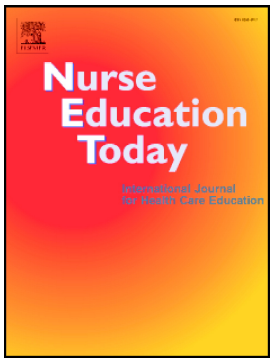

How do new graduated nurses from a competency-based program demonstrate their competencies? A focused ethnography of acute care settings

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Title

HOW DO NEW GRADUATED NURSES FROM A COMPETENCY-BASED PROGRAM DEMONSTRATE THEIR COMPETENCIES? A FOCUSED ETHNOGRAPHY OF ACUTE CARE SETTINGS

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Conflict of interest

None to declare

Ethics Approval

This project was approved by the IRB of the hospital where the research took place (#2015-5871)

HOW DO NEW GRADUATE NURSES FROM A COMPETENCY-BASED PROGRAM DEMONSTRATE THEIR COMPETENCIES? A FOCUSED ETHNOGRAPHY OF ACUTE-CARE SETTINGS

ABSTRACT

Background: Following major organizations' recommendations, healthcare professionals' education has been reformed in the last decade into competency-based education (CBE) to better prepare them with core competencies. This change was intended to prepare new graduates for the reality of health systems and future challenges. Few studies have focused on how new graduate nurses (NGNs) from these reformed programs use the competencies they have developed. Objective: To describe the competencies of NGNs from a Canadian competency-based baccalaureate program, as perceived by various actors in acute-care settings. Methods: A focused ethnography was conducted on three acute-care wards of an academic hospital. Participants (n=19) from four subgroups (NGNs, preceptors, clinical nurse specialists, and nurse managers) participated in individual semi-structured interviews or focus groups. Data were also collected through observation and fieldnotes; an ethnographic analysis framework was used. Results: Three themes were identified to describe the deployment of NGNs' competencies: NGNs' appropriation of their new role, fragmentation of practice into tasks, and development of practice; NGNs' collaboration within the interprofessional team, management of the dyad with licensed practical nurses, and ability to integrate patients and families into the team; and NGNs' scientific practice, increased scientific curiosity, and use of credible sources. Analysis of these themes' elements in light of the competency framework of the program showed that NGNs deploy seven of the eight competencies developed during their training. Conclusion: This study's results can be applied by nursing educators and hospital decision makers to ensure NGNs are able to use their competencies and to smoothen the transition period between the academic and clinical settings.

Keywords: Competency-based education, Nursing education, Nursing education research, Clinical competence, Qualitative research, Focused ethnography, New graduate nurse

INTRODUCTION

In the last two decades, many health science training programs have been revised following recommendations of major organizations (Frenk et al., 2010; Institute of Medicine, 2003), which identified a need to transform programs using a pedagogical approach based on core competency development. According to Frenk et al. (2010), reformed programs would prepare health professionals capable of working in an interprofessional system, using critical thinking and ethical

conduct, which would potentially improve quality of care and address gaps identified by the Institute of Medicine (2003).

Competency-based education (CBE) programs would equip nurses with necessary knowledge, skills, and attitude to deal with increasingly complex situations (Benner et al., 2009; Goudreau et al., 2009). Although there are many definitions of CBE, the "second-generation CBE" (Goudreau et al., 2009) seems more consistent with the integrative pedagogy advocated by many (Benner et al., 2010; Institute of Medicine, 2003). This second-generation CBE is based on cognitivism and constructivism (Billings and Halstead, 2016) and uses a holistic definition of competency, which (reference omitted) described as a demonstration of systemic knowledge/skills/attitudes bound to a context and developing continually.

Few studies have specifically examined how new graduate nurses (NGNs) from CBE programs use their competencies early in their professional journey (Klein and Fowles, 2009; Williams et al., 2012). Previous works focused on NGNs' competencies without considering their educational backgrounds (Higgins et al., 2010; Kantar, 2012; Lauder et al., 2008a, 2008b; Lima et al., 2014; Safadi et al., 2010). Since CBE was introduced in healthcare to improve quality of care and patient security, as well as to promote health system transformation, it is essential to empirically assess competencies demonstrated by newly graduated professionals from such programs (Morcke et al., 2013).

For consistency with CBE's contextual aspect, study of NGNs' competencies should consider this context (Blanchet-Garneau et al., 2017). In Canada, two-thirds of NGNs work on acute-care units, which offer general and short-term treatment of acute illnesses and include medical and surgical units, but not critical care, psychiatry, or palliative care. Some argue that acute-care units harbor a negative and oppressive culture influencing NGNs' practice (Duchscher and Myrick, 2008; Kelly and Ahern, 2009).

An original framework was designed, integrating Benner's novice to expert model (1982) and pedagogical vision (Benner et al., 2010) into CBE, to guide this study (reference omitted). This model of competency development and deployment in nursing practice (Figure 1) guides teachers and educators to develop learning activities by identifying essential ingredients: active teaching-learning activities to prioritize, competencies to be developed and their level (real and expected), context of care, and quality of care provided to patients. This conceptual framework posits that the context in which nurses work influences how they demonstrate their competencies. *(insert Figure 1 here)*

AIM AND RESEARCH QUESTIONS

This research aimed to 1) describe NGNs' competencies from a competency-based undergraduate program of a French-speaking Canadian university in acute-care settings and 2) explore acute-care settings' influence on competency deployment. This paper reports findings regarding the first objective. Accordingly, it focuses on two study questions: 1) *Which competencies do NGNs demonstrate in acute-care settings?* 2) *How do NGNs demonstrate competencies?* Findings regarding the second objective have also been published (reference omitted).

METHODS

Design

A focused ethnography design was used. Recent literature supports this design's usefulness in nursing research to explore a specific phenomenon and the context in which it takes place (Cruz and Higginbottom, 2013; Higginbottom et al., 2013; Roper and Shapira, 2000). Ethnography can help the researcher to immerse in the culture to understand the behaviors and beliefs of individuals in a culture. Since the object of this study was centered on NGNs and their practice, a focused ethnography was deemed more appropriate. Focused ethnography helps the researcher answers predetermined narrow research questions; it also involves a more restricted data collection period than conventional ethnography (Higginbottom et al., 2013; Roper & Shapira, 2000). The research protocol was approved by the institutional review board (#15.056), and written informed consent was obtained from all participants. Data were anonymized to prevent them from being identified. All participants received a $20 gift card as compensation.

Settings, sample and data collection

The study's settings were three acute-care units of a French-Canadian academic hospital affiliated with a university with a CBE undergraduate nursing program. Four groups of participants were selected (N=19): NGNs (6-24 months after graduation) (n=4), nurse preceptors (n=2), clinical nurse specialists (CNSs; n=9), and nurse managers (n=4). Participants other than NGNs had worked in acute-care settings and supervised or worked closely with NGNs over the last two years. Convenience and snowball sampling were used to recruit participants. During 40 hours of passive observation (Spradley, 1980), fieldnotes were taken, structured on an observation guide. This guide was developed from the framework of this study and Spradley's work (1980). He described that culture could be observed through what he called social situation, composed of three elements: the individuals present, the activity being done and the settings (Fetterman, 2010). Therefore, the observation guide comprised six categories: physical settings, general activities happening, behaviors of NGNs, communication and collaboration of NGNs with other health professionals, emotions expressed by NGNs and clinical documentation/references present. For each category, the observer could record fieldnotes and memos.

Clinical and orientation documentation was collected. NGNs, nurse preceptors, and nurse managers underwent one individual semi-structured interview (mean: 52 minutes). CNSs participated in one focus group (mean: 76 minutes). An interview/focus group guide validated by nursing education experts was used. During interviews/focus groups, participants had a summary of the competency framework used in the program NGNs graduated from, including a definition of the eight competencies presented in Table 1 and the expected level at the end of the program. Interviews and focus groups were audio recorded, fully transcribed and verified against the audio before analysis. All participants completed a demographic questionnaire. All interviews and focus groups were moderated by the first author (MC), who is a registered nurse (RN) completing a PhD at the time of the study. He had clinical experience in acute care settings, but not in the hospital where the study took place.

Data analysis

All collected data (transcripts from interviews/focus groups, fieldnotes from observation, documentation) were analyzed using QDA miner (version 4.1.16), following an ethnographic content analysis inductive method involving four steps: coding for descriptive labels, sorting for patterns, outliers identification, and generalization with constructs and theories (Roper and Shapira, 2000). The competency framework from the program from which the NGNs had graduated (FN-UdeM, 2010) was used for analysis. The competencies' complete statements are long, so abbreviated statements were used (Table 1).

All data were coded by the first author (MC) with a code close to the actual raw data. After the first round of coding, interjudge validation was performed with 20% of interviews with JG. Codes were regrouped into categories (based on the competency framework) and these categories were iteratively compared with raw data. Matrices were used to identity a semantic relationship between categories; cross-referencing categories led to the emergence of subthemes for each competency. Categories and subthemes were again cross-referenced using analysis matrices, which led to the emergence of three main themes. Throughout this process, regular meetings with JG and AB ensured validation. *(insert Table 1 here)*

RESULTS

Table 2 presents participants' demographic data of each group, their age, nursing experience (in years), and number of preceptorship experiences in the last year. Observation allowed to present a thick description of the cultural context, including the physical environment as well as the social and professional organization in another publication (reference omitted). Findings presented here relate to themes about NGNs' competency deployment. These findings are supported by transcripts (originally in French) and the participant's code (NGN: new graduate nurse; CNS: clinical nurse specialist; P; nurse preceptor; X: nurse managers).

- Theme 1: Role appropriation, fragmentation of practice and professional development;
- Theme 2: Collaboration within an interprofessional team, management of the dyad with the licensed practical nurse (LPN) and integration of patients into the team;
- Theme 3: Scientific practice, increased scientific curiosity, and use of credible sources.

Using the competency framework, Table 3 identifies the competencies related to each theme. All participants were female, so the feminine will be used in the following section to designate participants.

(insert tables 2 and 3 here)

Role appropriation, fragmentation of practice and professional development

The first theme is related to role appropriation and development of NGNs' practice, transitioning

from a student to an independent professional. According to participants, a difficult challenge for NGNs in role appropriation is work organization and prioritization of care. Adaptation to nursing practice represents a significant source of stress for some, which can be explained partly by differences between workloads experienced during clinical placement and beginning of practice. Workloads depend on both number of patients to care for and the complexity level of care. To cope, NGNs focus on their tasks (e.g., taking vital signs or preparing/administering medication):

[While in clinical placements], we had 1-2 patients, but here we have 12-14 patients right after the 19-days' orientation period. It takes a while to get used to it and to integrate the competencies we developed; at the beginning, you focus on tasks that must be done. (NGN-3)

CNSs and other nurses blame NGNs for breaking down their role this way during their first months of practice, since NGNs then do not demonstrate the complex and holistic know-how they developed during their training. Some also insist NGNs forget what they have learned and bend to their own way of doing things:

[NGNs] want to do as they were taught or look up information in their textbooks, but the context forces them to change to fit into the mold of nurses who supervise them. Preceptors assess them a lot at the technical level (skills and rapidity of execution) and not about their competencies. (CNS-2)

Some participants indicated that this difficulty in acting from a holistic perspective is only temporary, and NGNs usually do so by the end of their first year of practice. During this period, NGNs focus on developing their own practice. One NGN states that she utilizes several ways to improve her practice:

I use a reflexive approach, I talk about my practice [...] to my colleagues, not only to myself. [...] It's not as detailed and structured as the reflexive approach I learned, but I think all nurses should do it. (NGN-2)

Although wishing to improve their practice, NGNs do not yet feel ready to be agents of change among their colleagues neither to help them improve their own practice as expected in the competency framework (refer to the leadership competency in Table 1). NGNs' difficulty in acting as agents of change is corroborated by other groups' participants. Some argue that an NGN may feel uncomfortable approaching more experienced colleagues to talk about elements of their practice that are not optimal, or worse, unsafe practice; the problem is exacerbated when this more experienced nurse is the NGN's preceptor.

I also teach them *how* to say it. Because it's hard to say to an experienced nurse that the way she does something is outdated. But it needs to be said! I often tell my colleagues "*if you want to be a preceptor, you need to have an open-mind about learning new ways to do things*". (P-2)

Some CNSs encourage NGNs to tell them or the nurse manager when such situations arise. However, since different nurses (preceptor, CNS, and manager) are involved in NGNs' assessment and may decide to terminate their employment, some NGNs hesitate in denouncing these behaviors. Participants believe an atmosphere of open-mindedness where constructive feedback is welcome, and everyone is encouraged to improve and maintain evidence-based practice is needed, and that the nurse manager has an important role in creating such atmosphere:

[The atmosphere] really depends on the unit. I think it depends on the nurse manager, what she wants, what she expects, how she encourages her employees because. (CNS-3)

[When I welcome a NGN on my unit] I tell them "*I'm counting on you, if you see something wrong, tell me*". They might be new, but they can bring so much to us! They don't have the expertise yet, but they arrive here with up to date knowledge, with an evidence-based practice. We can learn from them. (X-4)

Collaboration within an interprofessional team, management of the dyad with the LPN and integration of patients into the team

The second theme is related to NGNs' collaboration within professional teams, which include overseeing of LPNs and integrating the patient/family into the team. This professional team is divided into two components: intraprofessional (other nurses, LPNs, and orderlies), and interprofessional (other non-nursing health professionals). During their first months of practice, NGNs may have difficulty engaging with other professionals, as their identity is still under construction. Since many NGNs work on evening and night shifts, interprofessional collaboration operates differently than during the day shift. Some participants say that NGNs develop a form of asynchronous collaboration, by reading other professionals' notes in patients' files.

NGNs often work on floating teams, and they feel it is more difficult to collaborate with intra- and interprofessional team members in such situations. Developing relationships of trust with team members helps NGNs collaborate, which is not easy as a float nurse:

It's harder to collaborate when you are on the floating team because you do not know the nurses or the orderlies. It's only since I've been here [on a stable unit] that I can push the collaboration I have with the physician, the occupational therapist, or the other nurses. We know each other, and we trust each other. (NGN-1)

One major challenge NGNs face early in their professional practice is leading a smaller team, comprising themselves and an LPN. In Canada, on some acute-care units, RN are paired with an LPN, who has limited scope of practice. RNs need to work closely with the paired LPN, because even though RNs are not responsible for LPNs' actions or omissions, they remain in charge of the patient's care. This can be quite challenging for NGNs' whose professional identity is still under construction. Several participants mentioned that this aspect of a nurse's responsibility is not taught sufficiently in school:

I find it difficult especially when you are younger, and they have more clinical experience. I am the leader but I'm younger. And I must tell them to do this and that, because I'm the one in charge. But then some of them look at you like "*you will not tell me how to do my job*" [...] But you know I'm not superior, the LPN is not inferior either, it's just that I have this responsibility. (NGN-2)

This is a particular challenge for NGNs because they are expected to be as efficient as experienced nurses, including in their work with LPNs.

Participants from every group mentioned that one strength of NGNs was developing a trusting relationship with patients and their families and listening to their concerns. However, at the beginning of their practice they may face difficulty in doing this while executing tasks:

Humanism and caring comes back a lot in their speeches [...] listening to the person, you know, not just giving physical care, but trying to explore the family situation, the psychosocial situation, everything that is less tangible [...] They may not be able to interact while they do a specific task, but they are definitely more aware of the concerns of patients. (CNS-1)

Scientific practice, increased scientific curiosity, and use of credible sources.

The third theme relates to NGNs' scientific practice. There is consensus among the participants that, at the beginning of practice, NGNs from CBE demonstrate scientific curiosity that stands out from other NGNs, through a propensity to ask pertinent questions and seek answers from credible scientific sources. Several participants elaborated on their capacity to collect and analyze data on a patient's situation, and plan and assess interventions. Participants mentioned that when NGNs have enough time, they are able to process patients' information and demonstrate clinical judgment. One nurse manager commented that NGNs from a CBE program have stronger ability to analyze situations:

With CBE, they better develop their analytical capacity. They are much stronger to establish links [...] when they start their orientation period, they are quick to process information, they are curious, they seek the information they need, it's not a problem. I think it is much better than before. (Nurse manager-2)

However, because of their workload at the end of the orientation period, NGNs rapidly lose that ability and become mainly task-oriented to the detriment of fully assess their patients or anticipate complications. The same nurse manager explains that some nurse preceptors do not encourage NGNs to have a more comprehensive and scientific approach to care:

I think NGNs are quickly engulfed. You know sometimes they want to demonstrate a more comprehensive health assessment skill or they want to look up something, but some preceptors will tell them "*don't go look it up*" or "*do as I do, I'll show you how to do it*." (Nurse manager-2)

Some NGNs interpret it as prescriptive that nurse preceptors, although not always meaning harm, expect them to stop looking up for information and prefer NGNs who ask their questions to more experienced nurses.

On acute-care units, credible scientific sources are available through electronic platforms or databases. Participants stated that NGNs regularly consulted these resources. However, NGNs shared that they sometimes lack time to consult resources, especially during their first months of practice, and must look up information on their own time. NGNs and other participants claim this habit of consulting credible sources is lost over time:

At first, they have the curiosity to look up [information] in credible sources, it is there. But after a while, I think the workload and maybe the desire to be part of the team, to be homogeneous in the group makes them lose some good habits that they had. (CNS-9)

A NGN mentioned that it is easier to maintain a scientific curiosity by working the night shift since it allows more time to read patient files, question themselves about patients' health situations, and seek information:

I find it easier [...] at night because, yes, we have more patients, but we have more time; patients are sleeping, they are not gone for an exam, we have the file, we can read it, read what happened in the last 24 or 48 hours. We are less in a rush, and we have more time to sit down and think about what is happening, and to anticipate the interventions that should be done soon. (NGN-4)

DISCUSSION

Results of this study show that NGNs were able to demonstrate seven of the eight competencies they have developed during their training; they could not demonstrate the health promotion competency in acute-care settings. According to Kemppainen et al. (2013), factors in acute-care settings both support and hinder health promotion interventions. The hindering factors include lack of time and documentation, which this study corroborated. Although some could argue this competency is not a priority in acute-care settings, it might be a precious effective moment to prioritize health promotion and disease prevention strategies to reduce burden on health care systems.

Our results suggest that NGNs from CBE programs are ready for practice, which is consistent with other recent findings (Batch-Wilson, 2016; Holland et al., 2010; Lima et al., 2014, 2016; Numminen et al., 2015; Wolff et al., 2010). The contribution of our study is to have identified the training background of NGNs, in a way to study the outcomes of the CBE program they were graduated from. Similar to Holland et al. (2010), our results show that NGNs should not be assessed as ready (or not) for practice based solely on demonstration of technical skills, but rather on demonstration of more complex competencies.

Our results also suggest that NGNs start their professional practice at the "advanced beginner" level described by Benner (1982). However, due to nurse staffing shortage, they are expected by managers and other experienced nurses to be at Benner's third stage, "competent," immediately upon graduating after a relatively short orientation period. These findings are similar to those of other researchers (Deagle, 2006; Freeling and Parker, 2015; Numminen et al., 2014). The expectation that NGNs should handle the same workload as experienced nurses can lead to high turnover in acute-care settings and many NGNs leaving the profession in the early years (Chan et al., 2013).

Although NGNs are struggling with planning and prioritizing care at first, they can integrate their role by the end of their first year. This corroborates studies (Ke et al., 2017; Lima et al., 2016) that found that competencies' level increased significantly during 6 to 12 months of practice. Our study participants reported that NGNs compensated for this lack of organization and prioritization by fragmenting their role into tasks. In a metaethnography of 17 studies, Voldbjerg et al. (2016) concluded that NGNs focus heavily on tasks to circumvent the discrepancy between what they have learned and what they observe on the units. This can lead to feelings of incompetence and low self-confidence, which have also been expressed by NGNs in our study. Other studies concluded that NGNs' ability to demonstrate competencies is strongly linked to a sense of empowerment (Kuokkanen et al., 2016; Numminen et al., 2015). Although our study participants did not specifically use the term "empowerment," they mentioned a relation between their competencies and self-confidence.

Other studies concluded that leadership is a very difficult competency to demonstrate for NGN (Blazun et al., 2015; Freeling and Parker, 2015; Lima et al., 2016). While working with LPNs is a challenge in the first months, NGNs seem able to integrate this part of their role after a few months. Expectations for this competency could therefore be modulated more gradually to allow an easier transition. This corroborates a survey report (n = 495 nurses; response rate = 90%) wherein leadership and supervision were rated by nurses in varying positions as the two least needed skills

among a list of 30 (Brown and Crookes, 2016). Without questioning its importance in nursing practice, leadership competency requires a longer period of time to develop in order to be demonstrated by NGNs.

Limitations

A few limitations of this study must be noted. First, this study included only one academic hospital experiencing a major administrative transformation at the time, which might impact the results' transferability. Second, recruitment was a challenge; less NGNs than anticipated participated in the study. This may be because several NGNs from the competency-based program were working on ineligible units, and NGNs experiencing heavy workloads might not have been physically or psychologically available to participate. However, we reached data saturation with data from other groups and with other data collection methods, which provided rigorous results.

CONCLUSION

This study's objective was to describe competencies of NGNs, from a competency-based undergraduate program in a French-speaking Canadian university in acute-care settings. Using a focused ethnography design, three themes emerged to describe how NGNs demonstrate their competencies: role appropriation, collaboration within an interprofessional team, and scientific practice. Findings show that NGNs demonstrate seven out of eight competencies (from their undergraduate program) during their first year of practice and are fit for practice. Since Benner's work in the 1980s, many researchers studied NGNs' experiences, transitions from academic to clinical settings, and utilization of competencies they developed during training. This study's results confirmed those of other recent studies on the deployment of NGNs' competencies, but our study's contribution is that it identified a link between NGNs' initial competency-based training program and competencies deployed while working in an acute-care setting.

Despite constant dialogue between the education and clinical communities, there is still a mismatch between the objectives of initial training and expectations of the clinical environment. Nurse managers and educators must have realistic expectations about NGNs' abilities right at the end of their education program. Being ready (or fit) for practice does not mean NGNs are ready to take the same workload as experienced nurses, although they are able to provide safe care to patients. They still need support from colleagues to help them during this transition phase and attain new levels of nursing expertise. Future research should investigate how to enhance this support and how to help NGNs to demonstrate their competencies during their first year of transition.

REFERENCES

Note: four references omitted for confidentiality

Batch-Wilson, W., 2016. Practice preparedness in new graduates: Exploring the education-practice gap. Accessible from ProQuest Dissertations & Theses (10109942).

Benner, P., 1982. From novice to expert... the Dreyfus model of skill acquisition. The American Journal of Nursing 82, 402-407.

Benner, P., Sutphen, M., Leonard, V., Day, L., 2010. Educating Nurses: A Call for Radical Transformation. Jossey-Bass, San Francisco, CA.

Benner, P., Tanner, C., Chesla, C., 2009. Expertise in Nursing Practice: Caring, Clinical Judgment, and Ethics, 2nd ed. Springer Publishing Company, New York, NY.

Billings, D.M., Halstead, J.A., 2016. Teaching in Nursing: A Guide for Faculty, 5th ed. Elsevier, St-Louis, MO.

Blanchet-Garneau, A., Lavoie, P., Grondin, M., 2017. Dichotomy and dialogue in conceptualizations of competency in health professionals' education. Journal of Nursing Education and Practice 7, 18-26.

Blazun, H., Kokol, P., Vosner, J., 2015. Survey on specific nursing competences: Students' perceptions. Nurse Education in Practice 15, 359-365.

Brown, R.A., Crookes, P.A., 2016. What are the 'necessary' skills for a newly graduating RN? Results of an Australian survey. BMC Nursing 15, 1-8.

Chan, Z.C.Y., Tam, W.S., Lung, M.K.Y., Wong, W.Y., Chau, C.W., 2013. A systematic literature review of nurse shortage and the intention to leave. Journal of Nursing Management 21, 605-613.

Cruz, E.V., Higginbottom, G., 2013. The use of focused ethnography in nursing research. Nurse Researcher 20, 36-43.

Deagle, G.M., 2006. The influence of expectations on the transition experience of baccalaureate nurses to acute care settings. Accessible from ProQuest Dissertations & Theses (MR20564).

Duchscher, J.B., Myrick, F., 2008. The prevailing winds of oppression: understanding the new graduate experience in acute care. Nursing Forum (Auckland) 43, 191-206.

Faculty of Nursing of Université de Montréal (FN-UdeM), 2010. Référentiel de compétences: Baccalauréat en sciences infirmières [Competency framework: Undergraduate program]. Author, Montréal, Québec.

Fetterman, D.M., 2010. Ethnography: Step-by-Step, 3rd ed. SAGE Publications, Thousand Oaks, CA.

Freeling, M., Parker, S., 2015. Exploring experienced nurses' attitudes, views and expectations of new graduate nurses: A critical review. Nurse Education Today 35, e42-e49.

Frenk, J., Chen, L., Bhutta, Z.A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., Garcia, P., Ke, Y., Kelley, P., Kistnasamy, B., Meleis, A., Naylor, D., Pablos-Mendez, A., Reddy, S., Scrimshaw, S.,

Sepulveda, J., Serwadda, D., Zurayk, H., 2010. Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. The Lancet 376, 1923-1958.

Goudreau, J., Pepin, J., Dubois, S., Boyer, L., Larue, C., Legault, A., 2009. A second generation of the competency-based approach to nursing education. International Journal of Nursing Education Scholarship 6, Article 15.

Higginbottom, G.M.A., Pillay, J.J., Boadu, N.Y., 2013. Guidance on performing focused ethnographies with an emphasis on healthcare research. The Qualitative Report 18, 1-16.

Higgins, G., Spencer, R.L., Kane, R., 2010. A systematic review of the experiences and perceptions of the newly qualified nurse in the United Kingdom. Nurse Education Today 30, 499-508.

Holland, K., Roxburgh, M., Johnson, M., Topping, K., Watson, R., Lauder, W., Porter, M., 2010. Fitness for practice in nursing and midwifery education in Scotland, United Kingdom. J. Clin. Nurs. 19, 461-469.

Institute of Medicine, 2003. Health Professions Education: A Bridge to Quality. The National Academies Press, Washington, D.C.

Kantar, L.D., 2012. Clinical practice of new nurse graduates in Lebanon: Challenges and perspectives through the eyes of preceptors. Journal of Continuing Education in Nursing 43, 518-528.

Ke, Y.-T., Kuo, C.-C., Hung, C.-H., 2017. The effects of nursing preceptorship on new nurses' competence, professional socialization, job satisfaction and retention: A systematic review. Journal of Advanced Nursing 2017, 1-10.

Kelly, J., Ahern, K., 2009. Preparing nurses for practice: A phenomenological study of the new graduate in Australia. Journal of Clinical Nursing 18, 910-918.

Kemppainen, V., Tossavainen, K., Turunen, H., 2013. Nurses' roles in health promotion practice: an integrative review. Health Promotion International 28, 490-501.

Klein, C.J., Fowles, E.R., 2009. An investigation of nursing competence and the competency outcomes performance assessment curricular approach: Senior students' self-reported perceptions. Journal of Professional Nursing 25, 109-121.

Kuokkanen, L., Leino-Kilpi, H., Numminen, O., Isoaho, H., Flinkman, M., Meretoja, R., 2016. Newly graduated nurses' empowerment regarding professional competence and other work-related factors. BMC Nursing 15, 1-8.

Lauder, W., Holland, K., Roxburgh, M., Topping, K., Watson, R., Johnson, M., Porter, M., Behr, A., 2008a. Measuring competence, self-reported competence and self-efficacy in pre-registration students. Nursing Standard 22, 35-43.

Lauder, W., Watson, R., Topping, K., Holland, K., Johnson, M., Porter, M., Roxburgh, M., Behr, A., 2008b. An evaluation of fitness for practice curricula: Self-efficacy, support and self-reported competence in preregistration student nurses and midwives. Journal of Clinical Nursing 17, 1858-1867.

Lima, S., Newall, F., Jordan, H.L., Hamilton, B., Kinney, S., 2016. Development of competence in the first year of graduate nursing practice: A longitudinal study. Journal of Advanced Nursing 72, 878-888.

Lima, S., Newall, F., Kinney, S., Jordan, H.L., Hamilton, B., 2014. How competent are they? Graduate nurses self-assessment of competence at the start of their careers. Collegian 21, 353-358.

Morcke, A.M., Dornan, T., Eika, B., 2013. Outcome (competency) based education: An exploration of its origins, theoretical basis, and empirical evidence. Advances in Health Sciences Education 18, 851-863.

Numminen, O., Laine, T., Isoaho, H., Hupli, M., Leino-Kilpi, H., Meretoja, R., 2014. Do educational outcomes correspond with the requirements of nursing practice: Educators' and managers' assessments of novice nurses' professional competence. Scandinavian Journal of Caring Sciences 28, 812-821.

Numminen, O., Leino-Kilpi, H., Isoaho, H., Meretoja, R., 2015. Newly graduated nurses' competence and individual and organizational factors: A multivariate analysis. Journal of Nursing Scholarship 47, 1-12.

Roper, J.M., Shapira, J., 2000. Ethnography in Nursing Research. Sage Publications, Thousand Oaks, CA.

Safadi, R., Jaradeh, M., Bandak, A., Froelicher, E., 2010. Competence assessment of nursing graduates of Jordanian universities. Nursing & Health Sciences 12, 147-154.

Spradley, J.P., 1980. Participant Observation. Holt, Rinehart and Winston, New York, NY.

Voldbjerg, S.L., Grønkjær, M., Sørensen, E.E., Hall, E.O.C., 2016. Newly graduated nurses' use of knowledge sources: A meta-ethnography. Journal of Advanced Nursing 72, 1751-1765.

Williams, B., Spiers, J., Fisk, A., Richards, L., Gibson, B., Kabotoff, W., McIlwraith, D., Sculley, A., 2012. The influence of an undergraduate problem/context based learning program on evolving professional nursing graduate practice. Nurse Education Today 32, 417-421.

Wolff, A.C., Regan, S., Pesut, B., Black, J., 2010. Ready for what? An exploration of the meaning of new graduate nurses' readiness for practice. International Journal of Nursing Education Scholarship 7, Article 7.

Table 1: Competencies from the undergraduate program

Complete statement	Brief description	Abbreviated statement
1. To care with humanism for a person	Humanistic values, connect with patient and his family, adapt his practice to the needs of the patient, respect for the uniqueness of the person	Humanism
2. To act together with individuals, families, and groups to promote healthy communities	Population-based approach, health promotion, disease prevention, caring for one's own health and environment	Health promotion
3. To collaborate within a professional team	Active participation in the team, sharing his point of view, respect different points of view	Collaboration
4. To demonstrate clinical leadership	Questioning and critiquing nursing practice, coordination of intraprofessional team activities	Clinical leadership
5. To act in a professional manner	Promotion of the profession, ethical reflection, improvement of its practice/continual professional development, use of reflective approach	Professionalism
6. To treat every activity related to the profession and discipline in a rigorously scientific manner	Use of scientific sources, keep up to date with scientific knowledge, clear communication	Scientific rigor
7. To demonstrate clinical judgment	Targeted health assessment, elaboration of the therapeutic nursing plan and appropriate nursing actions, application of procedures with rigor	Clinical judgment
8. To ensure continuity of care	Collaborative relationship, follow up actions (including with the therapeutic nursing plan)	Continuity of care

Source: FN-UdeM (2010)

Table 2: Sociodemographic data

	Group 1 NGN	**Group 2 Preceptor**	**Group 3 CNS**	**Group 4 Nurse managers**
n	4	2	9	4
Age (years)				
20-25	2	0	0	0
26-30	2	0	1	0
31-40	0	0	5	1
41-50	0	2	0	2
51 +	0	0	3	1
Experience (years)				
Mean	12 months	7	17	18
Minimum	11 months	6	3	3
Maximum	16 months	8	36	32
Preceptorship experiences				
Mean	2	12	33	0
Minimum	0	4	0	0
Maximum	5	20	55	0

Note: NGN: new graduate nurse; CNS: clinical nurse specialist.

Table 3: Relation between NGNs' competencies and themes

Competencies	Themes		
	Role appropriation	**Collaboration**	**Scientific practice**
Professionalism	X		
Clinical judgment	X		X
Continuity of care		X	
Clinical leadership	X	X	
Scientific rigor			X
Collaboration		X	
Humanism		X	
Health promotion			

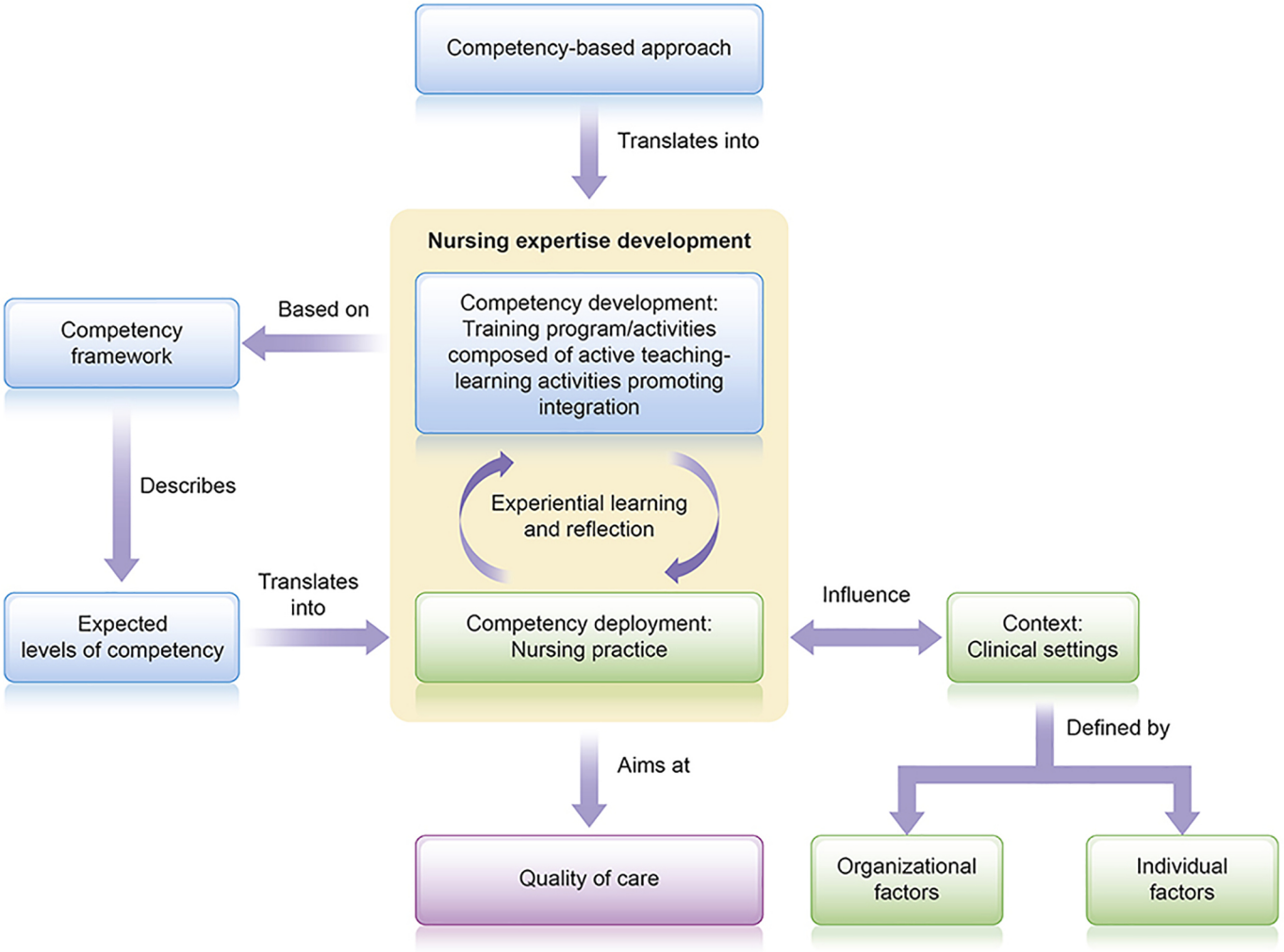
Competency-based approach
Translates into
Nursing expertise development
Competency framework
Based on
Competency development: Training program/activities composed of active teaching-learning activities promoting integration
Describes
Experiential learning and reflection
Translates into
Expected levels of competency
Competency deployment: Nursing practice
Influence
Context: Clinical settings
Defined by
Aims at
Quality of care
Organizational factors
Individual factors

Figure 1