



Feasibility of supporting newly qualified nurses: Nominal group technique of the perspectives of nursing stakeholders



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ARTICLE INFO

Article history:

Received 5 November 2021

Revised 17 May 2022

Accepted 5 July 2022

Keywords:

Nursing

Newly qualified nurses

Transition programs

Education, clinical

Students, nursing

Nominal Group Technique

ABSTRACT

Background: As the health industry grows, integration of newly qualified nurses into the workplace is critical to workforce sustainability. In one health service, a work-based student learning program, the Collaborative Clusters Education Model, was extended to support newly qualified nurses in their transition to the workplace.

Aim: To describe the feasibility of the Collaborative Clusters Education Model to support newly qualified nurses.

Design: Evaluative methodology using Nominal Group Technique.

Methods: Convenience and snowball sampling were used to recruit participants from three stakeholder groups: clinical nurse facilitators (two groups: n1 = 7; n2 = 5), nurse leaders (n = 9) and practice partners, registered nurses who support with newly qualified nurses (n = 5). Groups provided nominal rankings of ideas (quantitative data) and group discussions were recorded and professionally transcribed (qualitative data). Data analysis involved three stages: i) quantitative analysis; ii) qualitative analysis and iii) synthesising qualitative and quantitative data to create meaning.

Results: The priorities focused broadly on the challenges associated with individual and organisational capacity to support newly qualified nurses. In addition to capacity, clinical facilitator capability, teamwork and communication, and role ambiguity were identified as key issues.

Conclusions: The feasibility of supporting newly qualified nurses via the Collaborative Clusters Education Model would be enhanced with improved alignment between stakeholder roles and responsibilities. In contemporary workplaces, characterised by distributed responsibility for learning support, there is a need for increased role clarity across the stakeholder team. Furthermore, the need for improved access to experienced mentors points to the potential of team-based models of nursing care delivery.

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Summary of relevance

Problem or Issue

Transition of newly qualified nurses into the workplace is critical for workforce sustainability. Innovation is required to accommodate workforce changes whilst supporting transition of newly qualified nurses.

What is already known

Clinical models to support transition of newly qualified nurses, such as preceptorship and supervision models, are not sustainable. The Collaborative Clusters Education Model was developed to provide support for both student nurses and newly qualified nurses.

What this paper adds

There is a need for increased role clarity amongst stakeholders supporting transition of newly qualified nurses. Team nursing models may enhance newly qualified nurses' access to experienced mentors.

1. Introduction

The hours dedicated to work-based learning experiences in pre-registration nursing education are shrinking. For example, in Australia, the Registered Nurse program accreditation requirement is a minimum of 800 hours experience in clinical practice (ANMAC, 2019). Newly Qualified Nurses (NQN) require significant support as they transition to the workforce (Schwartz, 2019).

Recruitment and retention of Registered Nurses is necessary to maintain a sufficient, highly skilled nursing workforce. Transition programs have been found to increase retention of NQNs (Ackerson & Stiles, 2018; Van Camp & Chappy, 2017) and deliver financial benefits when balanced against the impact of turnover and contract labour usage (Trepanier, Early, Ulrich, & Cherry, 2012). Transition programs generally include didactic education, clinical support and mentorship by preceptors to develop practice (Van Camp & Chappy, 2017). As the workforce, and indeed the workplace, changes over time, clinical models to support the transition of NQNs into the workplace, such as preceptorship, are not sustainable (Snaveley, 2016). For example, in one health service, the costs associated with implementation and maintenance of the preceptorship model were considered too high for the organisation (Grealish et al., 2018). Sustainable models for transitional support are urgently required.

1.1. Background

The Collaborative Clusters Education Model (CCEM) is an adaptation of the Dedicated Education Unit (DEU) model of clinical placement for nursing students (Edgecombe, Wotton, Gonda, & Mason, 1999; Moore & Nahigian, 2013; Mulready-Shick & Flanagan, 2014). The CCEM is a hospital-led program and was originally developed to support Bachelor of Nursing students on clinical placement in hospital settings. In the CCEM, the hospital provides clinical nurse facilitators, known as Entry to Practice (E2P) Facilitators, who work in teams to support nursing student learning (Van de Mortel et al., 2020).

The CCEM was originally developed to address the risk of depleting the skill mix in wards. Depletion occurred through university recruitment of experienced clinical staff to supervise nursing students in small groups of six to eight students (Grealish et al., 2018). As with other countries, these supervisory registered nurses often do not work in their area of clinical expertise (Laugaland et al., 2021), thereby depleting the skill mix in the health service. In the CCEM, multiple wards are grouped into a 'cluster', providing

clinical placement for up to 30 students that are collectively supervised by three to four E2P Facilitators. Direct clinical support by Registered Nurses working on the ward, referred to as Practice Partners, is a key feature of this model. Practice Partners work closely with students, providing access to learning experiences that meet students' course requirements.

Although the CCEM was developed for student supported learning on placement, the E2P Facilitators also provide support for NQNs in their first six to eight weeks in the workforce (Van de Mortel et al., 2020). The NQNs work closely with their Practice Partner, carrying responsibility for the care of up to four patients. The Practice Partner provides ongoing collegial mentorship/support, in the form of teaching, demonstrating, listening and other supportive activities. All NQNs are provided with the opportunity to work surplus to the required staffing i.e., supernumerary, however the length of supernumerary working varies across wards. Nurse Educators and ward-based clinical facilitators, who are responsible for providing support to all nursing staff employed in the ward, carry oversight of NQN professional development in consultation with the Nurse Unit Manager. The Entry to Practice (E2P) Educator organises the didactic element of the NQN transition program, including an orientation day and three one-day professional development workshops offered throughout the first 12 months of practice. The feasibility of extending the CCEM to support the transition of NQNs to the workplace may assist in addressing the challenges associated with the dynamic and evolving workplace.

2. Methods

2.1. Aim

To describe the feasibility of the Collaborative Clusters Education Model to support newly qualified nurses.

2.2. Design

In this study, feasibility is operationally defined as the extent to which an innovation can be carried out within an agency or setting (Karsh, 2004). The foci of interest are the challenges experienced by stakeholders to integrate NQNs into the CCEM. To investigate these challenges, the study design followed an evaluative methodology using Nominal Group Technique. Nominal Group Technique provides a structured way to obtain consensus or agreement on a topic and involves collection of both qualitative (discussions generating ideas) and quantitative (ranking of ideas) data (McMillan, King, & Tully, 2016). Nominal Group Technique provides a time-efficient method of collecting data from multiple participants in a group setting, enabling all participants to contribute equally without risk of domination by an individual (McMillan et al., 2016).

2.3. Setting/Participants

Two hospitals from one health service in southeast Queensland, Australia were the setting for this study. These hospitals employ approximately 150 NQNs each year and provide placements for 230 student nurses each week from March to December.

Three groups were identified as nursing stakeholders in the CCEM: i) E2P Facilitators; ii) Clinical Leaders (including Nurse Unit Manager, Nurse Educator or ward-based Clinical Facilitator); and iii) Practice Partners, registered nurses who support NQNs. Recruitment of participants to represent each group involved convenience and snowball sampling. Flyers advertising the study were displayed in staffrooms. Study information was disseminated via staff email and presented at team meetings. Participants were encouraged to

Table 1
Nominal Group Technique steps of data collection*.

Step	Summary	Rationale
Step 1: Silent generation	Participants were given five minutes of silent writing time to independently document their ideas in response to the trigger question.	It was emphasised that there were no right or wrong answers; Participants were encouraged to note any idea that came to mind.
Step 2: Round robin	Each participant, in turn, contributed a single idea. Participant ideas were recorded on a whiteboard. This step continued until there were no further participant ideas.	No discussion of ideas occurred in this step. Participants were encouraged to add to their original list if another participant's response triggered a new idea.
Step 3: Clarification	Each idea was discussed to clarify the meaning of the idea for participants. Similar ideas were grouped (if all participants consent to this), duplicates were removed and any new ideas added.	The aim was not to achieve consensus, but rather ensure all ideas were represented on the whiteboard.
Step 4: Ranking	Participants individually and anonymously ranked the five most significant challenges of the CCEM from the list of ideas on the whiteboard, from most significant challenge (5 points) to the 5th most significant challenge (1 point).	Ranking permitted 'real-time' generation of results for each nominal group, enabling member validation.

* Adapted from McMillan et al. (2016).

identify colleagues who may also be interested in study participation.

Participants were provided with written information about the study and written consent was obtained. Participants were released to participate during work time. Ethics approval was obtained from the university (GU Ref No: 2018/971) and health service (LNR/2018/QGC/45768).

2.4. Data collection

A nominal group was held for each stakeholder group. This grouping avoided potential conflicts of interest or unequal power relationships that could unintentionally influence the contribution of a participant (Cleary, 2001). The groups met in hospital seminar rooms. Three members of the research team (KR, SM, RW) attended each group to: i) facilitate discussion; ii) record discussion ideas on the board; or iii) record field notes. Discussions were audio-recorded and professionally transcribed.

Participants were asked the question: What are the challenges of the Collaborative Clusters Education Model (CCEM) in supporting NQNs? This question was used to focus on the challenges related to structures and processes, and therefore feasibility, of the CCEM. Data collection proceeded over four discrete steps during a single group meeting: (1) silent generation, (2) round robin, (3) clarification and (4) ranking. These steps are summarised in Table 1.

2.5. Data analysis

i) Quantitative analysis

Participant demographic information and ranking sheets were entered into Excel for analysis. Demographic data were summarised by calculating frequency and percentage for categorical variables and mean and standard deviation for continuous variables. Participant rankings were scored by awarding five points to a 1st placed ranking (most significant challenge) through to one point for a 5th placed ranking (5th most significant challenge). The frequency (or popularity) of an identified challenge as well as the importance of the challenge through summing of ranking scores was calculated for each group. The top five challenges for each group were identified. Participants obtained a summary of the ranked findings for their group at the end of the session as part of Step 4 of the Nominal Group Technique.

i) Qualitative analysis

Two researchers (KR, SM) undertook inductive coding, as described by Miles and Huberman (1994), of the professional transcriptions created from the audio recording of each nominal group

discussion. This analysis resulted in a primary coding frame which was then discussed with the research team to establish agreement. Final categories were summarised and exemplified with key quotes from participants.

i) Synthesising quantitative and qualitative data

The research team met to review the two datasets and discuss what it might mean, generating a greater understanding of the feasibility of the CCEM to support NQN transition to the workplace. Discussion focused on integrating each of the qualitative themes with the most highly ranked challenges to identify key themes related to feasibility.

3. Results

Four nominal groups were held between February and May 2019. Two groups were held for E2P Facilitators (n1 = 7; n2 = 5), one group for Clinical Leaders (n = 9) and one group for Practice Partners (n = 5). The average duration of the group discussions was 48 minutes (range 42–59 minutes). Of the 26 participants, 85% were female and 78% had more than five years of experience in nursing (range 2–35 years; $M = 13.6$; $SD = 10.0$). Notably, 67% had five years or less in their current position. The majority of participants (86%) had completed the health service preceptorship workshop.

3.1. Quantitative findings

The five most significant challenges of the CCEM regarding support for NQNs according to ranked priorities for each group are presented in Table 2.

All groups ranked 'lack of E2P time' highly, reflecting a perceived unmet need for E2P Facilitator support for NQNs. E2P Facilitators were challenged by limited opportunities to support NQN, citing limited NQN supernumerary time and a focus on nursing student support by mid-year, limiting opportunities to monitor NQN progress. These concerns were further confounded when NQNs were reluctant to seek support, further reducing opportunities for E2P Facilitators to support NQNs.

The lack of understanding of the E2P role, and the necessary skill set to perform the role were expressed as challenges across groups. E2P Facilitators cited 'E2P understanding of the role', 'perception of the E2P role' and 'E2P workflow' as challenges that reflect the need for role clarification. For Clinical Leaders and Practice Partners, the 'E2P skillset' is raised as a challenge. The challenge of skillset may reflect unmet expectations about the E2P Facilitator role. Related to the need for role clarification, communication, and specifically what is communicated, by whom and when, were raised as challenges for E2P Facilitators.

Table 2
Aggregated NGT results, top 5 ranked results from each group.

E2P Group 1	Priorities (scores from each participant)							Sum of scores	Relative Importance (%)	Frequency of voting	Ranked priority (via score)				
	1	2	3	4	5	6	7								
Lack of E2P time	3	5	1	4	3	5	4	25	23.8	7	1 st				
Lack of NQN supernumerary time	2	3		5	2	4	2	18	17.1	6	2 nd				
Lack of support for mid-year / E2P time	4	4	2	3			1	14	13.3	5	3 rd				
E2P understanding of own role		1	3	2	1		3	10	9.5	5	4 th				
Lack of communication	5						2	7	6.7	2	5 th				
E2P Group 2	Priorities (scores from each participant)					Sum of scores	Relative Importance (%)	Frequency of voting	Ranked priority (via score)						
	1	2	3	4	5										
Lack of E2P time	5	5	5	2	3	20	26.7	5	1 st						
NQN reluctance to seek support	4	4		5	1	14	18.7	4	2 nd						
Perception of the E2P role	2	2	2	3	4	13	17.3	5	3 rd						
Communication		3	3	4	2	12	16.0	4	4 th						
Workflow of E2P	1	1	4	1		7	9.3	4	5 th						
Clinical Leaders	Priorities (scores from each participant)									Sum of scores	Relative Importance (%)	Frequency of voting	Ranked priority (via score)		
	1	2	3	4	5	6	7	8	9						
Limited E2P staff and time			4	4	5	4	4	4	5	5	5	40	29.6	9	1 st
Skill mix issues			5	2	2	3	5	3	3	1	4	28	20.7	9	2 nd
NQN workshops and training days and E2P skills on ward			1	5		5	3	2	2	4	3	25	18.5	8	3 rd
E2P skillset			2	3	4			2	5	4	2	22	16.3	7	4 th
Design and layout of clinical areas			3			2					3	8	5.9	3	5 th
Practice Partners	Priorities (scores from each participant)					Sum of scores	Relative Importance (%)	Frequency of voting	Ranked priority (via score)						
	1	2	3	4	5										
Limited E2P Facilitators				5	5	4	5			19	25.3	4	1 st		
Lack of E2P skill set (familiar face rather than constructive support)		4	4	4			2			14	18.7	4	2 nd		
Level of skill mix and acuity of ward				5	5	4				14	18.7	3	3 rd		
Lack of time (E2P) and lots of students		2	3	3	3					11	14.7	4	4 th		
Lack of time for practice partners				2	2					4	5.3	2	=5 th		
Need for preceptorship training		1					3			4	5.3	2	=5 th		

Table 3
Categories and sub-categories.

Category	Sub-category
Capacity	E2P Facilitator capacity
	Practice Partner capacity
	Health service capacity
E2P Facilitator Capability	Skill set
	Perceptions and expectations
Teamwork and communication	Within E2P teams
	Between E2P Facilitators and wards
Role ambiguity	Between E2P Facilitators and NQNs
	Feedback
	Expectations

For Clinical Leaders and Practice Partners, the challenges are related to how the NQN can be included into the ward team citing, the ‘skillmix’, or how many NQNs are rostered on each shift, as a shared challenge. Clinical Leaders reported several challenges, including: releasing NQNs for mandatory training components of the transition program, staffing the ward to accommodate its physical layout, and how to support NQNs in a single room environment that limited observation of practice. Reflecting their interest in providing high quality support to NQNs, Practice Partners ranked ‘lack of time’ and ‘need for preceptorship training’ as key challenges.

3.2. Qualitative findings

Four major categories were identified from analysis of transcriptions: capacity; E2P facilitator capability; teamwork and communication; and role ambiguity (see Table 3).

3.3. Capacity

The finite capacity of the E2P Facilitators to provide direct clinical support to NQNs was attributed to a lack of time and limited numbers of E2P Facilitators supporting large numbers of students.

“... we are so spread thin with students let alone even being able to think about NQNs.” (E2P Facilitator, Group 1)

Some E2P Facilitators highlighted that the challenges associated with limited time were exacerbated by disrupted workflow attributed to movement between multiple wards that were often geographically distant. Limited time was compounded when the NQN was not available when the E2P Facilitator arrived:

“...you go onto so many different wards that you don’t know routine...You go there and then you have to leave because [the NQN is] on a break or something like that... you waste a whole lot of time and achieve nothing.” (E2P Facilitator, Group 2)

Practice Partners expected E2P Facilitators to provide direct supervision of practice. For example, one described a request for clinical support to assist an NQN caring for a patient with a tracheostomy:

“We’re always told that the limited number of staff, and they have how many wards that they’re taking care of, so they cannot really do that...” (Practice Partner)

Practice Partners raised concerns about their own capacity to fulfil their clinical roles as well as providing support for NQNs. This group noted that no additional time is allocated for them to support NQNs, indicating that they see peer support and patient care delivery as separate activities.

“There’s not... allocated time to spend with them [NQNs]...As a more experienced nurse, you kind of precept everyone, but there’s not any specific time allocated for a NQN.” (Practice Partner)

Lack of supernumerary time for NQNs was identified and reiterated as a related issue, with variation in supernumerary time across the wards, from two days to three weeks. The lack of super-

numerary time was reportedly more pronounced for the mid-year NQN intake, when the health service was at capacity providing student nurse placements. Limited supernumerary days were reported to subsequently impact the capacity of E2P Facilitators and Practice Partners to support NQNs.

For health service capacity, staff skill mix and the ward layout was consistently identified as problematic and impacting support for NQNs. As described by one Clinical Leader:

“The size of the ward and the dilution of experienced nurses in the physical layout means that you don’t have that experienced nurse nearby at all anymore...You’re very isolated in the single rooms, and the single rooms take a very long, long, long corridor in every area.”

3.4. E2P Facilitator capability

E2P Facilitator capability was expressed as a tension between supporting learning technical nursing skills and supporting the acquisition of critical thinking skills to enhance clinical judgement. For E2P Facilitators, their clinical expertise may not be relevant to the cluster of wards in which they were supporting NQNs, raising questions about their capability to supervise NQNs in that practice area:

“Because a lot of us don’t have experience in the wards that we go to, they [NQNs] go, ‘what’s the point of you coming here, you guys don’t know.’” (E2P Facilitator, Group 1)

However, Clinical Leaders and Practice Partners recognised this diversity of specialisations within the E2P Facilitator team and acknowledged that whilst an E2P Facilitator may not have clinical experience in the area that the NQN is employed, they had a role in assisting NQNs to troubleshoot emerging problems:

“[E2P Facilitators] don’t really need to know everything; they just have to guide these [NQNs]. Because it would help the ward too, to guide [the NQN] to the right source, like the right source of information...” (Practice Partner)

3.5. Teamwork and communication

The sometimes short-term and emergent nature of E2P Facilitator positions, often in response to surges in nursing student placements, impacted on team stability. E2P Facilitators were challenged to communicate and develop shared beliefs and values about their work.

“...the varying expectations, even just between clusters of the facilitators and the different ways of working and those kind of things. There’s a lot of variation in that.” (E2P Facilitator, Group 1)

Some E2P Facilitators identified lack of communication between themselves and ward staff as a challenge. The nature of rotating rosters for both the E2P Facilitators and Practice Partners made communication challenging:

“We’re on all these rotating shifts and you’ve got ... seven different wards for example. It’s a lot of staff that you need to know to try and build rapport with...They work varying shifts so you build rapport with them and then you don’t see them again for three weeks ... you’re continually trying to figure out who’s who on each ward and that in itself can be draining.” (E2P Facilitator, Group 2)

This situation was also challenging for Practice Partners, who were interested in knowing the capability of the NQN, but not able to communicate with the E2P Facilitator:

“I’m thinking if we have a NQN, it would be great to know where are they at...what type of support they need? Because while we’re doing our job, clinically we’re rushing, we’re not even thinking [about the NQN].” (Practice Partner)

Both E2P Facilitators and Practice Partners carried responsibility for NQN support but there was an inherent tension between the local requirements of the clinical area and the broader education and professional support offered by the health service.

3.6. Role ambiguity

The misalignment of stakeholder perceptions of various roles and responsibilities constituted role ambiguity. Role ambiguity was most evident in the practice of providing feedback to NQNs on their performance. NQNs were often disappointed with the quality of feedback on their performance. For example:

“Some of the NQNs say that they don’t get any feedback, only room for improvement. So, they’re only focusing on - not all the positive things that they do but perhaps some things that they could improve on.” (Clinical Leader)

Further, provision of feedback was confounded when NQNs were reluctant to seek support or engage with the E2P Facilitators:

“Sometimes NQNs don’t want to call us because we were their student facilitator so they see us as the assessor ... as though we’re going to assess their abilities at being a nurse ... so we’re like it’s okay to make a mistake, we’re here to support you.” (E2P Facilitator, Group 2)

In the above quote, the E2P facilitator attributes NQN reticence to a misunderstanding about their role in supporting NQNs. In the CCEM, E2P Facilitators did work with NQNs who they knew as students. Whilst this previous experience may smooth transition for the NQN to the workplace, it can also pose a challenge, particularly as the intent of the E2P relationship shifts from assessment for the student to support for the NQN.

E2P Facilitators perceived the lack of Practice Partner support for day-to-day work as problematic. For example:

“[Practice Partners] usually give them a bit of a hand for their [supernumerary days] - [later] when they’re actually on the floor by themselves some of those expectations are, ‘well now you’re a registered nurse you should be able to do this.’ Some of these young individuals are struggling to find their feet and starting to understand exactly what it is to be a registered nurse.” (E2P Facilitator, Group 1)

There was an overall sense of ambiguity related to the roles of practice partner and E2P facilitator.

3.6. Integrating quantitative and qualitative data

Two key themes arose through discussion of the quantitative and qualitative data. Firstly, improved alignment of stakeholder expectations of their roles in providing NQN support is required to improve feasibility, with Clinical Leaders focused on setting the standard for NQN performance in their area. Of note, the role of the ward-based Clinical Facilitator was absent in the transcriptions and rankings. While teamwork and communication were emphasised as important, these challenges may be attributed to the lack of understanding of others’ responsibilities. This state of confusion is further complicated by the difference between the requirements for nursing student assessment and collegial support of NQNs.

The second key theme was that incorporating NQNs into the CCEM did not account for the organisational context of contemporary hospital wards. The geographical distribution of NQNs across multiple wards and the single room design of those wards reduced opportunities for observation of, and feedback on, their practice. Multiple E2P Facilitators and Practice Partners working rotating rosters increased the diversity of expectations, which contributed to confusion around performance. The patient allocation model of nursing care delivery reduced opportunities for Practice Partners to observe, and provide feedback on, NQN performance.

4. Discussion

The feasibility of the CCEM for supporting NQNs as they transition into practice could be improved with greater attention to the alignment of stakeholder perspectives on their respective roles

and consideration of an alternative model of care that would increase opportunities for Practice Partner observation and discussion of NQN performance. In this discussion, we propose a Team Nursing model of care.

Greater alignment of stakeholder perspectives on their roles could increase support for NQNs. Clearer role definition, stronger classification of the role boundaries of E2P Facilitators, and their pedagogical approaches, would make it easier to identify practice expectations that are beyond the scope of the role, and establish more structured communication pathways to help anticipate competing practice priorities (Singh, 2002; Whatman & Singh, 2015).

Stakeholder perspective alignment would be enhanced through clear standards for practice within the unique context of each ward. Practice Partners, who have the clinical expertise, could provide support to develop these clearly defined practices. However, the NQN needs to be in proximity to the more experienced nurse (practice partner). For example, an integrative review of preceptorship models, pairing NQNs with more experienced nurses was found to improve NQN satisfaction and retention (Quek & Shorey, 2018). In the CCEM, on cessation of the supernumerary stage when Practice Partners and NQNs have their own patient allocation assignments, the opportunity for Practice Partner support is reduced.

There were general expressions of misunderstanding about the E2P Facilitator role in NQN transition. In the CCEM, the E2P Facilitator role is focused on developing NQN skills to learn from their experiences, while the practice partner is focused on the performance of nursing practices. For example, the E2P Facilitator supports NQN reflection in and on practice, an important skill for learning (Schon, 1983). They also support NQN to discuss cases with staff from different disciplinary backgrounds in order to learn other ways of understanding healthcare (Billett, 2014) and to evaluate evidence to draw conclusions about a context-dependent situation, to develop their clinical judgement (Levett-Jones, 2017). To develop these generic skills, E2P Facilitators hold ward-based small group discussion or learning circles, known to develop generic skills around learning from practice (Walker, Cooke, Henderson, & Creedy, 2013). Further research into how E2P facilitators can support the development of generic skills required to learn from experience is required.

Another area for improved alignment is related to regulatory requirements. Mandatory training to meet regulatory performance requirements early in the NQN program requires continual negotiation by Clinical Leaders, E2P Facilitators, ward-based Facilitators, and NQNs. Establishing clear lines of communication, such as quarterly meetings between E2P Facilitators and Clinical Leaders, could enhance role function and alignment. There may also be an opportunity to further explore the role of the ward-based clinical facilitator in NQN transition to practice.

The CCEM extension to include NQN did not account for the organisational context of contemporary hospital wards, particularly the patient allocation model of care and single room structure. For feasibility of CCEM, and integration of NQNs a team nursing approach may be suitable. In a study of nursing managers, team nursing was considered a safer model of care because direct supervision could be provided to novice staff (Ferguson & Cioffi, 2011). In a study, comparing team nursing to patient allocation models of care across 12 wards, NQNs in team nursing models experienced higher satisfaction (Fairbrother, Jones, & Rivas, 2010). In addition, an integrative review found that team nursing reduced medication error, adverse intravenous events, and patient pain (Fernandez, Johnson, Tran, & Miranda, 2012).

To move from patient allocation to team nursing does carry some challenges. In a study of the change to a team nursing model, improvements to staff job satisfaction were noted however these were mediated by staff experiences of higher levels of stress at-

tributed to the change process (Deravin, Francis, Nielsen, & Anderson, 2017). Team nursing as a model of nursing care to facilitate NQN transition within the CCEM is worthy of further investigation.

4.1. Limitations

In this study, the focus was on the support mechanisms in place for NQNs within the CCEM. Further research that incorporates NQN perspectives are required. This study was conducted in 2019, before the worldwide COVID-19 pandemic and the findings need to be considered in that context.

In descriptions of the Nominal Group Technique, strengths as well as challenges would normally be explored. In this study, the focus was on continually improving the model and challenges were considered most important. The use of rankings to illustrate those elements of the CCEM that were most challenging provided a richer understanding of the qualitative data. Generally, alignment between rankings and number of votes is necessary for an accurate representation of participants' perceptions (McMillan et al., 2014). In this study, the rankings and voting numbers did align.

4.2. Clinical implications and future research

The NQN is actively learning during the transition to practice year. While transition to practice programs can improve retention, how NQNs are engaged in learning about nursing practice bears further investigation. In this study, collaborative models for NQN clinical support may assist in NQN practice development but these require greater clarification of the types of learning and identification of the most appropriate staff to support that learning. In addition, development of clear role descriptions for all stakeholders in the CCEM is needed.

In this study, NQN access to experienced nurses in the workplace is challenged by limited supernumerary time and the predominance of patient allocation models of care. Given the international shortage of nurses, and more specifically experienced nurses, new models of care to improve NQN access to experienced nurses are required. We suggest that team nursing may offer a model of care that aligns with the principles of the CCEM and identified learning roles. Further development and research into these bespoke models of care delivery and work-based learning is urgently required.

5. Conclusion

Clinical education models, developed in the 20th century, are no longer sufficient to meet contemporary workforce requirements. To sustain the high levels of recruitment of NQNs each year, transition support programs must attend to how NQNs develop nursing proficiency. For NQNs, the opportunity to access the clinical expertise of the Practice Partner can be increased through a change from patient allocation to team nursing models of care. The Collaborative Clusters Education Model provides a feasible model to support NQN practice development but refinement of this model through greater clarification of the types of learning and identification of the staff to support that learning is needed.

Authorship contribution statement

Study conception and design: KR, BG, SP, LA, LG; Acquisition of data: KR, SM, RW; Analysis and interpretation of data: KR, SM, BG, LA, LG; Drafting the article or revising it critically for important intellectual content: All authors; Final approval of the version submitted: All authors.

Funding

No external funding.

Ethical statement

Ethical approval for this study was provided in 2018 by the Human Research Ethics Committees:

Griffith University (GU Ref No: 2018/971)

Gold Coast Hospital and Health Service (LNR/2018/QGC/45768)

Acknowledgement of ethics approval is provided on page 6 of the manuscript.

Conflict of interest

None.

Acknowledgements

Thanks is extended to the Registered Nurses who participated in this project sharing their views and experiences of supporting both student nurses and newly qualified nurses in the workplace.

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