital as a registered nurse. Schedule Five hospitals were also excluded from the study as insufficient numbers of First Level Practitioners are employed in these hospitals in the Lower Hunter Valley to obtain reliable results.

Other limitations proved to be the geographical size of the area to be surveyed and the allocated time frame of six months to complete the survey. All hospitals surveyed were within a sixty kilometer radius of the University and as the researcher was required to return to each hospital on more than one occasion to collect completed survey forms this proved to be another limitation in terms of time and travel and cost.
4.11 IMPLEMENTATION

An initial letter was sent to each of the Directors (DON) of the Hospitals explaining the purpose and scope of the investigation. A request for a personal interview was made and a copy of the questionnaires to be completed by participants was provided at the same time.

Each DON consented to take part in the proposed research and to be interviewed about their perceptions of the roles of the NUM in the integration of the First Level Practitioners. During interview, agreement was reached for distribution of the questionnaires to the sample of NUMs and graduates within the hospital. Directors expressed high interest in their NUMs perceived role shift problems and provided a current list of the two levels of nursing staff. They were well aware that identification of such a role shift would help staff in their interpretation of their roles and perhaps guide understanding and development thus helping to develop further management techniques. Responses to these interview were recorded on FORM 1 at the time of interview.

Free access was given within each of the hospitals to all selected nursing staff. DONs approved the strategies used by the researcher to provide confidentiality of responses and all expressed interest in having a copy of the final results of the survey.

An introductory letter was given to each of the NUMs and graduates selected by the directors who were individually approached by the researcher re. their participation in the research.
4.12 ETHICAL CONCERNS

Consent to participate was indicated verbally at the time of informal discussion by the researcher with the prospective participants as well as by the return of the completed questionnaires. At the time of discussion, the researcher explained the procedures for completing the forms to each participant individually and answered any questions participants had prior to and upon presentation of the questionnaires.

Participants were asked not to put their names on the forms and to place the completed questionnaire into an unmarked envelope inside a larger envelope addressed to the researcher which was provided by the researcher. This was then personally collected by the researcher one week later from the ward/unit. Participants were assured that full confidentiality would be maintained and that results of the survey would be available to them should they desire to have same.

4.13 THE RESEARCH HYPOTHESIS

The major purpose of this study was to identify the changing role of the NUM. It was hypothesised that:

"THE ARRIVAL OF THE FIRST LEVEL PRACTITIONERS HAS HAD AN IMPACT ON THE ROLE OF THE NUMs"

The central hypothesis of this study is that: NUMs perceive that their role has altered since 1987 as a result of the presence of the First Level
4.14. MAJOR HYPOTHESES


4.14.1(a) There is no relationship between the time spent teaching staff and teaching clients since the First Level Practitioners became part of the ward nursing teams.

4.14.1(b) There is no relationship between the time spent coordinating client safety and the time spent performing administrative duties by the NUMs.

4.14.1(c) There is no relationship between the time spent supervising ward nursing staff and monitoring care activities of the First Level Practitioners.

4.14.1(d) There is no difference in the time available for the NUM to spend delivering direct patient care before 1987 and the time available for this since the First Level Practitioner became part of the ward nursing teams.

4.14.2 NO DIFFERENCE EXISTS BETWEEN THE INTEGRATION PROCESSES OF FIRST LEVEL PRACTITIONERS IN EACH OF THE MAJOR HOSPITALS IN THE HUNTER VALLEY
4.14.2(a) There is no difference between perceptions of NUMs and First Level Practitioners about the minimum time practitioners work before they are assigned a full patient load.

4.14.2(b) There is no difference between the perceptions of the NUM and the First Level Practitioner in the frequency of performance evaluation.

4.14.2(c) There is no difference between the evaluation methods used to assess performance levels of First Level Practitioners in selected hospitals throughout the Lower Hunter Valley.

4.14.4(d) There is no difference between hospitals as to which person is responsible for the evaluation of the First Level Practitioners during the first twelve months post graduation.

4.14.3 **THERE IS NO DIFFERENCE IN THE DEGREE OF SUPPORT PROVIDED BY NURSING ADMINISTRATION FOR NUMS SINCE FIRST LEVEL PRACTITIONERS BECAME PART OF THE WARD TEAM.**

4.14.3(a) There is no difference in perceptions of NUMs that Nursing administration generally understands their needs with regard to the First Level Practitioners.

4.14.3(b) There is no difference in the level of support given to NUMs since the First Level Practitioners became part of the nursing team in 1987.

4.14.4(a) There is no difference between the expectations of the NUMs and the First Level Practitioners about the abilities of the First Level Practitioners.

4.14.4(b) There has been no alteration in the expectations on the part of the NUMs and the First Level Practitioners as to the abilities of the First Level Practitioners since 1987.

4.14.4(c) There is no difference between perceptions of NUMs in their belief that they were well prepared for the arrival of the First Level Practitioners in 1987.

4.14.4(d) There is no difference between perceptions of the NUMs and First Level Practitioners as to which competencies would be most difficult for the new practitioners when they first commence in the wards.
The results of findings in this research are reported in Chapters Five and Six. Chapter Five consists of the NUMs perceptions of their own role as reported in the questionnaire. This is important as according to Foster (1981) and Sharkey and Buckley (1989), the NUMs role delineations are unclear. Such unclear roles often lead to role conflict which has been well described by Hardy and Conway (1978), Rabey (1979), Christman (1979), and Owen (1988). These results are reported in Chapter Five.

The second part of this research findings consists of hypothesis testing and results. The hypothesis is firstly stated and then followed by the analysis of data and the discussion of the findings. This is reported in Chapter Six.

As a result of the literature review and informal discussions with NUMs and First Level Practitioners in the planning stages of the research, the researcher noted that there appeared to be consensus about the role of the NUM.

There are clear indications that both the NUM and the First Level Practitioners consider that the supervisor role, facilitator role, teacher role and coordinator role are vital functions of the NUMs role. These they believe have been significantly impacted upon as a result of the integration
of nurses in the clinical setting. Such an observation led the researcher to focus on the importance of these roles in relation to the daily tasks of the NUMs. The abilities of these managers to still effectively fulfil the roles in the light of current changes experienced by them were also explored.

The researcher was concerned that some participant responses to questions may have been biased in that they depended on introspection on the part of respondents. It has not been possible to build on other researchers findings as different foci have been used in the past by researchers (for example, Kramer 1968; Pembury 1980; Bircumshaw 1989 and Duffield 1991) when they examined the role of the NUM. This concern (bias) was proven in some of the participant responses.

As stated earlier, the hospitals utilised in this survey were located within a sixty kilometer radius of each other, with the University of Newcastle occupying a geographically central location. Each hospital has fulfilled a teaching role for the University since the transfer of nursing education to the tertiary sector in 1985 and has regularly accepted the First Level Practitioners into their establishments since 1987.

Seventy-four Registered nurses who have graduated since 1987; fifty-two NUMs and five Directors of Nursing were approached, agreed to participate in the study and accepted survey questionnaires. Sixty-two graduates and fifty-two NUMs responded. Such response provided the researcher with a census sample of NUM population within the Lower Hunter Valley. Five directors of nursing participated in the formal interviews.

A note should be made about the response rate to the survey. During the
implementation of the research, the researcher was concerned that the response rate may be low. As suggested by Woods and Catanzaro (1988), non-response on questionnaires is a major factor affecting the validity of a study. The researcher is aware that whenever using questionnaires, there is always a high risk of non responding. Woods and Catanzaro (1988) believe the return rate for questionnaires can range from 20% to 80%. They also state that respondents who actually return questionnaires or who agree to be interviewed cannot be assumed to be representative of the intended sample if most of the sample do not respond. Therefore, in this study every effort was made to increase the response rate.

The response rate of graduates was 95.7%. Each of the smaller hospitals surveyed returned 100% for graduates. However hospital 1 (which at the time was the largest participating hospital and therefore employed the highest number of graduates) provided the lowest percentage of returns of 82%.

The response rate from the NUMs did not correspond with the response rate of the graduates. NUMs were eager to identify their perceptions. As a result, the response rate of NUMs was 100% from each of the participating hospitals which as earlier stated provided a census sample for this particular population.

All respondents were employed on a full time basis at the time of survey. 60% of NUMs were employed in institutions with more than 200 beds. 58% of graduates were employed in institutions with more than 200 beds. This factor is noted as the size of the hospital may be significant in that hospital size may have influenced participants responses to the questionnaires (in terms of involvement of NUMs and preceptors in the
integration of the first level practitioners).

Confidence interval and test (between hospitals surveyed and the wards used in each for integration of the first level practitioners) resulted in a correlation $W=10.00$ significant at 1.00. This indicated that there was consistency in the wards used for the purposes of integration between hospitals.

62% of the NUMs had undertaken tertiary studies since completing their training and since becoming NUMs. This is significant in that these registered nurses had completed a diploma or degree which comprised a similar theoretical base to studies undertaken by the graduates. Such NUMs perhaps, should have at least been aware of the knowledge base of the beginning practitioners and therefore more understanding and sympathetic to their problems.

At the time of the survey, only 6.8% of graduate respondents stated that they had undertaken further tertiary study since completing the nursing diploma. This did not appear to influence any of the survey responses however. Concerns on the part of the NUMs about the First Level Practitioners were still mainly related to the graduates ability to perform specific psychomotor skills. 80% of graduates stated that they were still employed at the original hospital where they had started as a First Level Practitioner. Length of employment of graduates ranged from one month (6.6%) to more than twelve months (25%).

Raw data is included in Appendix VI. Statistical analysis where appropriate was completed using Minitab. Percentage results were rounded upwards to the nearest correct number and Chi square goodness
of fit test was employed to determine proportional differences between the variables. In order to evaluate the extent to which observed frequencies deviated from expected frequencies based upon chance occurrence results were calculated using Yates' Correction Tables for continuity.

5.1 NUMS' PERCEPTIONS OF THEIR OWN ROLE

This section describes the NUMs perceptions of their changing role. The majority of NUMs surveyed agree that their role has altered due to the inclusion of the First Level Practitioner in the ward team since 1987. 56% of the NUMs stated that their role has altered since 1987. They attributed this change in role directly to the presence of the first level practitioners in their wards as part of the nursing team, thus precipitating role conflict on their part. (Data is summarised in Table 5.1 and Figure 5.1) This result supports the literature (Hardy & Conway 1978; Strong 1979; Tappen 1983 and Owen 1988) which suggests that role theory is the basis of practice, especially for a middle manager such as the NUM.

Cowan (1984), Russell (1988) and Sharkey and Buckley (1989) have each suggested that the role of the NUM has been changing over a recent period of time and that the lack of role delineations has caused role conflict to emerge for these managers.
Table 5.1 - Role Alteration.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Agree</td>
<td>19</td>
<td>37</td>
</tr>
<tr>
<td>Disagree</td>
<td>20</td>
<td>38</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>52</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

There is little to indicate whether any such change is due directly to the presence of the first level practitioner.

5.1.1 Supervisor Role

The majority of NUMs believe that they now spend more time supervising their staff than they did prior to the arrival of the First Level Practitioners (see Table 5.2). This supervisor role was seen by First Level Practitioners as being one of the most important functions of the NUM. The NUMs saw it as being just another of
the manager functions which made up their role.

NUMs attributed the change in supervising time to the perceived need on their part to closely monitor the performance of the First Level Practitioners who, they believe, are lacking in many of the required skills needed to be a competent practitioner.

Table 5.2 - More Time Performing the Supervisor Role.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>15</td>
<td>29</td>
</tr>
<tr>
<td>Agree</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>Disagree</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

This result enhances findings by Bircumshaw (1989). It is likely that this perception on the part of the NUMs in turn influenced all of their other responses concerning the First Level Practitioners. Managers identified that they believed a beginning practitioner or novice (Benner 1982) should be a competent or an expert practitioner (Benner 1982) with those skills normally only gained by experience over a period of at least three years during hospital training.

An aspect of supervising includes monitoring nursing care activities. 79% of NUMs stated they now spend more time directly monitoring nursing care activities as a result of the presence of First Level Practitioners in the ward. 24% stated that they felt that First Level Practitioners were unable
to be left unsupervised with clients to manage as they are unable to safely and appropriately make clinical decisions. Table 5.3 summarises the perceptions of the NUMs regarding this aspect of the role.

Table 5.3 - More Time Now Monitoring Direct Care Activities.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>42</td>
<td>80</td>
</tr>
<tr>
<td>NO</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

Specific care activity deficits identified by NUMs at the time of interview were the ability to prioritise care activities (i.e. showering, sponging meeting general hygiene needs for more than one patient/client during a given shift). Communication skills were not seen as being poorly developed in these new graduates. NUMs stated that they had been impressed with this aspect of graduate preparation.

Eighty percent (80%) of NUMs agreed that they now spend more time monitoring and directing what they saw as being basic care activities in the ward since the First Level Practitioner became part of the ward team. Respondents stated that as a result of this, they now have less time to spend performing administrative duties such as ordering, communicating, role modelling and data compilation than before the First Level Practitioner became part of the ward team.
5.1.2 Facilitator Role

According to Yura, Walsh and Ozimek (1980), the facilitator function of the NUM's role works well when other role dimensions (ie administrator, teacher, co-ordinator and consultant) are being constructively implemented. This enables the NUM to act as overseer, prime mover and to ensure progress and stability to achieve a state of optimal health for clients.

5.1.2(a) Interacting With Clients

To be an effective facilitator, the NUM needs to interact with clients and to update knowledge of progress and test results each day. Table 5.4 identifies NUM responses when asked if they now spend more or less time interacting with clients on a daily basis in the ward. A small majority (56%) of NUMs stated that they now spend less time interacting with their clients than they did before the arrival of the First Level Practitioners in 1987 (see Table 5.4).

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Time</td>
<td>23</td>
<td>44</td>
</tr>
<tr>
<td>Less Time</td>
<td>29</td>
<td>56</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

The time they now spend interacting with clients was not seen by the NUMs as an opportunity for them to be more involved in daily management of their clients nor was it seen as an
increased opportunity for them to enact the advocate role but, in their own terms, rather as "picking up after the graduates". NUMs identified this as a negative outcome of graduate presence in the wards in the form of a distracter from the manager role and an extension of the supervisor role.

5.1.2(b) Consulting With Other Staff

Part of the NUM function involves consulting with medical staff. NUMs were asked therefore to identify whether or not they perceived that they spend more time now or less time now performing this role function. The NUMs responses are summarised in table 5.5

Table 5.5 Increased Time Available Now For Consulting With Medical Staff.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Agree</td>
<td>14</td>
<td>27</td>
</tr>
<tr>
<td>Disagree</td>
<td>24</td>
<td>46</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>99</td>
</tr>
</tbody>
</table>

59% of NUMs stated that they now spend less time consulting and communicating with medical staff since the First level practitioners became part of the ward team. This was seen as providing a barrier to the obtaining of relevant information about clients and as impeding required information flows between nursing and other members of the health team.
The NUMs suggested that this was significant. This supports the work of Hardy and Conway (1978). They suggest that much of nursing is intuitive, based on information obtained from both informal and formal communication processes at ward levels between nursing staff and other members of the health team (i.e. doctors, physiotherapists, occupational therapists plus other ancillary staff personnel).

5.1.2(c) Reading Charts

Another aspect of the NUMs facilitator role relates to reading clients charts so that they are aware of the clients condition and progress. NUMs were asked if they now have more time available to read patients charts. Responses identified that they spend less time performing this task (see Table 5.6).

Table 5.6 - More Time For Reading Clients Charts.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>8</td>
<td>15</td>
</tr>
<tr>
<td>Agree</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Disagree</td>
<td>24</td>
<td>46</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>
58% of NUMs stated that they now spend less time reading clients charts and records. During the informal interview they stated that they no longer have enough time to check results for each of the clients as they are returned from pathology or X-Ray. The fact that most wards or units have ward clerical staff who attach pathology results into clients charts may also have influenced the decreased time spent performing this part of the role of the NUM.

Checking the charts was identified by the NUMs as a necessity. The NUMs perceive they need to spend more time doing this as the First Level Practitioners perform poorly in the area of report writing. Report writing was also identified by the First Level Practitioner as one of their difficulties. This was due to their inexperience and limited opportunity to practice as a student.

Participants suggested that a high level of knowledge of client progress on the part of the NUM plays an important part in their ability to have informed discussions with medical staff. It also was seen as affecting their ability to then fulfil the facilitator part of the Nursing Unit Manager role as is relates to nursing care interventions and outcomes and quality control.
5.1.2(d) Administration

The administrator role was broadly identified by NUMs during informal interviews as being part of their facilitator role. This was in terms of informal interviews and as encompassing direction and conduction of policy implementation in order to provide maximum benefits from health care given within their units.

Shanks (1988), suggests that administration is a scientific process consisting of thinking, planning, communicating, gaining group acceptance, organising, delegating, guiding and evaluating outcomes in order to meet client needs, directing the care and controlling the setting and facilitating the accomplishment of care. NUMs stated that they are now "all things to all people" and seem to be "on the run all the time". This aspect of the role of manager was perceived by them to be lost, as was their control over their time.

NUMs perceive that their administrator role is being fulfilled less than adequately now since 1987. Five respondents stated that they have no time for management duties due to the needs of the First Level Practitioners, four stated that they have to be "all things to all people", whilst one respondent stated that they now need to act as a go between for all other staff.
5.1.3 Co-ordinator Role

Related to the facilitator role is the NUMs duty as co-ordinator. The majority (82.6%) of NUMs stated that they now spend more time co-ordinating care activities since the First Level Practitioner became part of the nursing team.

5.1.3(a) Co-ordinating Care Activities

NUMs perceived no relationship between performing administrative duties and co-ordinating client safety. This indicates that although the NUMs stated they felt that they have less time now to perform these functions of the role, this loss of available time was not caused by an increase in their time spent co-ordinating client care. Responses to this question are summarised in Table 5.8.

Table 5.7 - More Time For Administration.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Time</td>
<td>24</td>
<td>46</td>
</tr>
<tr>
<td>Less Time</td>
<td>28</td>
<td>54</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5.8 - Co-ordinating Care Activities.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Time</td>
<td>43</td>
<td>82.6</td>
</tr>
<tr>
<td>Less Time</td>
<td>9</td>
<td>17.3</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>99.9</td>
</tr>
</tbody>
</table>
5.1.3(b) Co-ordinating Client Safety

It is interesting to note that the majority of NUMs specifically identified that more time is now spent directly co-ordinating those activities in the ward to maintain client safety (eg. transferring clients in and out of bed, walking clients, medication administration, performance of complex procedures) since the First Level Practitioners became part of the ward team (see Table 5.9).

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Time</td>
<td>31</td>
<td>60</td>
</tr>
<tr>
<td>Less Time</td>
<td>21</td>
<td>40</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>52</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

This response was attributed to the acknowledged fact (by educators and First Level Practitioners) that the practitioners are unskilled in the area of clinical decision making and the realities of functioning within the policies and guidelines of specific hospitals and wards. Unspoken expectations on the part of the NUM could also have contributed to this attitude of the NUMs for, as earlier stated, (see p 25) in the role acquisition process, expectations will be a major determining factor during acceptance of new roles within a system such as a hospital.
5.1.4 Teacher Role

The teacher role was seen as being an important part of manager role by the NUMs. Even those wards which had preceptors or clinical specialists still felt this facet was important in the NUM role, as it is necessary to maintain ongoing provision of information to staff at all levels.

5.1.4(a) Teaching Staff

Participants were asked to identify whether they now spend more time teaching, despite the appointment of preceptors in the wards. They were asked to specifically identify which type of teaching was being undertaken. That is, was it teaching staff or teaching clients and their significant others. Responses indicated that the NUMs feel that they spend more time teaching in each of the identified areas on a daily basis. NUMs agreed (71%) that they now spend more time directly teaching nursing staff than before First Level Practitioners became part of the nursing team (see Table 5.10).

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>23</td>
<td>44</td>
</tr>
<tr>
<td>Agree</td>
<td>14</td>
<td>27</td>
</tr>
<tr>
<td>Disagree</td>
<td>15</td>
<td>29</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>
Respondents identified specifically the teaching of procedures and skills required for safe practice as well as the teaching of specific policies for pre and post operative patients. These were related to hospital policies and legal implications of care duties as they became relevant to the particular area of practice. This response occurred from hospitals with more than 200 beds as well as the smaller hospitals with less than 200 beds. Perhaps this may indicate that NUMs in the larger hospitals are not fully utilising the services of preceptors even though these are available.

It was suggested by NUMs that this time spent directly teaching staff limited their ability to provide inservice/staff development for all staff in order to keep them informed of relevant changes within wards/units.

5.1.4(b) Teaching Clients

46% of NUMs identified that they now need to spend more time directly teaching clients. During informal interviews with the researcher, respondents stated that the teaching relates directly to the provision of information about care outcomes (in terms of operative procedures and post operative restrictions and capabilities) which the First Level Practitioners were unable to provide. It was not the provision of information relating to daily care activity outcomes such as assistance with activities of daily living. This is summarised in Table 5.11.
Table 5.11 - More Time Directly Teaching Clients.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Agree</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Disagree</td>
<td>28</td>
<td>54</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

The 46% of NUMs who stated that they spend more time performing this task perceived that they were providing basic information to clients pre and post operatively about expected outcomes of care. The NUM believed that the graduates should have been able to provide this information as part of routine client management processes.

5.1.4(c) Assumption of Patient/Client Load

Table 5.12 summarises the results to determine if the NUMs have to assume a client load of his/ her own in addition to performing their role as manager within the ward on a daily basis since 1987.

Table 5.12 - Assumption Of Client Load By Nursing Unit Manager.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>21</td>
<td>40</td>
</tr>
<tr>
<td>NO</td>
<td>31</td>
<td>60</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>
The majority (60%) of NUMs stated that they have not had to assume a patient load as a result of the presence of the First Level Practitioners in their wards. This was identified as one area of their role which has not altered since 1987. NUMs who previously assumed a client load prior to 1987 state that they now do not assume a larger load for the purposes of care delivery and NUMs who previously did not assume a specific client care delivery load still do not do so.

5.2 OTHER EMERGING ISSUES

5.2.1 Methods of Evaluation of Graduates Throughout the Lower Hunter Valley Hospitals.

In addition to NUMs perceptions of their role, DONs and NUMs were asked questions which related to the evaluation processes used in their particular hospitals at ward level to assess the progress and performance levels of the First Level Practitioners. This was done in order to determine the degree of NUM involvement in this aspect of staff development for the First Level Practitioners. The researcher also wanted to determine whether all hospitals held the same expectations concerning the profile of the First Level Practitioners.

Results as indicated in Tables 5.13, 5.14 and 5.15 revealed that there is no consistency in this aspect of the development/integration of the First Level Practitioners. DONs were asked if the same method was used to evaluate the First Level Practitioners as is used for all other registered nurses within the wards. It was revealed that in two of the five hospitals this is not the case. DONs also
stated that the NUM is the person responsible for the evaluation of the new practitioners. This was confirmed by the NUMs and the First Level Practitioners when they were asked the same question.

The evaluation of performance levels of the First Level Practitioners within each of the participating hospitals is further examined in chapter six.

<table>
<thead>
<tr>
<th>DON RESPONSE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same as for other RNs</td>
<td>3</td>
</tr>
<tr>
<td>Different Methods</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>

**Table 5.13 - Evaluation Methods Used For First Level Practitioners.**

KEY: DON - Directors of Nursing  
RNs - Registered Nurses

5.2.2 Provider of the Most Relevant Information for the Graduates During their Orientations to Wards

Only 19% of First Level Practitioners stated that the NUM provided the most useful information during their orientation to the wards (see table 5.14 AND figure 5.2). This is not surprising given that most of the information likely to be required would be relating to specific procedures of client related care activities and this is a part of the prescribed role of the ward preceptors.
Table 5.14 - Provider Of The Most Important And Relevant Information For The First Level Practitioners.

<table>
<thead>
<tr>
<th>NURSING UNIT MANAGER RESPONSES</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUM</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Preceptor</td>
<td>29</td>
<td>47</td>
</tr>
<tr>
<td>CNS</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>SDO</td>
<td>18</td>
<td>29</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>62</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

KEY: NUM - Nursing Unit Manager  
CNS - Clinical Nurse Specialist  
SDO - Staff Development Officer

First Level Practitioners stated that the most useful information was in fact supplied by the preceptor indicating that this role would appear to be being adequately fulfilled within the ward or unit. This latter fact related specifically to the larger hospitals (i.e. those with more than 200 beds) where the role of preceptor existed.

![Pie chart showing percentages](image-url)  

Provider Of Most Useful Information.  
Figure 5.2
In the smaller hospitals the most useful information was seen as being provided by whichever registered nursing staff happened to be on duty in the ward at the time the information was needed. It was stated by some participants (see Table 5.14) that the Staff Development Officer who conducted the hospital orientation programmes also provided relevant information. This information was more directed to hospital policies rather than the major skills required at ward level.

5.3 OPEN ENDED RESPONSES

Both NUMs and First Level Practitioners were also asked questions which were perceived as being relevant to the integration and assimilation of the First Level Practitioners. NUMs were asked: WHAT IMPACT HAS THE PRESENCE OF THE FIRST LEVEL PRACTITIONER HAD UPON YOUR ROLE AS THE NURSING UNIT MANGER SINCE 1987? Responses to this question are summarised in Table 5.15. NUMs were also asked to identify how effectively they perceived that the First Level Practitioners performed as a part of the nursing team in their wards. Results obtained for this question are summarised in Table 5.16
Table 5.15 - N.U.M Responses Identifying The Impact The Presence Of The First Level Practitioner Has Had Upon Them As A Manager.

<table>
<thead>
<tr>
<th>Responses</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spend more time now checking that First Level Practitioner's skills are appropriate</td>
<td>2</td>
</tr>
<tr>
<td>Inclusion of First Level Practitioners has been beneficial</td>
<td>1</td>
</tr>
<tr>
<td>Impressed by their ability</td>
<td>2</td>
</tr>
<tr>
<td>My role now more relaxed</td>
<td>1</td>
</tr>
<tr>
<td>I have confidence and trust in them</td>
<td>3</td>
</tr>
<tr>
<td>I spend more time acting as a go-between for them and the other R.N.s</td>
<td>1</td>
</tr>
<tr>
<td>Assimilation for them is more time consuming</td>
<td>1</td>
</tr>
<tr>
<td>There has been no adverse impact upon my role</td>
<td>6</td>
</tr>
<tr>
<td>My role focus has not changed but my workload has increased</td>
<td>7</td>
</tr>
<tr>
<td>There has been a role alteration for the clinical specialist and the preceptor</td>
<td>2</td>
</tr>
<tr>
<td>I now have no time for administrative duties because of their needs</td>
<td>5</td>
</tr>
<tr>
<td>Their presence leads to disharmony in the wards</td>
<td>1</td>
</tr>
<tr>
<td>I am now all things to all people</td>
<td>18</td>
</tr>
<tr>
<td>My stress levels have doubled as a result of their presence</td>
<td>3</td>
</tr>
</tbody>
</table>

5.3.1 Effectiveness of First Level Practitioners as Part of Nursing Teams.

Responses by NUMs are summarised in Table 5.16. The majority of participants stated that graduates are unprepared for clinical practice and are slow with psychomotor skills.
Table 5.16 - How Effectively First Level Practitioners Perform As Part Of The Nursing Team.

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unprepared for reality of clinical practice</td>
<td>6</td>
</tr>
<tr>
<td>Need to place more emphasis upon nursing care</td>
<td>1</td>
</tr>
<tr>
<td>They have great difficulty with time management</td>
<td>7</td>
</tr>
<tr>
<td>Need more clinical experience</td>
<td>3</td>
</tr>
<tr>
<td>Require greater amount of time for orientation</td>
<td>2</td>
</tr>
<tr>
<td>They are competent and well adjusted</td>
<td>4</td>
</tr>
<tr>
<td>Slow with skills</td>
<td>10</td>
</tr>
<tr>
<td>Excellent communication skills</td>
<td>6</td>
</tr>
<tr>
<td>Assimilation is time consuming</td>
<td>1</td>
</tr>
<tr>
<td>They have little idea of the nursing workload</td>
<td>2</td>
</tr>
<tr>
<td>Need more realistic experience in college</td>
<td>16</td>
</tr>
</tbody>
</table>

As may be seen in the two above tables, these results suggested that NUMs believe that practitioners have difficulty adjusting to the role of member of the health team in that NUMs as a group identified; "LACK OF KNOWLEDGE, LACK OF CLINICAL SKILLS, INEXPERIENCE, REPORT WRITING, DECISION MAKING" as skill deficits of the graduates and "INCREASED WORKLOAD, INCREASED STRESS LEVELS, NEED TO SPEND MORE TIME CHECKING UP ON THEM, NEED TO ACT AS A GO-BETWEEN FOR THEM AND THE OTHER REGISTERED NURSES".

13% of respondents stated that they (NUMs) have confidence and trust and have been impressed by the abilities of the First Level Practitioners. 2% stated that their own workload had increased due to the presence of the First Level Practitioner (see Table 5.14).
Similarly, First Level Practitioners were asked to identify the major difficulties which they experienced during the first twelve months after they commenced working as a registered nurse. Responses are summarised in Table 5.17.

Table 5.17 - Graduate Responses/Difficulties.

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of experience in clinical area</td>
<td>21</td>
</tr>
<tr>
<td>Not adequately prepared to become a professional nurse</td>
<td>3</td>
</tr>
<tr>
<td>I over-reacted too much</td>
<td>6</td>
</tr>
<tr>
<td>General jitters</td>
<td>3</td>
</tr>
<tr>
<td>Ability to write reports</td>
<td>5</td>
</tr>
<tr>
<td>Presentation of verbal reports</td>
<td>8</td>
</tr>
<tr>
<td>General lack of skills</td>
<td>15</td>
</tr>
<tr>
<td>Unprepared for accountability as a nurse</td>
<td>2</td>
</tr>
<tr>
<td>Unprepared for reality of decision making</td>
<td>4</td>
</tr>
<tr>
<td>Time management</td>
<td>14</td>
</tr>
<tr>
<td>Unprepared for assumption of responsibility</td>
<td>5</td>
</tr>
<tr>
<td>Insufficient crisis theory management</td>
<td>1</td>
</tr>
<tr>
<td>Inexperience</td>
<td>8</td>
</tr>
<tr>
<td>Unprepared to cope with full client load in wards</td>
<td>10</td>
</tr>
<tr>
<td>Need more respect from other ward nurses</td>
<td>2</td>
</tr>
<tr>
<td>Lack of unity amongst other staff</td>
<td>2</td>
</tr>
<tr>
<td>Very restricted by my own limitations</td>
<td>1</td>
</tr>
<tr>
<td>Amount of time spent documenting</td>
<td>4</td>
</tr>
<tr>
<td>Need to be willing to ask more questions</td>
<td>3</td>
</tr>
<tr>
<td>Pressured by other ward staff to know all procedures</td>
<td>14</td>
</tr>
<tr>
<td>Most of my fears were unfounded</td>
<td>8</td>
</tr>
<tr>
<td>Hierarchy was the hardest to come to terms with</td>
<td>19</td>
</tr>
<tr>
<td>Most of my inadequacies were psychological</td>
<td>1</td>
</tr>
<tr>
<td>Mature age was an advantage</td>
<td>2</td>
</tr>
</tbody>
</table>
There is clear evidence from responses that First Level Practitioners as a group identified different problems to those identified by the NUMs. These were: "TIME MANAGEMENT, LACK OF EXPERIENCE, SHIFT WORK, REACTIONS OF OTHER STAFF TO THEM UNPREPARED FOR THE REALITY OF THE HIERARCHY, UNPREPARED FOR THE REALITY OF A FULL CLIENT LOAD". These responses support statements made by writers such as Cowan (1984), Baker (1988) and Bircumshaw (1989), Brun (1988) who identified many of these issues as stumbling blocks in the integration of the new graduates. 72% of First Level Practitioners identified that their energies at the time they became a First Level Practitioner were directed mostly at 'survival' in the new system, rather than consciously trying to apply their learning to the situations in which they now found themselves.

First Level Practitioners suggested to the researcher that although most of the identified problems were addressed in class, when they undertook clinical practicum, they were unable to appreciate the full implications of the information they were receiving due to the fact that they were protected by their clinical teachers, and their own inexperience and naivete. As earlier suggested, (p 22) this is a normal process of role development and acceptance which must be experienced by all people in a new role situation whatever the organisation. The major concern (see Table 5.17) as identified by the First Level Practitioners was lack of experience (34%), followed by coming to terms with the 'hierarchy' (31%) and lack of skill (24%) on their part as new graduates.
NUMs generally feel that their role has altered since the First Level Practitioners became a part of the nursing team in that they now have less time available for the facilitator, manager roles. This was perceived by the group as a whole as being due to the need to spend more time directly teaching staff elementary skills and providing clients with basic information. The NUMs perceive the First Level Practitioners as being unable to provide these services. Also identified by the NUMs was the need to spend more time supervising the actual delivery of care by these First Level Practitioners as less than required knowledge and skill levels were evidenced. Increased client contact by the NUMs was neither formally nor informally identified by any respondent as being a positive outcome of the situation.

With the exception of time management as a major concern, most First Level Practitioner responses differed to those of the NUMs in that they perceived that apart from a general fear of the unknown, they were in fact well prepared to assume the role of the registered nurse by the time they had completed their tertiary education.
CHAPTER SIX

RESULTS OF FINDINGS

PART 2

TESTING OF HYPOTHESES

This chapter examines the results of hypothesis testing and analysis. The hypotheses have been grouped into four major categories with the relevant sub-hypotheses being discussed under each grouping.

6.1 HYPOTHESES RELATED TO THE ALTERED ROLE FOCUS OF THE NUM SINCE 1987 DUE TO THE PRESENCE OF THE FIRST LEVEL PRACTITIONER IN THE WARD NURSING TEAM.

HYPOTHESIS 1.1

THERE IS NO RELATIONSHIP BETWEEN THE TIME SPENT TEACHING STAFF AND TEACHING CLIENTS SINCE THE FIRST LEVEL PRACTITIONERS BECAME PART OF THE WARD NURSING TEAMS.

A significant relationship was found between time spent teaching staff and teaching clients (see Table 6.1). NUMs attributed this to the inadequate knowledge level of the First Level Practitioners. This was related by NUMs to their reduced clinical experience which limits their ability to appropriately relay expected outcomes to clients.
Table 6.1 Comparison Between Time Now Spent Teaching Staff And Teaching Clients (Results Collapsed Vertically).

<table>
<thead>
<tr>
<th></th>
<th>Teaching clients</th>
<th>Teaching staff</th>
<th>Total</th>
<th>$x^2$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>More time</td>
<td>46%</td>
<td>71%</td>
<td>117%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less time</td>
<td>54%</td>
<td>29%</td>
<td>83%</td>
<td>27.231</td>
<td>0.05</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>100%</td>
<td>200%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Analysis of chi square goodness of fit between time teaching clients and staff was performed revealed a significant result $X^2 = 27.231$ (df=7), $p = 0.05$. The null hypothesis was therefore rejected at .05 level (see Table 6.1). 71% of NUMs agreed that they now spend more time directly teaching staff since the First Level Practitioner became part of the ward team due to the low ability of the First Level Practitioners to provide adequate inputs relating to operative procedures and expected outcomes of care. Bircumshaw (1989) suggests this discrepancy was inevitable as senior nursing staff expected that new graduates would not have requisite skills in order to perform adequately and therefore would require extra teaching in the ward thus restricting the manager performance part of the NUM role.

HYPOTHESIS 1.2
THERE IS NO RELATIONSHIP BETWEEN THE TIME SPENT COORDINATING CLIENT SAFETY AND THE TIME SPENT PERFORMING ADMINISTRATIVE DUTIES BY THE NUM.
A series of one way analysis of variance was carried out on coordinating client safety, monitoring care activities, coordinating
care activities and administration time and revealed $F=1.74, p>0.001$ (see Table 6.2). Results suggest that the NUMs perceive that there is a direct relationship between the time they spend monitoring and coordinating care activities with the time spent coordinating patient safety.

**Table 6.2 - Analysis Of Variance Between Coordinating, Monitoring And Administration.**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sums of Squares</th>
<th>Degrees of Freedom</th>
<th>Mean Squares</th>
<th>$F$ Ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring</td>
<td>43.692</td>
<td>51</td>
<td>.857</td>
<td>1.7014 1</td>
</tr>
<tr>
<td>Administering</td>
<td>38.981</td>
<td>51</td>
<td>.764</td>
<td>1.7014 1</td>
</tr>
<tr>
<td>Coordinating safety</td>
<td>62.692</td>
<td>51</td>
<td>1.229</td>
<td>1.7014 1</td>
</tr>
<tr>
<td>Coordinating care</td>
<td>43.442</td>
<td>51</td>
<td>.852</td>
<td>1.7014 1</td>
</tr>
</tbody>
</table>

The implication here is that the NUMs perceive that the First Level Practitioners have less than the required knowledge and skill levels. This deficit is considered by NUMs as being serious enough to affect client well being and therefore to require the NUM to intervene in order to provide the appropriate information for clients and extra supervision for the First Level Practitioners.
HYPOTHESIS 1.3

There has been no increase in the time spent supervising ward nursing staff and monitoring care activities since the first level practitioners became part of ward teams.

Chi square goodness of fit test was performed to determine if a positive relationship existed between the increased time spent now between NUMs supervising at ward level and directly monitoring the care delivery activities if the First Level Practitioners.

Table 6.3 Comparison Between Supervision And Monitoring Activities Performed By The N.U.M Since 1987.

<table>
<thead>
<tr>
<th></th>
<th>Supervising</th>
<th>Monitoring</th>
<th>Total</th>
<th>X²</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>more time</td>
<td>41</td>
<td>42</td>
<td>83</td>
<td></td>
<td></td>
</tr>
<tr>
<td>less time</td>
<td>11</td>
<td>10</td>
<td>21</td>
<td>15.4</td>
<td>0.05</td>
</tr>
<tr>
<td>TOTAL</td>
<td>52</td>
<td>52</td>
<td>104</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chi square testing yielded a result of 15.4 (df=1) p<0.05. The decision was made to reject the null hypothesis at alpha .05 level. Results indicated that there is a significantly greater amount of time now spent by NUMs supervising staff and directly monitoring the delivery of direct patient care by the First Level Practitioner.
HYPOTHESIS 1.4

THERE IS NO DIFFERENCE IN THE TIME AVAILABLE FOR THE NUM TO SPEND DELIVERING DIRECT PATIENT CARE BEFORE 1987 AND THE TIME AVAILABLE FOR THIS SINCE THE FIRST LEVEL PRACTITIONER BECAME PART OF THE WARD NURSING TEAM.

Chi square goodness of fit test was performed to determine if a relationship existed between the care delivery role of the NUM and the identified alteration in role experienced by the NUMs. Results are summarised in Table 6.4.

Table 6.4 - Comparison Between Results Indicating Role Alteration And Care Delivery Role of the NUM.

<table>
<thead>
<tr>
<th></th>
<th>Altered Role for NUM</th>
<th>Care delivery since 1987</th>
<th>TOTAL</th>
<th>X²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>27</td>
<td>27</td>
<td>54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>25</td>
<td>25</td>
<td>52</td>
<td>9.92</td>
<td>0.05</td>
</tr>
<tr>
<td>TOTAL</td>
<td>52</td>
<td>52</td>
<td>104</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Analysis of the relationship between role focus alteration and care delivery yielded a result = 9.92, significant at 0.05. Testing for goodness of fit between the four broad areas of role focus (i.e. facilitator, teacher, co-ordinator and care deliverer) revealed chi square = - 2.809, (df=3), probability = p < .422 which was not significant at 0.05.
HYPOTHESES RELATED TO THE INTEGRATION PROCESSES OF THE FIRST LEVEL PRACTITIONERS IN EACH OF THE MAJOR HOSPITALS IN THE LOWER HUNTER VALLEY.

HYPOTHESIS 2.1
THERE IS NO DIFFERENCE BETWEEN PERCEPTIONS OF NUMS AND FIRST LEVEL PRACTITIONERS ABOUT THE MINIMUM TIME PRACTITIONERS WORK BEFORE THEY ARE ASSIGNED A FULL CLIENT LOAD.

Perceptions of DONs, NUMs and First Level Practitioners were sought about the integration processes implemented by each of the hospitals throughout the Lower Hunter Valley. DONs reported that approximately $900 is allocated to each hospital per graduate for the purpose of conducting a graduate orientation/integration programme throughout the twelve month practitioner period as the graduates undergo role acquisition.

Information was sought from NUMs, and First Level Practitioners about specific activities and processes of integration programmes. The information sought included the minimum period of time the First Level Practitioner may work before being allocated a full client load of their own to manage (see Figure 6.3); who actually orientates the graduates to the ward (see Table 6.5) and who provided the most useful information for the new practitioners (see also Table 6.6). They were also asked who evaluates the performance of these First Level Practitioners (see Table 6.8); how often this is assessed (Table 6.3) and whether or not the same assessment tool is used for the First Level Practitioners as for other
registered nurses.

29% of NUMs stated that the orientation programme for the First Level Practitioners lasts up to three weeks whilst only 2% of the First Level Practitioners agreed. 55% stated that they received less than three days orientation to the wards or units. The latter reported that once they were no longer "buddied" with another registered nurse (usually during the first three days), they were no longer being orientated and that they were then expected to perform as well as each of the other staff in the unit.

No significant relationship was found to exist. Chi square analysis result was 24.325 (df=4), with a Probability < .001. The decision was made to reject the null hypothesis at alpha .05) between the NUMs responses and the First Level Practitioners responses as to the minimum time worked by First Level Practitioners before they are given their own patient load (see Figure 6.1).
Minimum Time Worked by Graduates for Orientation.
(Figure 6.1)

KEY:

NUM Responses
FLP Responses

First Level Practitioners stated that once the initial orientation period was over, it was assumed by all ward staff (including NUMs) that unless they specifically asked for directions or information, they "knew what needed to be done". Unspoken expectations on the part of the NUMs may have led to conflict rather than the real or perceived inadequacies of the First Level Practitioners. This supports evidence provided by Kramer (1974), who reported unspoken expectations as being very influential in the appropriate assumption of a new role in any situation.
HYPOTHESIS 2.2


Pearson correlation yielded $r = 0.099$ (df = 60) indicating no significant relationship between the responses of the NUMs and the graduates at 0.05 level about the frequency of evaluation of the First Level Practitioners in any of the hospitals (see Figure 6.2). Periods stated ranged from once every six months to once every twelve months. The researcher was surprised to note that the responses from NUMs did not tally with the responses of the First Level Practitioners within hospitals or between hospitals. Nor did responses of First Level Practitioners from each hospital correspond with the practitioners responses within or between the other hospitals surveyed. The decision was made not to reject the null hypothesis.
HYPOTHESIS 2.3

THERE IS NO DIFFERENCE BETWEEN THE EVALUATION METHODS USED TO ASSESS PERFORMANCE LEVELS OF FIRST LEVEL PRACTITIONERS IN SELECTED HOSPITALS THROUGHOUT THE LOWER HUNTER VALLEY.

DONs were asked to identify which evaluation tool is used to evaluate the performance level of the First Level Practitioners. Results indicated that each hospital uses a slightly different method for this purpose and are summarised in Table 6.5.
Chi square goodness of fit test of results from NUMs and First Level Practitioners provided a result of 100.795 (df = 3), with a probability of < .001. The decision was made to reject the null hypothesis at .05. Such a result indicates that hospital evaluation policies concerning the First Level Practitioners during this first twelve months following graduation is individually set by the employing hospitals.

It is of concern that within these hospitals, there was no consensus between the First Level Practitioners and the NUMs as to how often the First Level Practitioners performance is assessed given that DONs stated that the evaluation process includes a self evaluation by the First Level Practitioners.
HYPOTHESIS 2.4

THERE IS NO DIFFERENCE BETWEEN HOSPITALS AS TO WHICH PERSON IS RESPONSIBLE FOR THE EVALUATION OF THE PERFORMANCE OF THE FIRST LEVEL PRACTITIONERS DURING THE FIRST TWELVE MONTHS POST GRADUATION.

Directors of Nursing, NUMs and First Level Practitioners were each asked who performs the assessment of the First Level Practitioners. Results obtained from the surveys are summarised in Table 6.6 and Figure 6.4.

Table 6.6 Which Member Of Staff Evaluates The Performance Level Of First Level Practitioners.

<table>
<thead>
<tr>
<th>STAFF MEMBER</th>
<th>N.U.M RESPONSE</th>
<th>%</th>
<th>GRAD RESPONSE</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NUM</td>
<td>39</td>
<td>72</td>
<td>49</td>
<td>79</td>
</tr>
<tr>
<td>Preceptor</td>
<td>9</td>
<td>14</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>CNS</td>
<td>4</td>
<td>8</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>52</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

KEY NUM - Nursing Unit Manager
CNS - Clinical Nurse Specialist

Chi square result = 17.92 with df = 4. The decision was made to not reject null hypothesis at .001 level of significance. NUMs and graduates stated that the Nursing Unit Manager is responsible for the evaluation of the First Level Practitioner in most of the wards surveyed. There was no correlation of responses as to the frequency of evaluation, with responses ranging from once every three months to once every twelve months.
Methods of evaluation were not standard throughout the Lower Hunter Valley with each hospital adopting a slightly different method for this purpose. Also different methods were used to evaluate the First Level Practitioner and the other registered nurses in these hospitals.

Correlation of NUM, First Level Practitioners Responses As To The Person Responsible For First Level Practitioner Evaluations. (Figure 6.3)

**KEY**

NUM = nursing unit manager,
PRCPT = preceptor
CNS = clinical specialist
SDO = staff development officer
The implication of the above responses is that at ward level, the NUMs have different expectations of the abilities of the First Level Practitioners compared to the beginning abilities of other registered nurses in the hospitals and that these expectations differ from hospital to hospital.

6.3 HYPOTHESES RELATED TO NUMS PERCEPTIONS THAT NURSING ADMINISTRATION HAS PROVIDED ADEQUATE SUPPORT SINCE THE FIRST LEVEL PRACTITIONERS BECAME PART OF THE NURSING TEAM.

HYPOTHESIS 3.1

THERE IS NO DIFFERENCE IN PERCEPTIONS BETWEEN NUMS THAT NURSING ADMINISTRATION GENERALLY UNDERSTANDS THEIR NEEDS WITH REGARD TO THE FIRST LEVEL PRACTITIONERS.

NUMs were asked how they felt regarding whether senior nursing administration staff actually understood the implications of the presence of the First Level Practitioner in the wards. They were also asked if they believed that the nursing administration generally understood the needs of the NUM in regard to the changed emphasis in practices due to the presence of the First Level Practitioners. Results are summarised in Table 6.7.
Table 6.7 Understanding By Nursing Administration Of Needs Of NUM Relating To The Presence Of The First Level Practitioners.

<table>
<thead>
<tr>
<th>Nursing Unit Manager Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>Agree</td>
<td>22</td>
<td>42</td>
</tr>
<tr>
<td>Disagree</td>
<td>15</td>
<td>29</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

Chi square goodness of fit test provided a result $X^2 = 10.615$, with df = 3, (p < .014). The null hypothesis was rejected at .05 level. NUMs agreed that the hospital administration understands their needs relating to the integration of the First Level Practitioners. This response was stated in terms of the following; time for integration purposes, (i.e. ability to free these First Level Practitioners from the wards during periods of staff overlap for the purposes of education to be conducted by Staff Development Officers) and the time to teach the First Level Practitioner the requisite skills and appropriate techniques as they related to the particular ward areas. It was acknowledged by the NUMs that administration recognised that some of the ward work would now take longer to complete due to inexperience on the part of the new First Level Practitioner. Nursing Administration also acknowledged, the fact that generally these graduates would require a longer period of time than did the registered nurses who trained in the hospital system before they would be fully a part of the ward team.
This statement supports findings of Bircumshaw (1989) who cited this admission as one of the reasons for the negative attitudes of senior nurses towards newly registered nurses in the American study.

**HYPOTHESIS 3.2**

**THERE IS NO DIFFERENCE IN THE LEVEL OF SUPPORT GIVEN TO NUMs SINCE THE FIRST LEVEL PRACTITIONERS BECAME PART OF THE NURSING TEAM IN 1987.**

NUMs were asked if they believed that they: received the same amount of support from senior nursing administration; more support or less support since the First Level Practitioners became a part of the nursing team in the wards. Results are summarised in Table 6.8

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Agree</td>
<td>20</td>
<td>38</td>
</tr>
<tr>
<td>Disagree</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>TOTAL</td>
<td>52</td>
<td>100</td>
</tr>
</tbody>
</table>

Chi square analysis revealed a result = 10.05 (df = 1), p <05). It was decided not to reject null hypothesis at 0.001 level. 55% of NUMs agreed that the hospital administration has continued to provide adequate support for them as NUMs since the First Level Practitioners became part of the ward staff. This support was expressed in their terms as being "understanding but not extra staff
to help out". In the larger hospitals (i.e. more than 200 beds) this was seen as being the provision of a preceptor or clinical nurse specialist in the area who was able to teach these practitioners "when they were not too busy with their own client loads".

Verbal responses from the NUMs indicated that whilst the administration "seemed to understand"; there "really wasn't a great deal that they could do", short of "providing extra staff" so that the First Level Practitioners could be supernumerary for a "reasonable length of time".

6.4. HYPOTHESES RELATED TO EXPECTATIONS OF THE PERFORMANCE ABILITY OF THE FIRST LEVEL PRACTITIONERS SINCE 1987 BY NUMS.

HYPOTHESIS 4.1
THERE IS NO DIFFERENCE BETWEEN THE EXPECTATIONS OF THE NUMS AND FIRST LEVEL PRACTITIONERS ABOUT THE ABILITIES OF THE BEGINNING FIRST LEVEL PRACTITIONERS.

Directors of Nursing, NUMs and First Level Practitioners were asked what were their expectations of the knowledge and skill levels possessed by the First Level Practitioners when they first commenced in the wards as a First Level Practitioner. They were also asked if these expectations had been realistic in 1987. Following this, they were asked whether or not their expectations had altered since that time. DONs stated that their expectations had been realistic and had not altered since 1987. Results of First Level Practitioners and NUMs are summarised in Tables 6.9, and 6.10 and Figure 6.4.
Table 6.9  Expectations As Being Realistic.

<table>
<thead>
<tr>
<th>GROUP</th>
<th>RESPONSE</th>
<th>FREQUENCY</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Unit Manager</td>
<td>YES</td>
<td>44</td>
<td>84</td>
</tr>
<tr>
<td>Nursing Unit Manager</td>
<td>NO</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>First Level Practitioner</td>
<td>YES</td>
<td>37</td>
<td>59.6</td>
</tr>
<tr>
<td>First Level Practitioner</td>
<td>NO</td>
<td>21</td>
<td>40.3</td>
</tr>
</tbody>
</table>

COMPARISON OF NURSING UNIT MANAGER RESULTS WITH FIRST LEVEL PRACTITIONER RESULTS.

Chi square goodness of fit test = 33.071, df = 3, probability < .001. The decision was made not to reject the null hypothesis at .05(5.99) significance (see figure 6.4).
HYPOTHESIS 4.2


NUMs and First Level Practitioners were asked whether or not their expectations about just "what the First Level Practitioners could do" had been appropriate and realistic. They were also asked if these expectations had altered since 1987 now that they had spent some time working with the new practitioners in their wards and units (see Tables 6.10 and 6.11).

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>NUM %</th>
<th>FLP %</th>
<th>TOTAL</th>
<th>X²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>10</td>
<td>58</td>
<td>68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td>50</td>
<td>24</td>
<td>74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>31</td>
<td>8</td>
<td>39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>9</td>
<td>10</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>100</td>
<td>200</td>
<td>23.538</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Chi square goodness of fit revealed no significant relationship between responses of the NUMs and the First Level Practitioners ($X^2 = 23.538 \text{ (df=3)} \ p < .001$). The decision was made to reject null hypothesis at .05 level. 84% of NUMs and 59.6% of First Level Practitioners stated that their expectations of the performance abilities of the new practitioners were realistic in 1987 when First Level Practitioners commenced in their wards. The expectations however, differed according to the degree of daily interaction with the graduates which that took place (i.e. NUMs had higher
expectations than DONs, NUMs also had higher expectations than new practitioners). This would have most certainly impacted upon the attitudes of these nurses towards the First Level Practitioners who were coming to terms with the role acquisition process which is integral to becoming part of an hierarchical organisation such as a hospital or large company.

Sixty percent (60%) of the NUMs stated that their expectations of the First Level Practitioners had altered since 1987 (they now expected less of the First Level Practitioners). Each of the DONs interviewed at the commencement of the study, stated that their expectations had remained realistic and unchanged since 1987.

First Level Practitioners stated that their expectation had been different in the area concerning reactions of other staff members to "them"; "time management"; "shift work"; but not in their abilities and what they felt "they could contribute to the wards".

**HYPOTHESIS 4.3**

**THERE IS NO DIFFERENCE BETWEEN PERCEPTIONS OF NUMS IN THEIR BELIEF THAT THEY WERE WELL PREPARED FOR THE ARRIVAL OF THE FIRST LEVEL PRACTITIONERS IN 1987.**

NUMs believed that they were not well prepared for the arrival of the First Level Practitioners nor for their own part in the integration processes. One way analysis of variance resulted in $F = 3.17$. The null hypothesis was rejected at .05 level. A direct relationship exists between how well the NUMs believed that they were prepared and what they expected that the First Level Practitioners
would be able to do as registered nurses. This suggests that expectations may have been much different had an alternative approach been used to introduce the arrival of the First Level Practitioner into the ward nursing teams and to familiarise the NUMs regarding their part in the integration processes.

HYPOTHESIS 4.4

THERE IS NO DIFFERENCE BETWEEN PERCEPTIONS OF NUMS AND FIRST LEVEL PRACTITIONERS WHEN IDENTIFYING THOSE COMPETENCIES/SITUATIONS PRESENTING THE MOST DIFFICULTY FOR THE FIRST LEVEL PRACTITIONERS WHEN THEY FIRST COMMENCE IN THE WARDS.

Respondents were asked to rank in order which competencies/situations they felt would be the most difficult for the new graduates. This question required retrospection from each group and therefore results may be biased in some cases. Participants were asked to rank their responses from one to four, indicating the expected degree of difficulty. Table 6.10 displays the responses from the NUMs and the First Level Practitioners on each competency listed in the questionnaires. On examination of Table 6.10, it can be seen that there is no consistency between the responses of the NUMs and the First Level Practitioners, with the exception of line 12 (Reactions of other staff members) which both groups expected to cause the third highest degree of difficulty for the new practitioners.
Table 6.11 Comparison of Responses as Ranked by NUMs and First Level Practitioners About Those Competencies Presenting the Most Difficulty for New Graduates.

<table>
<thead>
<tr>
<th>COMPETENCY/SITUATION</th>
<th>NUM RESPONSES</th>
<th>FIRST LEVEL PRACTITIONER RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A  B  C  D</td>
<td>A  B  C  D</td>
</tr>
<tr>
<td>Lack of knowledge</td>
<td>9  3  4  4</td>
<td>15 34 2 0</td>
</tr>
<tr>
<td>Report Writing</td>
<td>4  5  2  6</td>
<td>7  4  6  0</td>
</tr>
<tr>
<td>Communicating with patients</td>
<td>5  1  3  4</td>
<td>4  1  2  2</td>
</tr>
<tr>
<td>Aggressive patients</td>
<td>9  1  1  3</td>
<td>2  1  8  0</td>
</tr>
<tr>
<td>Shift work</td>
<td>4  6  3  4</td>
<td>2  1  5  4</td>
</tr>
<tr>
<td>Administration of Medications</td>
<td>1 12 2 10</td>
<td>4  2  9  3</td>
</tr>
<tr>
<td>Accountability</td>
<td>2  3  5  2</td>
<td>0  0  5  5</td>
</tr>
<tr>
<td>Legal Aspects of practice</td>
<td>2  5  4  7</td>
<td>0  0  4  4</td>
</tr>
<tr>
<td>Decision making</td>
<td>3  4  5  4</td>
<td>3  2  3  10</td>
</tr>
<tr>
<td>Interacting with relatives</td>
<td>1  4  3  4</td>
<td>3  0  3  16</td>
</tr>
<tr>
<td>Inexperience</td>
<td>4  5  7  2</td>
<td>19 15 3  0</td>
</tr>
<tr>
<td>Reactions of other staff members</td>
<td>6  2  1  0</td>
<td>3  2  12  2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>52 52 52 52</td>
<td>62 62 62 62</td>
</tr>
</tbody>
</table>

KEY: A = Expected to be the most difficult  
B = Expected to be second most difficult  
C = Expected to be the third most difficult  
D = Expected to be the fourth most difficult

As a group, the NUMs expected that the new practitioners would experience the most difficulty with a lack of knowledge, whilst the First Level Practitioners expected that they would experience the most difficulty with their inexperience in the clinical area. They did however, expect that
their lack of knowledge would cause them the second highest degree of
difficulty. NUMs on the other hand expected that medication
administration would cause the new practitioners the second highest
degree of difficulty.

Using the findings of Table 6.10, the researcher collapsed the ranked
responses horizontally. Responses 'A' and 'B' were collapsed to
represent the anticipated 'most difficult' and became columns 'E' and
'G', whilst 'C' and 'D' were collapsed to represent the 'less difficult'
skills and became columns 'F' and 'H'. (Table 6.11 displays the
responses by each group using the horizontally collapsed method). From
Table 6.12, it may be seen that lack of knowledge, inexperience and
interacting with relatives of clients were the most worrisome for the
graduates.

Chi square analysis performed on the horizontally collapsed responses
revealed $X^2 = 181.9$ (df = 33, p 0.05) no significant relationship between
the groups. The researcher rejected the null hypothesis that there would
be no difference between the perceptions of the NUMs and the First Level
Practitioners as to what would cause the most difficulty for the new
practitioners.
### Table 6.12 - Responses By Groups Using Horizontally Collapsed Results From Table 6.11.

<table>
<thead>
<tr>
<th></th>
<th>NUM</th>
<th>NUM</th>
<th>FLP</th>
<th>FLP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>F</td>
<td>G</td>
<td>H</td>
</tr>
<tr>
<td>Lack of knowledge</td>
<td>12</td>
<td>8</td>
<td>49</td>
<td>2</td>
</tr>
<tr>
<td>Report Writing</td>
<td>9</td>
<td>8</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Communicating with</td>
<td>6</td>
<td>7</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Aggressive patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shift work</td>
<td>10</td>
<td>7</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Medications</td>
<td>13</td>
<td>12</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Accountability</td>
<td>5</td>
<td>7</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Legal Aspects of Practice</td>
<td>7</td>
<td>11</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Decision making</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Interacting with relatives of patients</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Inexperience</td>
<td>9</td>
<td>9</td>
<td>34</td>
<td>3</td>
</tr>
<tr>
<td>Reactions of other staff members</td>
<td>8</td>
<td>1</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>TOTAL</td>
<td>91</td>
<td>86</td>
<td>119</td>
<td>103</td>
</tr>
</tbody>
</table>

**KEY:**

E,G = (expected to cause most difficulty) Response A and B collapsed from table 6.10

F,H = (Expected to cause less difficulty) Response C and D collapsed from table 6.10

This may have been due as suggested by Sharkey and Buckley (1989) to the fact that the NUMs were not included in many of the interchanges between the college and the hospitals prior to the commencement of the first graduates in 1987. As a consequence, they were unaware of the different skills with the graduates would be prepared. Results are further summarised in figure 6.5
Most Difficult Skill For New Practitioners.
(NUM And First Level Practitioner Responses)
(figure 6.5)

KEY:  
K = Lack of Knowledge
R = Report Writing
C = Communicating with Difficult Patients
S = Shift Work
M = Administration of Medications
A = Dealing with Aggressive patients/clients
L = Legal Aspects of Practice
D = Decision Making
I = Interacting with Relatives
IN = Inexperience
RE = Reactions of Other Staff Members

NUM Responses
First Level Practitioner Responses
6.5 SUMMARY OF CHAPTER

NUMs stated they perceive that they have less time to perform their manager role now since the arrival of the First Level Practitioners. Role areas of facilitator and co-ordinator were those areas identified as being most affected in terms if diminished time available. This was stated as being due to a need on their part to now spend more time directly teaching clients and staff and supervising what the new graduates are doing.

Writers such as Owen (1988), Singleton and Nail (1984) and Sharkey and Buckley (1989) suggest that the lack of available time for manager role fulfilment has produced a situation of role conflict caused in part by lack of clear role delineation. This has occurred at a time when health delivery as it relates to nursing is already undergoing change (caused by the changing politics of the health care delivery system and needs of society coupled with decreased availability of services available).

Integration policies appear to be standard throughout the Lower Hunter Valley however evaluation procedures vary quite markedly between the hospitals. The researcher questions if this is due to specific hospital policy making processes or to varying expectations by nursing administrators within these hospitals.

At informal interview, the NUMs expressed concern that their manager role is being eroded and that they were not given adequate preparation for the arrival of the First Level Practitioners, whilst the First Level Practitioners perceive that they are experiencing difficulties due to the unrealistic expectations of the NUMs. It is not difficult therefore to understand why the situation of role conflict has emerged on the part of
the NUM who has expectations of the manager role in which they find themselves but is unable to fulfil these own expectations due to unexpected demands by a new tier of nurse within the team.
CHAPTER SEVEN

DISCUSSION AND CONCLUSIONS

This study has explored the development of and problems arising from the transfer of nursing education into tertiary educational institutions. The role of the NUM has been viewed from a number of different perspectives: historically; in the organisational setting; within a given definition by nursing management; in the perceptions of the participants (NUMs and First Level Practitioners) and thorough examination of service requirements. A number of important features have emerged which are brought together in this concluding chapter. Since there are no similar studies or literature available on the changing role of the NUM, comparisons with other findings cannot be made.

Chapter One sets out the concept of changes in the patterns of illness through advances in medical knowledge and technology. In the sixties, advances in medical technology and affluence in lifestyle experienced by the country as a whole impacted on the standard of health of the community. Patients experienced longer hospital stays, required more intensive rehabilitation and re-entered the community in larger numbers with long term disabilities which required health and nursing care at a community level. These features have changed the pattern of health care services. Inextricably linked to this is the economic responsibility forced onto health boards which flowed down to all involved in the delivery of services and ultimately, to the patient. As a result the argument of costs
versus care of health led to bias in governmental health decisions, with money flowing more into community services as a result of a shift in focus of acute health care delivery services. Ultimately this lead to restructuring of staffing establishments at institutional levels. This had the effect of producing conflicts as the roles of nursing altered especially at the level of the Charge Nurse, who in the eighties became known as the NUM.

Hospitals cannot escape economic reality and the NUMs find themselves in an unfamiliar role dealing no longer with apprentices who have been within the hospital for three years of on-the-job training but with First Level Practitioners, who are university graduates with a different knowledge base and skills. These graduates are perceived to lack adequate clinical experience and confidence in the acceptance of responsibility.

There is lack of evidence in the literature reviewed to suggest that this change as noted by NUMs is due to any more than alterations in social demands and limitations placed upon management at all levels within hospital domains. Health service cuts in the areas of staff establishments, shorter stays of patients due to laser and laparoscopic surgery, minor surgery being performed by doctors in their surgeries. This has generated more paper work, more admissions and discharges and transfers to theatre and ongoing staff shortages have each contributed to this situation.

Chapter Two explored the concepts of change and role theory as they relate to the NUMs current role. Role theory helps nurses comprehend that hospitals bureaucratic hierarchies need to slot people into categories with predictable role expectations to ensure continuous efficient
functioning of the organisation. Such a statement would mean however that the onus is on the nurse to conform to the expectations of the organisation, thereby ignoring his/her own needs in performance of his/her role. This in fact may be the situation faced by the new graduates. These people are unaware of often unspoken but nonetheless accepted cultural expectations of an organisation such as those within a hospital (and more specifically those of the NUMs).

Results from the study support literature by Strong (1979), Tappen (1983), Owen (1988), Hardy and Conway (1978) suggesting that role theory is the model underpinning practice - especially for a middle manager such as the NUM. Similarly, Cowan (1984), Russell (1988) and Sharkey and Buckley (1989) have each suggested that the role of the NUM has been changing over a recent period of time and that lack of role delineations has caused role conflict to emerge for the NUM.

Within any organisation, role differentiation occurs to facilitate optimal functioning of the organisation with role frames being shaped by political wills and changing circumstances. This has impacted upon the role of NUM as identified by participant responses to the survey. Of the many factors which can moderate job satisfaction for the NUM, job design and role clarity are two of the most important which have been linked with job satisfaction and stress levels. Fifty six percent (56%) of NUMs stated that their role has altered since 1987 and that they are unable to fulfil the role they expected to be able to carry out. For these people, the result has produced an ongoing situation of role conflict which has then been attributed by NUMs to being due to the presence of the First Level Practitioner at the same time.
Role conflict occurs in a situation in which more than one set of expectations operate (in this instance, those operating are NUM expectations, hospital administration expectations, graduate expectations, client expectations). Role overload is typically a problem of priorities or quantity within time pressures and is one of the most common causes of nurse frustration. Resolution of such a situation lies to a great extent with NUMs role being more clearly delineated. This could be achieved by these managers unifying to enhance their professional status through improved, continuing education and by developing and clarifying a defined role as a distinct body within the health care organisation.

The findings of this study harmonise with those of researchers such as Kramer (1974), Lewin (1951), Schlotfeld (1977), Bircumshaw (1989), Sharkey and Buckley (1989), and Swansburg (1990). These writers focussed on role conflicts and changes which might occur in the future given a particular set of circumstances. The present study however, focussed on changes identified by NUMs as having in fact occurred since 1987. These changes were identified as being due to the transfer of nursing education in 1984 which led to the presence of the First Level Practitioner in the unit nursing teams. In order to fulfil this purpose, Schlotfeld's Health Seeking Behaviour Model (1977) was adapted to describe the relationships identified within the changing role of the NUMs which were then explored within this study.

Chapter Three explored the historical aspect of those factors altering the role of NUMs as expressed by various Nursing and Government committees and reports since the 1960's (e.g. NORC (1975), The Chittock Report (1968) and the Sax Report (1979). The reports, coupled with a Government desire to transfer nursing education from the Health portfolio
to the Education portfolio in 1984 ultimately led to the removal of nursing education from hospitals into tertiary institutions throughout NSW in 1984. According to Parry (1984), this would "...improve the quality of care by having a more highly efficient, trained stable workforce" (p 14). This also indicated a shift from a care philosophy to a management philosophy and led to uncertainties on the part of NUMs as to what the future now held for them in terms of career pathways.

This conceptual framework led to an examination of the particular role focus areas as they were affected by those intervening factors identified in the literature review (e.g. nursing pressure groups, educational philosophy versus service needs, financial limitations, controls of nursing decision making processes at the time and informal discussions held with NUMs throughout the region). Four interpretable factors of the manager role of the NUM were identified on the basis of the literature reviewed and from informal interviews held with the NUMs and the First Level Practitioners. These were: the supervisor role, facilitator role, teacher role, and coordinator role.

Data from the survey demonstrates that NUMs perceive changes in their role which may be identified in terms of behaviours relating to coordinating care and safety, teaching patients and staff, supervisory activities in monitoring client care and safety and facilitating activities such as communicating with paramedical and medical staff. Managers stated they now have less time to perform these roles adequately and that they attribute this change directly to the presence of the First Level Practitioners and to their direct involvement with them which they (NUMs) perceive prevents them allocating sufficient time to their management role.
Chapters Four, Five and Six explored and discussed the factors which directed the formation of the tool to be used for the survey as well as exploring participant responses to questions. Given that some participant responses depended on introspection, it is acknowledged that some responses may have been biased. It has not been possible to build on the findings of other researchers as different foci have been used (e.g. Kramer 1968, Pembury 1980 and Bircumshaw 1989) when they examined the role of the NUM.

It was thought possible that the size of the hospital (i.e. more than two hundred beds or less than two hundred beds) may have influenced the results of the study. However, this was not so. Hospital size appears to have had no impact upon the survey results in terms of NUM involvement in First Level Practitioner integration. No difference was noted between results from hospitals with less than 200 beds and those with more than 200 beds, indicating that resources such as preceptor availability had little impact on the NUM role in this study. Information suggests that eighty percent (80%) of graduates remained at their original place for more than the initial 12 month period as a beginning practitioner. This would indicate that once the initial integration period was completed, graduates did in fact feel as if they were an integral part of the employing organisation.

Results indicated that NUMs perceive that their involvement with the First Level Practitioners, has altered their role as facilitator, supervisor and co-ordinator. These changes, linked with cuts in the provision of Government finances for health services appears to have resulted in increased stress levels, role ambiguity, overload and many perceived role
conflicts amongst those NUMs surveyed. The general feeling of being threatened rather than excited by the eventual rapidity of the changes was exhibited throughout the State and was also in Lower Hunter Valley. This has led to misconceptions at times on the parts of both the NUMs and the First Level Practitioners in terms of expectations.

In terms of the desired length of the integration period of First Level Practitioners into nursing practice a twelve month period was identified by all of the hospitals. The new practitioner rotates through various wards for nine months and then is able to specialise in a general care area chosen by them for the remainder of the twelve months.

This study revealed no direct association between the perceptions of the NUMs and the First Level Practitioners about ward orientation periods or processes utilised for the new practitioners. Responses of the graduates ranged from no orientation to more than three weeks. First Level Practitioners revealed in informal interview that they believed that once they were no longer buddied, their orientation period was completed and that they were now on their own.

Roles specifically affected by the presence of the First Level Practitioners as identified by the NUMs have been those role areas identified previously in the literature review. NUMs in the present study attributed those changes directly to the presence of the new graduates in the nursing teams and not as part of a natural growth/alteration of their role due to concurrent changes in the health delivery systems.

NUMs stated that they now spend more time performing supervisory functions and as a direct result now spend less time performing
administrative functions such as role modelling, ordering, communicating with other hospital service areas and leadership functions (such as planning, implementing and evaluating outcomes of care).

Perhaps the preceptor/staff development officer role for nurses is not being utilised as well as it might in some wards and/or hospitals. Results confirm statements made by NUMs during the informal interviews as to why they perceive that they now spend more time checking up on care delivered by the First Level Practitioners each shift.

The majority of NUMs stated they do not now perform more direct patient care than before 1987. Those who undertook direct patient care prior to 1987 still do so but they have not assumed a bigger quota of clients whilst those who did not directly deliver care still do not do so.

Supervision is perhaps the narrowest of the NUM roles and is closest to the hierarchic structure where specific activities are operationalised having been delegated from hierarchic levels. It is viewed by Rabey (1987) as being an indispensable, dynamic process in which the leader encourages or participates in the development of subordinates. The supervisor role was seen as involving monitoring nursing care (i.e client care) activities, and evaluation of staff performance levels and overseeing the implementation of specific hospital management policies.

NUMs perceived this as part of the manager role which has devolved since 1987. Eighty percent (80%) of participants stated that they now spend more time monitoring direct care outcomes in the wards and checking up on graduates performance on a daily basis. The question arises, is this because the new practitioner is less confident to perform the
task; slower at their work generally or is it in fact that they (First Level Practitioners) are undertaking more nursing duties and thus freeing the NUM for this aspect of the nurse role?

In the present study, change in the facilitator behaviours or demands was found to be directly related to the presence of the First Level Practitioner in forty seven percent (47%) of responses. Individual differences in perceptions of the role of the NUM as it specifically relates to the First Level Practitioners were noted between both of these groups of respondents.

Consulting with medical staff and reading through client charts were identified as being those roles the NUMs spend less time performing now than they did before the First Level Practitioners became part of the nursing teams. This was attributed by these respondents as being directly due to the need to spend more time supervising the First Level Practitioner. Respondents suggested that this decreased time interfered with their perceived need (based upon the traditional role whereby a ward sister was and is expected) to be knowledgeable about all aspects of patient progress and management. As a result, they stated (during informal interview with the researcher) that they felt ineffective in the role.

The role of teaching staff has assumed more of the NUMs time as has teaching clients. DONs believed that this was undertaken by the preceptors whilst the First Level Practitioners felt that they were mostly taught by and received the most useful information from the other ward staff (i.e. other registered nurses rather than preceptors or NUMs). This may have been due to fact that most NUMs are available for five days a
week from 7am until 3.30 pm in the wards for teaching. Perhaps NUMs were including informal teaching in their responses whilst the First Level Practitioners were only including specific formal teaching situations. This point was not clarified at the time of interview and may have obscured some results.

The final role area discussed in this study was that of coordinator. Teamwork demands that team members communicate with each other about what they are doing. Effective communication reduces duplication and the possibility of people working at cross purposes. For the NUM, this includes pointing out relationships between policies, procedures, suggestions and situations within their wards or units. Sixty percent of NUMs revealed that they now spend more time now fulfilling the coordinator role than they did prior to 1987. Coordination was not seen as merely being a linking role but rather as one of ensuring patient safety as it relates to activities of daily living (not complex nursing procedures).

Major differences were noted in the expectations between DONs and those of the NUMs in terms of abilities of the First Level Practitioners. This is an interesting phenomenon in that ready communication exists between these two parties each day. Why is it that only one of the parties (i.e. DONs) appears to have specific working knowledge? First Level Practitioners expressed concern about the performance expectations placed upon them by NUMs (many of which were unspoken) as they were far greater than is the reality for the new practitioners. Yet another point of interest arising concerning expectations is that DONs appeared to take a more holistic view of the First Level Practitioner whilst NUMs were mainly only concerned with the task/psychomotor abilities of these First Level Practitioners.
Perhaps the latter is a traditionally held view which has not been sufficiently taken into account when preparing the NUMs for this particular change? Perhaps when information was presented about the new practitioner to NUMs, the main focus in fact remained on the psychomotor skills rather than on the holistic preparation given to the new graduates. This would seem to suggest that it is the NUMs who need further education. Do the communication channels require improvement so that those who are immediately involved with the First Level Practitioners obtain accurate information before they are required to be actively involved in integration practices. Who would then be the person best able to provide such information?

The hypothesis testing of responses relating to NUMs and First Level Practitioners perceptions revealed several interesting aspects. Fewer differences were noted between the DONs' and the graduates' perceptions. DONs, NUMs and First Level Practitioners stated that their expectations of the abilities of the First Level Practitioner had not altered since 1987 with each of the five DONs identifying that their expectations had been realistic. However the NUMs' perception were quite different to those of the DONs and the First Level Practitioners.

Eighty percent of the NUMs stated that their expectations had been realistic (in that the graduates would be inadequately prepared to become as effective a team member as had other registered nurses in the past). The First Level Practitioners stated that their expectations of their own abilities had been realistic in sixty percent of responses. The latter group expressed concern at the expectations placed on them by the NUMs. In fact, the NUMs may have held greater expectations than is the reality for
these new practitioners as a result of their not being directly included in the planning processes prior to the commencement of the First Level Practitioners.

Concerns which were major issues for graduates were; working within the system, time management, the expectation of other staff that they could do everything that traditional graduates had done with the same speed and efficiency; report writing and general legal accountability and finding that they were in fact not allowed to participate in decision making processes as they had expected resulting in frustration and insecurity. The latter perception may have been due to the fact that, as suggested by Brun (1988), graduates as students are now unprepared for the hierarchy and bureaucratic management into which those nurses previously trained in hospitals had been gradually socialised in the past.

The First Level Practitioners saw their deficit as being inexperience however NUMs attributed it to "less than adequate preparation for students by the educational institutions". Such a response from NUMs once again identifies their perception that graduates are ill-equipped to perform tasks involving decision making involving client well being and daily needs.

Evaluation processes were different in each of the hospitals surveyed. Given this factor, it is not surprising that expectations differ also between NUMs participating in the survey. The question arises as to whether this is due to individual hospital expectations or poorly disseminated information from the university at which the graduates were prepared. Alternatively, it may have been due to traditional views being rigidly maintained despite an adequate information flow or perhaps it was a
combination of all of these? NUMs and First Level Practitioners agreed that the NUM is responsible for their evaluation but they differed in their view as to the frequency of these evaluations. Again this may be due to poor communication flowing in either direction or it may have been due to lack of verbalising some unspoken expectations by both parties.

No learning methods or instructional programme will lead to success if there is uncertainty concerning the parameters of ability which must be developed and manipulated in the preparation of the First Level Practitioner. It is therefore essential that NUMs become more aware of the actual abilities and limitations of the new registered nurses as well as the problem solving strategies with which they have been prepared during their education.

The fundamental improvement of processes of learning for both nursing unit manager and nurses generally is the major concern of practising nurses in order to produce a more effective nursing team. As earlier stated, the scope of responsibility and control is far too important to be relegated to a poorly prepared manager. This shift (in focus) has forced the change from clinical skills to a sharp emphasis on solid managerial skills (parenthesis added). Equally, it is important for the new graduates to recognise that the system into which they are going to work is still in the process of change and development itself and therefore "ideal" will not necessarily be the norm in the practice situation.

Exposure of NUMs to the results of this study may lead to the provision of more valid expectations for these managers of the preparation and abilities of the beginning First Level Practitioners than are currently being identified. The operationally defined role behaviours constitute a
prerequisite for intervention procedures designed to enhance the NUMs coping strategies and thus enhance role satisfaction and reduce role conflict for these people.

If nurses are to continue to strive for a more professional approach to nursing care delivery, all must recognise/address problems as they relate to these new and somewhat different First Level Practitioners who are now emerging from tertiary institutions throughout the State. This includes hospital educators, educational faculties, governments who provide costing and therefore education policy guidelines.

Some suggestions for improvement of role retention and job satisfaction for the NUM might be that; hospital administrations demonstrate effective action in solving such ongoing problems as restrictions on staffing levels, budgets, profiles of patients (who now experience much shorter hospital stays post operatively) already inherent in nursing organisation. Further education might be provided so that misconceptions about the profile of the emerging graduates at all organisational levels including health departments, hospital management, ward/unit levels and learned role behaviours might be clarified.

Perhaps information flows to NUMs could be enhanced so that they are provided with information which will be appropriately interpreted and transferred at unit levels. Educational institutions might better appraise students and prospective students of the 'realities' of the nursing industry and organisation. This would better equip them with the skills to deal with the issues of hierarchy and management at appropriate levels. Further studies might be undertaken to more clearly define the NUM role in consultation with NUMs within hospitals.
Management is a complete set of attitudes, cognitions and learned skills. Currently, few courses exist locally (in the Lower Hunter Valley), therefore a deficit exists in the preparation of these managers (some hospitals do however offer first line management courses on an inservice basis). Nurses generally should increase their efforts to educate professional, government and public groups about the role responsibilities and limitations placed upon them in the current climate of health care delivery.

Opportunities for continuing education should be enhanced for the NUMs. This is a particular problem for NUM in the Lower Hunter Valley which is geographically isolated from many of the institutions offering specific nursing management courses at tertiary level. It is often not practical for these nurses to undertake courses which will provide them with the specific skills they require for job enhancement, given that they need to travel to a capital city to undertake them.

Stronger links should be forged between educational facilities and hospitals at ward levels so that ward nursing staff may be more involved in the clinical experiences of the student nurses. The joint appointment of some staff members who have clinical teaching qualifications may be one such means of accomplishing this.

NUMs should be included in decision making processes as they relate to hospital management and newly graduated registered nurses. This would enhance all areas of communication, quality of nursing outcomes and assurances as well as appraising the NUMs of levels of preparation of the First Level Practitioners.
The development of peer support groups for beginning practitioners would support these newly registered nurses by assisting in reality testing, increasing empathy for peers, allowing ventilation of feelings and decreasing any sense of isolation. This would thus provide a forum for problem analysis and solution for these newly registered nurses.

**SUMMARY**

This study set out to explore the relationship between the presence of the First Level Practitioners and the altering role of the NUMs. The general climate of organisations such as a hospital exercises a pervasive influence on the role expectation messages and behaviour of NUMs. These intrinsic expectations in turn greatly influence role performance.

NUMs are effective in helping the First Level Practitioners and in fact all of their nurses, to develop their professional careers if the following criteria are met:

i) Collaborate and help them accurately assess their professional needs;

ii) Allow enough time for training and development experiences of both the First Level Practitioner and the NUM;

iii) Provide opportunities for new skills to be practised on the job;

iv) Deliver timely and accurate feedback and coaching for staff.

Given that today's First Level Practitioners will ultimately be tomorrow's administrators, it may well be that nursing will continue to develop towards increased job satisfaction through organisational cooperation with all levels of health carers being involved in the decision making processes as a result of increased knowledge of requisite skills.
Results from the current study have indicated that NUMs believe that the transfer of nursing education away from its traditional base to the tertiary centres has meant for them as first level managers a change in direction in terms of major areas of their role focus. This, they believe, coupled with inadequate information provision, has led to an inability on their part to adequately fulfil the management portion of their role as it currently exists.

It would appear that much of the experienced change in the role of the NUMs is due to poorly disseminated information concerning their own role since 1983. This has contributed to the role conflict currently being experienced by them.

The transfer of nursing education to tertiary education centres, has provided nurses with the opportunities to develop interpersonal skills, organisational skills and professional competence. By taking part in the decision making processes concerning the profession, these nurses will be in part controlling their own occupational environment instead of as in the past largely leaving the decision making to others. As a result, nurses of the future may not need to place so much reliance upon the hierarchical system (which has been the case in the past).

If professional practice is to be guided by change and nursing theory, competence in planning and evaluating performance levels is an essential skill for NUMs. It follows, that these NUMs must seek/be supplied with accurate and relevant information. Failure to do so will ensure that problems associated with role expectations, overload and conflict will continue unchanged. Similarly, inaction on the issue makes collection of
past, present and future data a useless activity. The present study may have raised more questions than it has actually answered. This may be regarded as proper in a domain in which to date little cumulative research has taken place. An important task for further research is to validate the findings of this study with varying samples of subjects from other hospitals employing graduates from the other universities throughout the state. This would determine whether or not those problems identified in this study are specific to the Lower Hunter Valley or are universal throughout NSW. Future research issues are identified below:

1. Do NUMs throughout other areas of Australia have the same perceptions as those in the Lower Hunter Valley as to how and why their role has changed since 1987?

2. How may role diffuseness and conflict be reduced for the NUMs in hospitals today?

3. How do the unspoken expectations of all staff, members impact upon the role performances by other members of the nursing team?

4. Has the advent of short-stay hospital care had a greater impact upon the role of the NUM than the presence of the First Level Practitioner?

5. What responsibility should graduate programmes and educational institutions each assume in preparing students for nursing practice realities?

It is suggested that these issues should be addressed in future studies.
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APPENDIX I

JOB DESCRIPTION FOR THE CHARGE NURSE

May: 1984

REQUIREMENTS FOR THE POSITION:

Fifth year and thereafter Registered General Nurse with a wide clinical experience in surgical (medical) nursing

LINE OF AUTHORITY: - Assistant Director of Nursing
- Deputy Director of Nursing
- Director of Nursing

DUTIES: (in broad terms)

[A] Communications
1. Paramedical departments
2. Relatives and friends of the patient
3. Ambulance transport
4. Accompanying medical officers on ward rounds
5. Nursing administration staff
6. Requisitions for store(extra ordinary store not on impress)
7. Requisitions for maintenance of the ward area and equipment in the area
8. Confer with team leaders and nursing staff team members as deemed necessary re the condition of patients.

[B] Records
2. Patient categories
3. Allocation of nurse to patients to cover both a.m. and p.m. shifts
4. Checking the medical records
5. Update the diet board
6. Check daily S8 and S4AD drugs
[C] General supervision of patients and staff
1. Frequent consultation with team leaders in ward areas
2. Inspection of bed areas and utility rooms
3. Attend routine round of the patients
4. Delegate responsibilities in absence

[D] Team Conference - 2.30 p.m. (handover)
JOB DESCRIPTION FOR NURSING UNIT MANAGER.

SEPTEMBER/89

HOSPITAL: NURSING DIVISION

JOB SPECIFICATION PROFILE: Nursing Unit Manager—Level

DATE ISSUED: REVISED NOVEMBER '86, AREA

DISTRIBUTION: i) Registered Nurse appointed to position
ii) Clinical/Departmental personnel folder

1. TITLE:
Nursing Unit Manager (in accordance with the New South Wales Public Hospital Nurses' (State) Award).

2. DEPARTMENT:
Nursing

3. ESSENTIAL QUALIFICATIONS OF THE REGISTERED NURSE:
3.1 Certified to practise in New South Wales
3.2 Appropriate clinical expertise and ability and a want to impart knowledge
3.3 Experience in clinical/departmental management, leadership qualities, ability to assess nursing and manpower needs, make sound judgement, and initiate appropriate action
3.4 Possess integrity and the ability to work congenially with superiors and relate harmoniously with other groups
3.5 Initiative and a desire to continually improve the quality of nursing practice
3.6 Satisfactory personal and professional standards in keeping with the "international code of nursing ethics" and in keeping with the "philosophy of the hospital"
3.7 Knowledge of the Nurses' Registration Act; relevant Department of Health circulars; New South Wales Public Hospital Nurses (State) Award; industrial framework.

4. POST BASIC AND TERTIARY QUALIFICATIONS:

4.1 The incumbent will be registered in the relevant discipline, and in other related specialty fields if appropriate.
4.2 The incumbent will possess/be undertaking relevant tertiary qualifications which possess appropriate management strands.

RESPONSIBLE TO: Director of Nursing

REPORT TO: Area Coordinator

STAFF APPRAISAL: At three months after appointment, annually and as necessary

5. FUNCTIONS AND RESPONSIBILITIES OF APPOINTEE:

5.1 PROFESSIONAL:

5.1.1 Act as role model for personal and professional standards for all staff. As necessary, give guidance in these matters to staff members in sphere of control.

5.1.2 Maintain level of knowledge and clinical competence in accordance with current developments (including legal aspects relevant to nursing practice).
5.2 ADMINISTRATIVE:

5.2.1 Administer (and provide) nursing service in areas assigned, in accordance with the philosophy, objectives, rules, policies, procedures and requirements of the:

i) Hospital, its Board of Management and other relevant bodies of authority (Department of Health, Nurses Registration Board and like bodies, as well as influencing Acts, e.g. Poison's Act)

ii) Nursing Division - to aim to maintain a satisfactory standard of care which will enhance the hospital's reputation in terms of both quality and cost effectiveness.

5.2.2 Prepare and adjust unit roster in accordance with the provisions of both the Public Hospital's (State) award and the staffing needs of the clinical area. Ensure individualised needs of patients are met by assigning nursing personnel commensurate to patients needs.

5.2.3 Carry out managerial functions so there is a safe environment for patients and staff and ensure that all members of the nursing team, are able to effectively function/coordinate activities and be aware of individual duties and responsibilities. Refer, when appropriate, to middle/senior management personnel when matters are beyond the scope of the nursing unit manager.

5.2.4 Ensure that nursing staff within the sphere of control do not violate patients' rights and that relatives and friends are treated with respect and understanding. Provide/arrange for provision of appropriate support to all persons.

5.2.5 Regularly evaluate and recognise performance standards of nursing personnel and offer counsel/guidance and/or appropriate praise as required. Complete performance appraisals on nursing staff rostered to the area at required intervals; or as
requested. Confer frequently with nominated team leaders.

5.2.6 As necessary confer with, through committees/meetings personnel from hospital disciplines/services and interested community groups in order to organise the delivery of optimal patient education and care, as total care extends beyond the hospitalisation period.

Convene Nursing Unit Meetings monthly with nursing staff. The nursing unit manager will convene and chair the meeting. The role of minute taker (arranged by the nursing unit manager) will be rotated through unit members. Minutes will be made available for all unit members to read. A copy of the minutes will be forwarded to designated senior nursing personnel.

5.2.7 Is a member by position, of various meeting memberships which evaluate nursing practice and utilise results of such programmes as a guideline for corrective action in areas where actual performance does not meet desired goals.

5.2.8 Attend and participate in, other relevant nursing staff meetings held for the purpose of discussing matters relevant to the nursing division. Ensure requests are forwarded to appropriate personnel for maintenance/requirement/additions, etc as necessary.

5.2.9 Provide information on statistical data to nursing Administration and/or other branches of the hospital administration as directed (including notification of patients death and staff/patient incidents etc)

5.2.10 Provide support and guidance and direction as required for student nurses (N.C.A.E.) gaining clinical experience in the hospital.
5.2.11 Establish and maintain an intelligent liaison between all members of the professional health team.

5.2.12 Ensure adequate stock levels are maintained by reviewing requirements regularly. A positive attitude will be promoted to nursing personnel about cost containment and staff will be routinely made cognisant of peaks in utilisation and reasons for same.

5.2.13 All documentation which is recommending change will be supported by adequate research to enable those persons to whom the submission is being forwarded to be cognisant of all related factors.

5.3 CLINICAL

5.3.1 Monitor the implementation of the nursing process and documentation of patient care within the clinical area. Provide support and feedback/guidance to nursing staff as appropriate to ensure that the management of patient care is adequate and appropriate. Ensure that drugs are stored and handled appropriately within the unit, and accountable drugs are checked according to the policy of the nursing unit division, with discrepancies being reported/documentated appropriately.

5.3.2 Ensure that special clinical procedures for patient care are safely implemented after the initiation of a suitable clinical education programme for self and staff.

5.3.3 Ensure that nursing staff working within the unit are cognisant of the procedures to be followed in the event of cardiac arrest, fire and internal or external disaster.

5.3.4 Maintain effective communication utilising such avenues as change of shift handover sessions, unit conferences, unit meetings, documentation.
5.4 PERSONNEL:

5.4.1 Initiate and ensure continuing education (Education forum, inservice staff development, special education programmes, orientation and clinical nurse teaching rounds) activities are viable for clinical/departmental personnel. Initiate and follow up as necessary.

5.4.2 Ensure new/redeployed nursing personnel are adequately oriented to the new clinical departmental area. Self initiated follow up of such personnel will occur as a matter of routine.

5.4.3 Liaise with the Infection Control Nurse and appointed resource personnel to keep abreast of and maintain infection control and clinical goals.

5.4.4 Confer frequently with senior administrative staff to discuss nursing and personnel problems that require action beyond the scope of authority.

5.4.5 Foster an environment that is conducive to promoting self development, self awareness and self esteem.

5.4.6 Maintain an awareness of sickness/absenteeism of staff in scope of control, taking relevant action as necessary.

5.4.7 Confer and advise ward hostess in regard to assigned duties, policies and procedures as necessary.

5.4.8 Confer with auxiliary staff (ward hostess, wardsmen, and ancillary personnel responsible on a day to day basis to the person in charge of the clinical/departmental area) with regard to assigned duties, policies and procedures as necessary. Participate in/complete performance evaluation as requested by the ancillary person's departmental head through nursing administration.
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<tr>
<th>Name of Incumbent</th>
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<tr>
<td>Director of Nursing</td>
<td>Date of Appointment</td>
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APPENDIX III

QUESTIONNAIRE FOR DIRECTORS OF NURSING

1. Name of Hospital
   ROYAL NEWCASTLE 1
   MATER 2
   WALLSEND 3
   MAITLAND 4
   BELMONT 5

2. Is there a formal policy which dictates the number of graduates employed by the institution?
   YES 1
   NO 2

3. How many graduates are normally placed into a specific unit at a time?

4. Who allocates resources for the purposes of integration of the first level practitioners:
   FEDERAL GOVERNMENT 1
   STATE GOVERNMENT 2
   HUNTER AREA HEALTH SERVICE 3

5. Is there a set amount allocated to this hospital?
   YES 1
   NO 2
6. How much is allocated each year?

7. Are specific programmes available for the integration of the first level practitioners?
   YES 1
   NO  2

8. Are the programmes cost effective in terms of cost?
   YES 1
   NO  2

   Resources  YES 1
              NO  2
   Time       YES 1
              NO  2
   Personnel  YES 1
              NO  2

9. Have the programmes been altered during the last three years?
   YES 1
   NO  2

10. What was the reason for changing the programmes?

11. Is it hospital policy to "buddy" the First Level Practitioners?
    YES 1
    NO  2

12. How long are the First Level Practitioners buddied before being allowed to work independently in the wards?
    1 WEEK   1
    2 WEEKS  2
    3 WEEKS  3
    >3 WEEKS 4
13. Do First Level Practitioners spend a predetermined length of time rotating through the various units during the first twelve months?
   YES 1
   NO 2

14. How much time is spent in each unit by the First Level Practitioners?
   < 6 weeks 1
   6 weeks 2
   7-10 weeks 3
   11-12 weeks 4
   >12 weeks 5

15. Are specific wards/units used for the integration of the First Level Practitioners?
   YES 1
   NO 2

16. If the answer to question 15 was yes, please state which wards are used?

17. Is the same method used to evaluate the performance of the First Level Practitioners as is used for the rest of the registered nurses in the hospital?
   YES 1
   NO 2

18. Which method is used to evaluate the performance of the First Level Practitioners?

19. Who is responsible to evaluate the performance of the First Level Practitioners?
   NURSING UNIT MANAGER 1
   PRECEPTORS 2
   CLINICAL NURSE SPECIALIST 3
   STAFF DEVELOPMENT PERSONNEL 4
20. Are you given the results of the performance of the First Level Practitioners?
   YES 1
   NO  2

21. How often is the performance of the first level practitioner evaluated?
   EVERY 3 MONTHS  1
   3-5 MONTHS      2
   6-9 MONTHS      3
   10-12 MONTHS    4

22. As a result of being involved in the writing of the course curriculum for the tertiary education of these nurses did you have any preconceived expectations regarding the clinical skills of the graduates?
   YES 1
   NO  2

23. Were these expectations realistic?
   YES 2
   NO  2

24. Have these expectations altered since 1987?
   YES 1
   NO  2

25. If you answered yes to question 24, please identify which of your expectations has changed?
26. Which specific needs of the First Level Practitioners were identified by your staff prior to the commencement of the First Level Practitioners?
**APPENDIX IV**

**QUESTIONNAIRE FOR NURSING UNIT MANAGERS**

CONFIDENTIAL

PLEASE NOTE: FIRST LEVEL PRACTITIONER REFERS TO GRADUATES FROM TERTIARY INSTITUTIONS WHO HAVE LESS THAN TWELVE MONTHS EXPERIENCE.

**PART A**

1. Name of Hospital where you are working:
   - Royal Newcastle Hospital 1
   - Mater Hospital 2
   - Wallsend Hospital 3
   - Belmont Hospital 4
   - Other Hospital 5

2. Type of Ward/Unit in which you are working:
   - Medical 1
   - Surgical 2
   - Oncology 3
   - Gynaecology 4
   - Rehabilitation 5
   - Trauma 6
   - Accident & Emergency 7
   - Orthopaedic 8
   - Paediatric 9
   - Other (please specify) 10
3. Do you have any Post Registration/Tertiary qualifications?
   YES  1
   NO   2

4. If you answered yes to Question 3, please state type of qualification.
   If you answered no, please proceed to question 5.

5. Is there a hospital policy which states when a First Level Practitioners may work independently in the ward/unit?
   YES  1
   NO   2

6. If you answered yes to Question 5, please answer this question. If you answered no, please proceed to question 7.
   What is the minimum time before a first level practitioner may work independently in the ward/unit?
   LESS THAN 3 DAYS 1
   3 DAYS 2
   1 WEEK 3
   2 WEEKS 4
   > 4 WEEKS 5

7. As the Nursing Unit Manager, you have autonomy in decision making relating to your unit.
   STRONGLY AGREE 1
   AGREE 2
   DISAGREE 3
   STRONGLY DISAGREE 4

8. You were well prepared for the arrival of the First Level Practitioners.
   STRONGLY AGREE 1
   AGREE 2
   DISAGREE 3
   STRONGLY DISAGREE 4
9. Your expectations of the ability of the First Level Practitioners were realistic.
   STRONGLY AGREE  1
   AGREE  2
   DISAGREE  3
   STRONGLY DISAGREE  4

10. Your expectations of the First Level Practitioners have altered since their arrival in 1987.
    STRONGLY AGREE  1
    AGREE  2
    DISAGREE  3
    STRONGLY DISAGREE  4

11. Your role focus has altered since the First Level Practitioners became part of the nursing team.
    STRONGLY AGREE  1
    AGREE  2
    DISAGREE  3
    STRONGLY DISAGREE  4

12. Since the inclusion of the First Level Practitioner as part of the unit team, you spend more time;
    A) Interacting with clients/patients:
       STRONGLY AGREE  1
       AGREE  2
       DISAGREE  3
       STRONGLY DISAGREE  4

    B) Coordinating patient client care:
       STRONGLY AGREE  1
       AGREE  2
       DISAGREE  3
       STRONGLY DISAGREE  4
C) Performing administrative duties:

- STRONGLY AGREE 1
- AGREE 2
- DISAGREE 3
- STRONGLY DISAGREE 4

D) Coordinating client safety:

- STRONGLY AGREE 1
- AGREE 2
- DISAGREE 3
- STRONGLY DISAGREE 4

13. The Nursing Administration of the Hospital generally understands the needs and priorities of the Nursing Unit Manager with regard to the First Level Practitioners:

- STRONGLY AGREE 1
- AGREE 2
- DISAGREE 3
- STRONGLY DISAGREE 4

14. Effective organisational support for your needs is offered to Nursing Unit Managers by the Nursing Administration in the Hospital:

- STRONGLY AGREE 1
- AGREE 2
- DISAGREE 3
- STRONGLY DISAGREE 4
15. The inclusion of the First Level Practitioner as part of the nursing teams has increased your time spent;

a) Supervising staff

| STRONGLY AGREE | 1 |
| AGREE          | 2 |
| DISAGREE       | 3 |
| STRONGLY DISAGREE | 4 |

b) Monitoring Nursing Care Activities:

| STRONGLY AGREE | 1 |
| AGREE          | 2 |
| DISAGREE       | 3 |
| STRONGLY DISAGREE | 4 |

16. How frequently is the performance of the First Level practitioner evaluated?

| LESS THAN 3 MONTHS | 1 |
| EVERY 3 MONTHS     | 2 |
| 3-6 MONTHS         | 3 |
| EVERY 6 MONTHS     | 4 |
| EVERY TWELVE MONTHS | 5 |

17. Who is responsible for evaluating the performance of the first level practitioner?

| NURSING UNIT MANAGER | 1 |
| PRECEPTOR            | 2 |
| STAFF DEVELOPMENT OFFICER | 3 |
| CLINICAL SPECIALIST  | 4 |
| WARD STAFF           | 5 |
| OTHER (PLEASE SPECIFY) | 6 |
18. Who is responsible for integrating the First Level Practitioners into the ward/unit?

- NURSING UNIT MANAGER 1
- PRECEPTOR 2
- STAFF DEVELOPMENT OFFICER 3
- CLINICAL SPECIALIST 4
- WARD STAFF 5
- OTHER (PLEASE SPECIFY) 6

** PART C **

19. Please rank in order (from 1 to 13) those skills which you expected the First Level practitioner to have the most difficulty with when they commenced as part of the nursing team.

- LACK OF KNOWLEDGE
- REPORT WRITING
- COMMUNICATION WITH CLIENTS
- DEALING WITH AGGRESSIVE CLIENTS
- SHIFT WORK
- MEDICATION ADMINISTRATION
- ACCOUNTABILITY
- LEGAL ASPECTS OF PRACTICE
- DECISION MAKING
- INTERACTING WITH CLIENTS RELATIVES
- INEXPERIENCE
- OTHER

20. The inclusion of the First Level Practitioners as part of the nursing team has increased the time you spend;

a) Directly teaching staff:

- STRONGLY AGREE 1
- AGREE 2
- DISAGREE 3
- STRONGLY DISAGREE 5
b) Directly teaching patients/clients:

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** PART D **

21. Do you normally assume a patient/client load each day?

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22. How many patients/clients do you normally care for?

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23. Did you assume a patient/client load prior to the commencement of the First Level Practitioners?

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24. Since the inclusion of First Level Practitioners into the nursing team you now spend more time;

a) Delivering Direct patient care

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b) Consulting with Medical/other staff:

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<tr>
<td>DISAGREE</td>
<td>3</td>
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<tr>
<td>STRONGLY DISAGREE</td>
<td>4</td>
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</tbody>
</table>
c) Reading reports (x-ray, pathology, patient progress notes):

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<table>
<thead>
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<tbody>
<tr>
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<td>AGREE</td>
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<tr>
<td>DISAGREE</td>
<td>3</td>
</tr>
<tr>
<td>STRONGLY DISAGREE</td>
<td>4</td>
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</tbody>
</table>

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY. PLEASE MAKE ANY FURTHER COMMENTS WHICH MAY IDENTIFY HOW YOUR ROLE FOCUS HAS ALTERED SINCE THE FIRST LEVEL PRACTITIONERS BECAME PART OF THE NURSING TEAMS.
APPENDIX V

QUESTIONNAIRE FOR FIRST LEVEL PRACTITIONERS

THANK YOU FOR AGREEING TO PARTICIPATE IN THIS SURVEY. ALL INFORMATION COLLECTED WILL BE TREATED CONFIDENTIALLY AND WILL BE ONLY USED FOR THE PURPOSES OF RESEARCH. YOU WILL NOT BE ABLE TO IDENTIFY YOURSELF WHEN THE RESULTS ARE FINALISED. PLEASE DO NOT WRITE YOUR NAME ON THIS FORM.

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS BY PLACING THE NUMBER WHICH CORRESPONDS WITH YOUR ANSWER INTO THE BOX ON THE RIGHT HAND SIDE OF THE PAGE E.G.

1
2
3  2
3

1. Hospital at which you are employed;
   Royal Newcastle Hospital  1
   Mater Hospital  2
   Wallsend Hospital  3
   Belmont Hospital  4
   Maitland Hospital  5

2. In which year did you graduate?
   1987  1
   1988  2
   1989  3
3. Do you have a:
- NURSING DIPLOMA 1
- NURSING DEGREE 2
- OTHER 3

4. How long have you been employed by this hospital?
- 1 month 1
- 3-6 months 2
- 7-12 months 3
- >12 months 4

5. Is this the only hospital at which you have worked?
- YES 1
- NO 2

6. Please identify the type of unit in which you are currently working;
- Medical 1
- Surgical 2
- Oncology 3
- Gynaecology 4
- Rehabilitation 5
- Trauma 6
- Accident and Emergency 7
- Orthopaedic 8
- Paediatric 9
- Other (please specify) 10

7. Is this the first unit in which you have worked?
- YES 1
- NO 2

8. How long have you worked in this unit?
- 1 month 1
- 1-3 months 2
- 4-6 months 3
- 7-12 months 4
- >12 months 5
9. Are you the only First Level Practitioner working in this unit?
   YES  1
   NO   2

10. If you answered no to Question 9, please identify how many other First Level Practitioners work with you in the unit. If you answered yes to Question 9, please proceed to Question 11.

** PART B **

11. How long was your orientation programme at this hospital?
   3 DAYS  1
   1 WEEK  2
   2-3 WEEKS  3
   4-6 WEEKS  4
   > 6 WEEKS  5

12. How long was your orientation to this unit?
   1 HOUR  1
   2 HOURS  2
   3 HOURS  3
   4-6 HOURS  4
   > 6 HOURS  5

13. Did you receive sufficient support for your needs from the Nursing Unit Manager to prepare you for your responsibilities when you commenced as a First Level Practitioner?
   YES  1
   NO   2
14. Which member of staff orientated/integrated you into the unit when you first commenced?

NURSING UNIT MANAGER 1
PRECEPTOR 2
CLINICAL NURSE SPECIALIST 3
WARD NURSING STAFF 4
OTHER (PLEASE SPECIFY) 5

15. Which of the following people provided the most useful information during your integration into the unit?

NURSING UNIT MANAGER 1
PRECEPTOR 2
CLINICAL NURSE SPECIALIST 3
OTHER (PLEASE SPECIFY) 4

16. When you commenced as a First Level Practitioner were you "Buddied " with another registered nurse?

YES 1
NO 2

17. How long did you work in the unit before you were given the responsibility of a full client/patient load:

1 DAY 1
3 DAYS 2
1 WEEK 3
2-3 WEEKS 4
>3 WEEKS 5

18. If you have worked night duty, please answer this question. Otherwise proceed to Question 21.

How long did you work before you commenced night duty?

< 6 MONTHS 1
6 MONTHS 2
7-12 MONTHS 3
19. In what capacity did you work on night duty?
   NURSE IN CHARGE OF WARD  1  
   JUNIOR REGISTERED NURSE  2  

20. Do you feel that you were well prepared for the responsibility of 
    night duty when you first commenced it?
   YES  1  
   NO   2  

21. How often is your performance as a registered nurse evaluated?
   > 3 MONTHS  1  
   EVERY 3 MONTHS  2  
   3-6 MONTHS  3  
   EVERY 6 MONTHS  4  
   EVERY 12 MONTHS  5  

22. Who evaluates your performance?
   NURSING UNIT MANAGER  1  
   PRECEPTOR  2  
   STAFF DEVELOPMENT OFFICER  3  
   CLINICAL NURSE SPECIALIST  4  
   OTHER (PLEASE SPECIFY)  5  

** PART C  **

23. Were your expectations of being a registered nurse when you were a 
    student different to the reality you now experience?
   YES  1  
   NO   2  

XXVIII
24. If you answered yes to Question 23, please identify what it was that was different for you by placing a cross in the appropriate boxes:

1. RESPONSIBILITY
2. ACCOUNTABILITY
3. COMMUNICATION WITH CLIENTS
4. TIME MANAGEMENT
5. SHIFT WORK
6. INTERACTION WITH OTHER STAFF
7. OTHER (PLEASE SPECIFY)

25. Please rank from 1 to 6 which of the following roles you expected the Nursing Unit Manager to fulfil during your integration to the unit team.

SUPPORT PERSON
TEACHER
FACILITATOR
ASSESSOR
ROLE MODEL
SUPERVISOR
CARE DELIVERER

26. Do you feel that the tertiary institution prepared you appropriately for your role of Registered Nurse?

YES  1
NO  2

27. If you answered No to question 26, please explain what was inadequate about you preparation?

28. Please rank in order from 1 to 13 your greatest concerns before you commenced practice as a Registered Nurse;

LACK OF KNOWLEDGE
INEXPERIENCE
REPORT WRITING
COMMUNICATION WITH CLIENTS
REACTIONS OF OTHER STAFF MEMBERS TO YOU
DEALING WITH AGGRESSIVE CLIENTS
SHIFT WORK
MEDICATION ADMINISTRATION
ACCOUNTABILITY
LEGAL ASPECTS OF PRACTICE
DECISION MAKING
INTERACTING WITH CLIENTS RELATIVES

29. Were these concerns justified?
   YES  1
   NO   2

30. If you answered No to question 29, please explain what was different?

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY. PLEASE MAKE ANY FURTHER COMMENTS WHICH MAY IDENTIFY YOUR PERCEPTIONS OF YOUR INTEGRATION AS A FIRST LEVEL PRACTITIONER.
APPENDIX VII

RAW DATA FROM QUESTIONNAIRES TO FIRST LEVEL PRACTITIONERS

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231213122125122231213122125122
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