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ABSTRACT

The purpose of this study was to explore challenges facing newly qualified nurses in the first year of practice, a cultural perspective on Norway and Zambia. This was a qualitative type of study with a purposeful convenience sampling of newly qualified nurses in their first year of practice. However, the inclusion criteria extended to nurses who had more years in service and their responses proved to be relevant to the study. Data were gathered using a semi-structured interview guide, which was electronically sent for data collection and analyzed with a colour coding process through which four categories of intra-personal, inter-personal, organizational and structural levels emerged. The intra-personal level mainly presented similarities for the two countries, showing that the newly qualified nurses had the will and drive to work as nurses in the first year of practice, while the inter-personal level showed differences in caring for patients and/or their relatives between Norway and Zambia and this was linked to differences in the type of culture. The organizational level showed differences between the two set-ups associated with hierarchy and finally the structural level brought out more challenges from the Zambian respondents because of the country's Lower Middle Income status. Ethical considerations were ensured by means of privacy, anonymity and confidentiality.

The authors recommend that more research should be done on how potential gender differences may have an impact on the challenges facing newly qualified nurses in their first year of practice.

1.0 BACKGROUND

Being a newly qualified nurse can be a challenging experience. Kramer, (1974), coined the term 'reality shock' which is defined as the reactions of new workers when they find themselves in a work situation for which they have spent several years preparing, for which they thought they were going to be prepared, and then suddenly find they are not. This study by Kramer formed a basis of reference for researchers on the subject of challenges facing newly qualified nurses. More recent literature tells us that new nurses experience heavier responsibilities than expected, fragmentation of patient care, and stressful interactions with colleagues. The lack of a supportive work environment and role models increases the new nurses' experience of overwhelming responsibility in their daily work situations (Bjerknes and Bjork, 2012). This is in line with Burton and Omrod, (2011), who found that “suddenly the newly qualified nurse is the one who must ‘know the answer’, whether it is a query from a patient, a carer, a work colleague or a student. The newly qualified nurse will encounter many challenging situations where she or he must lead care delivery. This includes dealing with care management within the team, dealing with patients/service users, dealing with other professionals, and dealing with the required needs of the whole workplace environment”. There is little literature on challenges facing newly qualified nurses in Africa. However, from the authors' experience, challenges these nurses face in a Sub-Sahara African country like Zambia are mainly due to shortage of staff. Therefore, the newly qualified nurses assume a lot of responsibilities and receive little or no guidance in the practical area.

To overcome these challenges facing newly qualified nurses, Benner, (1984), suggested that “staff development departments have a significant role in creating the environment in which a new version of nursing can be nurtured”. Similarly, other literature says that introducing a mandatory preceptorship programme would offer support to newly qualified nurses (Whitehead and Dinah, 2011). Despite this vast literature on the topic, there is little or no research aimed at comparing the challenges of these nurses in cultural perspectives,

hence the need for this study. The aim of this research is to explore the challenges of newly qualified nurses in their first year of practice and compare them in two different cultural perspectives namely, Norway and Zambia. The authors of this paper are nurses on an exchange program between Norway and Zambia, who had been placed in different kinds of health institutions in Norway, where they conducted this study. Additionally, the authors also used their experience as nurses to offer some insight on the topic under study.

1.1 PURPOSE OF THE STUDY

The purpose of this study is to explore the challenges facing newly qualified nurses in their first year of practice in a comparative cultural perspective of Norway and Zambia.

1.2 RESEARCH QUESTIONS

1. What are the challenges that newly qualified Norwegian and Zambian nurses face in their first year of practice?
2. What similarities and differences in challenges that Norwegian and Zambian nurses face in their first year of practice.
3. What perceptions do newly qualified nurses have toward nursing practice?

2.0 LITERATURE REVIEW

In order to understand fully the challenges that newly qualified Norwegian and Zambian nurses face in the first year of practice, the authors reviewed relevant literature on the topic ranging from e-journal, printed journals, e-books, books, articles and student papers. These were accessed from data bases through the Sogn og Fjordane University College library such as CINAHL, Eric, Google Scholar, Medicine and Pubmed. Key search words included “Newly qualified nurse”, “Recently qualified nurse”, “Graduate nurse”, “First year of practice”, “Norway”, “Europe”, “Sub-Saharan Africa”, and “Zambia”.

Benner (1984) outlined how nurses gain clinical competence from the time they graduate to the time they become experts in their profession. Her findings were from a descriptive research based on dialogue with newly qualified nurses, their mentors and experienced nurses. Her ultimate goal was to compare Novice and Expert nurses' descriptions and responses to the same clinical situations. Using the Dreyfus model, which describes how individuals progress through various levels in their acquisition of skills and subsumes ideas which regard to how individuals learn (Peña 2010), Benner identified five levels of clinical competency for nurses, which are; *novice*, *advanced beginner*, *competent*, *proficient* and *expert*.

Novice- These are beginners who have no experience of situations in which they are expected to perform; hence they must be given rules to guide their performance.

Advanced Beginner- The ones who can demonstrate marginally acceptable performance, ones who have coped with enough real situations to note (or to have pointed out to them by a mentor) the recurring meaningful situational components.

Competent- After two to three years in the same area of nursing the nurse moves into the Competent Stage of skill acquisition. The nurse still relies on conscious planning, efficiency, and organization skills.

Proficient- Proficient nurses understand a situation as a whole because they perceive its meaning in terms of long term goals and they learn from experience what typical events to expect in a given situation and how plans need to be modified in response to these events.

Expert- Expert nurses no longer rely on rules and guidelines to grasp the situation at hand and to take appropriate action but rely on their own intuition, drawing from their vast

experiences to solve problems. The experts perform at a very high level and are very efficient in getting to the bottom of a problem with speed and accuracy. The expert nurses can incorporate evidence based nursing practices into patient care, using the latest research available to treat patients in an effort to achieve the best possible patient outcomes.

These first two levels are the most challenging for newly qualified nurses because “novices and advanced beginners can take in little of the situation: it is too new, too strange and besides, they have to concentrate on remembering rules they have been taught” (Benner 1984).

2.1 CULTURE

In order to explore the challenges facing newly qualified nurses in their first year of practice in a cultural comparative context in Norway and Zambia, it is essential to understand the culture of the two countries.

The term ‘culture’ has had multiple meanings in different disciplines and in different contexts (Samovar et al, 2007). Culture is a set of human-made objective and subjective elements that in the past have increased the probability of survival and resulted in satisfaction for the participants in an ecological niche, and thus became shared among those who could communicate with each other because they had a common language and they lived in the same time and place (Triandis in Samovar et al, 2007). The rich complex of meanings, beliefs, practices, symbols, norms and values prevalent among people in society are manifestations of the underlying culture (Schwartz, 2006).

Culture provides the overall framework wherein humans learn to organize their thoughts, emotions, and behaviours in relation to their environment. Although people are born into a culture, it is not innate. Culture is learned. It teaches one how to think, conditions one how to feel, and instructs one how to act, especially how to interact with others, how to communicate (Neuliep, 2012).

As noted by Hofstede, in Schwartz, (2006), the prevailing value emphases in a society may be the most central feature of culture. They express conceptions of what is good and desirable. He further observes that even the way social institutions are organized; their policies and every day practices explicitly or implicitly communicate expectations that

express underlying cultural value emphases. Culture influences what people communicate, to whom they communicate, and how they communicate (Samovar et al, 2007). Yet the influence of culture on human interaction is paradoxical. As we conduct our daily lives, most of us are unaware of our culture; however, culture influences our every thought, feeling and action (Neuliep, 2012).

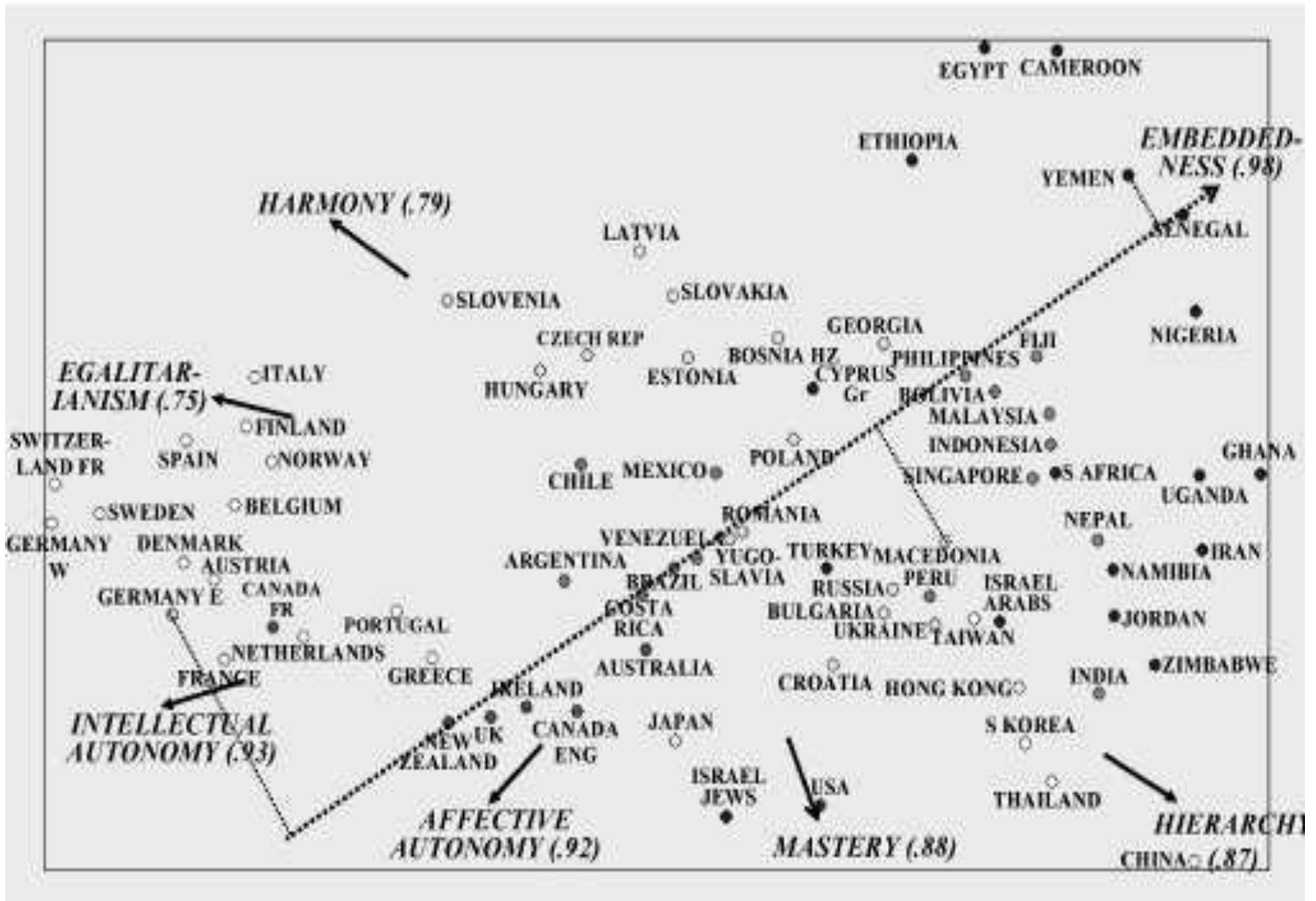
According to Benner (1984), staff nurses who had been qualified for six months (advanced beginners) felt their abilities were constantly being tested, leading to a feeling of self – consciousness. This is in line with Samovar et al (2007), who state that one of the most important responsibilities of any culture is to assist its members in forming their identities. It assigns roles to the various players’ expectations about how individuals will behave. Charon as quoted by Samovar, et al, (2007) makes much the same point when he notes, “we learn our identities-who we are-through socialization which takes place within a cultural context. Edward Hall as quoted in (Neuliep, 2012) asserts that culture hides more than it reveals, particularly from its own members. However, Roger Keesing in Neuliep, (2012) argues that culture provides people with an implicit theory about how to behave and how to interpret the behaviour of others. People from different cultures learn different implicit theories, and these theories are learned through socialization. And through socialization, individuals also learn the dominant values of their particular culture and their self- identities.

CULTURAL VALUE ORIENTATIONS

Cultural dimensions of values reflect the basic issues or problems that societies must confront in order to regulate human activity. Societal members, especially decision-makers, recognize and communicate about these problems, plan responses to them, and motivate one another to cope with them (Schwartz, 1999). According to Schwartz. S, (2006), there are seven different cultural orientations namely; *Egalitarianism, Harmony, Embeddedness, Hierarchy, Mastery, Affective Autonomy, Intellectual Autonomy*. Figure 1 show where some selected countries are distributed under Schwartz's theory of cultural value orientations. Figure 2 outlines a theoretical pattern of inter-correlations among values

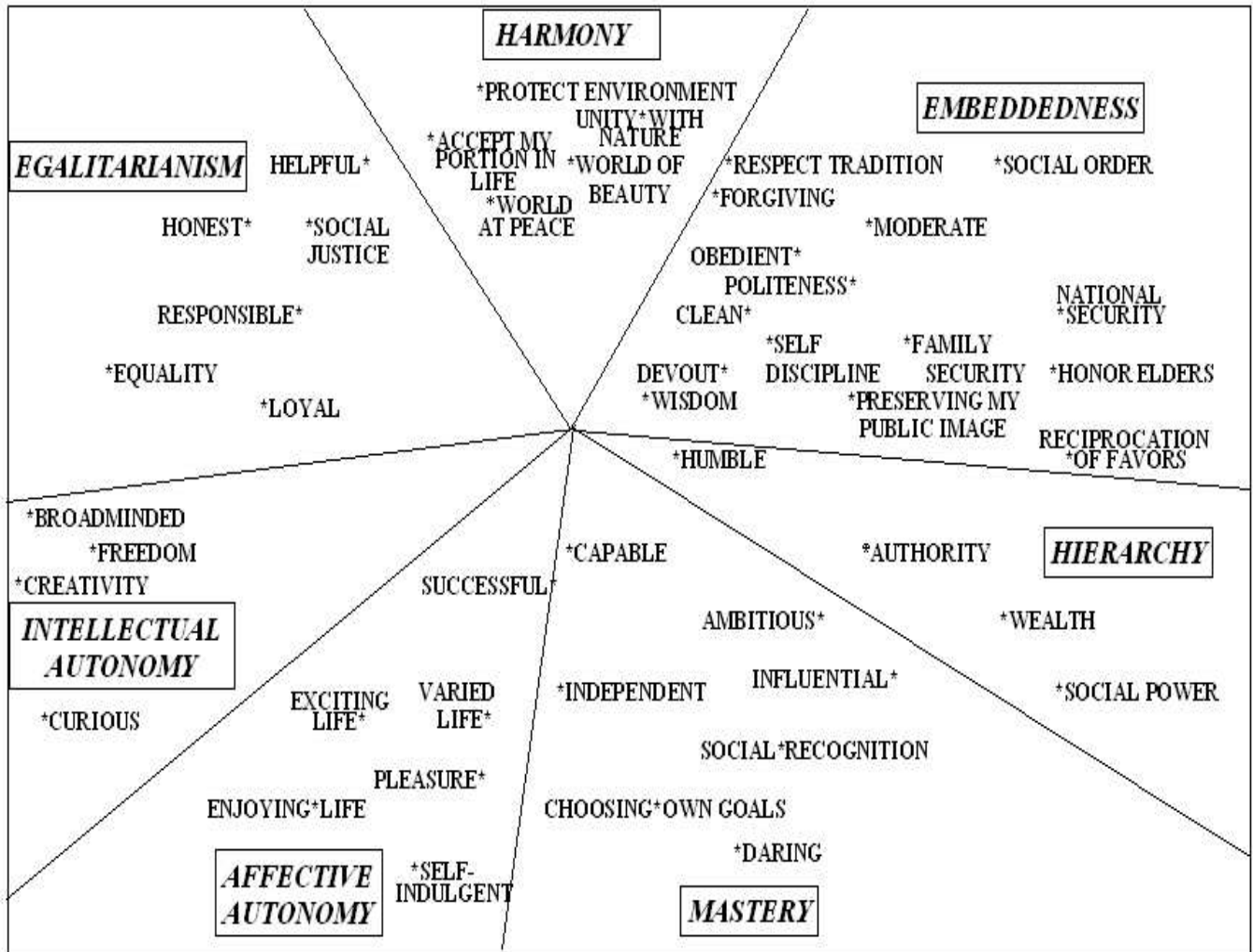
and cultural orientations. A comparison of figure 1 and figure 2 drives a deeper understanding of national cultures, and what each cultural orientation and dimension is comprised of.

Figure 1



Co-plot's National groups of seven cultural orientations: Source: Schwartz (2006)

Figure 2



Culture level MDS-233 samples, 81 cultural groups: Source: Schwartz (2006)

2.1.1 NORWEGIAN CULTURE

Egalitarianism

There is a principle of cultural equality in Norway and the egalitarian commitment is strong (Eyjólfsdóttir & Smith, 1997 in Rostrup.H, 2010). Egalitarianism is the belief that all people are of equal worth and should be treated equally in society (Schwartz, 2001). People are socialized to internalize a commitment to cooperate and to feel concern for everyone's welfare as a matter of choice. Important values in such cultures include equality, social justice, responsibility, help, and honesty. They are expected to act for the benefit of others (Schwartz, 2006). The needs are few and needs are easily satisfied. Not appearing rich is an important characteristic to the Norwegians; equality is the foundation of educational principles (Rostrup, 2010). The distribution of Norway as an egalitarian culture oriented country is further elaborated in figure 1 and figure 2.

Low-Context Communication

Riedel, (2008), elaborates that in high-context cultures, speakers tend to use a more indirect communication style, while in low-context cultures, speakers tend to use a more direct communication style. Norway is considered to be a low-context culture meaning communication is more explicitly verbal and direct – the non-verbal context of the message has less value. Riedel, (2008) further found that People from low-context cultures would tend to seek information that emphasized personal or individual aspects rather than social or group aspects.

CULTURAL DIMENSIONS

Individualism-Collectivism

Individualism pertains to societies in which the ties between individuals are loose; everyone is expected to look after himself or herself and his or her immediate family.

Collectivism as its opposite pertains to societies in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty (Hofstede 1991). Individualism emphasizes personal freedom and achievement. Individualist culture therefore awards social status to personal accomplishments such as important discoveries, innovations, great artistic or humanitarian achievements and all actions that make an individual stand out. Collectivism, in contrast emphasizes embeddedness of individuals in a larger group. It encourages conformity and discourages individuals from dissenting and standing out (Gorodnichenko and Roland, 2011). Norwegians are considered to possess both individualistic and collectivistic cultural tendencies meaning they are taught to put the needs of the society above their own and to embrace a class society, while they value personal independence (Neuliep 2006). Individualists tend to use low-context messages, which are direct, precise, and clear.

On the other hand, in collectivist cultures, group goals take precedence over individual goals, tending to be concerned with avoiding hurt feelings and not imposing on others. They emphasize harmony and cooperation within the in-group and will try to save face for the group and in-group members. They see direct requests as the least effective way to accomplish goals (Riedel, 2008).

Power distance

Power distance refers to the way in which power is distributed. People in some cultures accept a higher degree of unequally distributed power than do others (Basset 2004). In Norwegian culture, people have low power distance and consider every person as equal. "There is a low power distance culture, which means that it is less hierarchical than countries with high power distance. Less hierarchy means a more egalitarian view of people and consequently less respect for role or position power. So in Norway appealing to authority is much less likely to succeed. Likewise, emotional appeals (appealing to values) are relatively rare in Norway and less likely to succeed if used" (Bacon, 2013). It is common for a ward manager or charge nurse to prefer being called by their first name

rather than using the titles 'Mr, Mrs, madam or sir'. Likewise, subordinates are co-workers and carry out their duties with little or no supervision, which influences them to take initiative that they are rewarded for. Additionally, Riedel, (2008), found that low power distance people tend to use informal, rather than formal, communication channels. They tend to be less traditional and seek more innovative answers to problems. They have a greater need for technology and independent thinking.

2.1.2 ZAMBIAN CULTURE

Embeddedness/Hierarchy

According to the coplot map of national groups of seven cultural orientations (fig 1 and 2), Zambia is associated with an embeddedness and hierarchical type of cultural orientations. Meaning in life is expected to come largely through social relationships, through identifying with the group, participating in its shared way of life, and striving toward its shared goals (embeddedness). On the other hand, people are socialized to take the hierarchical distribution of roles for granted, to comply with the obligations and rules attached to their roles, to show deference to superiors and expect deference from subordinates. Values of social power, authority, humility, and wealth are highly important in hierarchical cultures (Schwartz 2006).

Oppression in Hierarchal societies: By definition

“Oppression refers to relations of domination and exploitation - economic, social and psychologic - between individuals; between social groups and classes within and beyond societies; and, globally, between entire societies. Injustice refers to discriminatory, dehumanizing, and development-inhibiting conditions of living (e.g., unemployment, poverty, homelessness, and lack of health care), imposed by oppressors upon dominated and exploited individuals, social groups, classes and peoples. These conditions will often cause people to turn to social services for help. Oppression seems motivated by an intent to

exploit (i.e., benefit disproportionately from the resources, capacities, and productivity of others) and it results typically in disadvantageous, unjust conditions of living for its victims. It serves as a means to enforce exploitation toward the goal of securing advantageous conditions of living for its perpetrators. Justice reflects the absence of exploitation-enforcing oppression.” (Gil, 1994, p. 233).

It is common that oppression exists in Hierarchical societies as Freire (1970), notes that characteristics of an oppressed group arise from a dominant group's ability to control a lower, submissive group.

Collectivism

In collectivistic culture people are not isolated individuals, they see themselves as interdependent with others their in-group where responsibility is shared and accountability is collective. The values and beliefs are consistent with and reflect those of the in-group. Moreover, a collectivist's association with others may last a life time. The primary value is harmony with others. (Neulip, 2006). Hofstede as quoted by (Jandt, 2007) states that in a collectivist culture, the interest of the group prevails over the interest of the individual.

Zambia, like most African countries, is considered as collectivistic because people are integrated into strong, cohesive in-groups that continue throughout a life time to protect in exchange for unquestioning loyalty. Jandt further elaborates that in collectivist cultures, the employer- employee relationship is perceived in moral terms, like family link, and hiring and promotion decisions take the employee's in-group into count. As suggested by Triandis in Samovar (2007), the following are some of the behaviours found in collectivist culture that puts greater emphasis on: The views, needs and goals of the in-group rather than oneself; social norms and duty defined by the in-group rather than behaviour to get pleasure; beliefs shared with the in-groups rather than beliefs that distinguish self from in-groups; and great readiness to co-operate with in-group members. Additionally, collectivistic cultures are linked to Ubuntu, which is an ancient African world-view based on the primary values of intense humanness, caring, sharing, respect, compassion and

associated values, ensuring a happy and qualitative human community life in the spirit of family (Broodryk, 2002).

High-context Communication

Edward Hall in Gamsriegler, (2005), points out that in high-context communication a large part of the meaning lies in the physical context, which includes facial expressions, tone of voice and gestures. As a result, the message itself carries less information. People do not explicitly say what they want to convey. Instead, they beat around the bush until their interlocutor decodes the message correctly. Hofstede in Samovar (2007), further explains that “high context cultures are more often found in traditional cultures” (p159).

Power Distance

Power distance tells us about dependence relationships in a given culture. In high power distance cultures, organizations place more importance on status and rank, a larger proportion of supervisory personnel, a rigid value system that determines the worth of each job, and subordinates adhering to a rigid hierarchy. The individuals accept power as part of society. As such superiors consider their subordinates to be different from them and vice versa. They believe that power and authority are facts of life (Samovar A, et al, 2007). Neulip, (2006) reaffirms this idea when he suggested that in high power distance cultures there is considerable dependence of subordinates on superiors. This is supported by Jandt, (2007), who says in work place, superiors and subordinates consider each other existentially unequal.

3.0 RESEARCH METHODOLOGY AND STUDY DESIGN

Research design is a systematic plan for a research project specifying whom to integrate in the research (sampling), whom or what to compare for which dimensions (Flick, 2011). This is a *Qualitative* type of a study, which is an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting (Creswell,1994).

3.1 DATA COLLECTION METHODS

The authors opted to use a *semi-structured interview* in this study. A semi-structured interview is a set of questions formulated in advance, which can be asked in a variable sequence and perhaps slightly reformulated in the interview in order to allow the interviewees to unfold their views on certain issues (Flick, 2011). This type of data collection method was favoured for this study because it allowed the authors to cover the intended scope of the interview while accommodating individual views of the interviewees. Hence, an interview guide with *open ended questions* was used. By virtue of them being in Norway, the authors intended to physically collect data in Norwegian set up through their practical placement in home-based care and recovery units. Permission to use a room for the one to one interviews was granted by the charge-nurses to promote confidentiality. The researchers assigned each other duties; one was the interviewer while the other was taking down notes. However, the interview guide was electronically sent for data collection to Zambia. The researchers identified a contact person to oversee the data collection process by identifying newly qualified nurses at the hospital of the authors' origin in Zambia and giving them questionnaires to answer over a period of one to two days. After completion of the data collection process, the contact person scanned and sent the filled in questionnaires back to the researchers. The respondents maintained their anonymity so that neither the researchers nor the contact person could know who they were.

3.2 POPULATION

Population is defined as the entire set of individuals having some common characteristics. (Polit and Beck, 2010). The population under study were *newly qualified nurses* in their first year of practice in Norway and Zambia.

3.2.1 SAMPLING

Flick, (2011) defines sampling as “the selection of cases or materials for the study from a larger population or variety of possibilities”p.253. A *purposeful convenience sampling* method was used in this study because it referred to choosing cases that are most easily accessible under given circumstances (Flick, 2011). Due to limited resources and time, this sampling method was suitable for this study because it allowed the researchers to collect as much data as possible. The authors intended to collect data from practical placement areas in Norway, which were suitably accessible while questionnaires were sent to the hospital of the authors' origin in Zambia.

3.3 ETHICAL CONSIDERATION

Creswell, (2009), elaborates that it is useful to consider the ethical issues that can be anticipated and described in the proposal. These issues relate to all phases of the research process.

To carry out this study, the authors had to write letters requesting permission from the relevant authorities. Written informed consent was to be obtained from the participants after giving them clear information regarding what the research was all about. Participants were also informed that the research was voluntary and they could discontinue participation if they wished to do so. Confidentiality would be maintained throughout the

research and the researchers respected the anonymity of the participants. Any literature used in the research was cited correctly to give recognition to the author.

3.4 PILOT STUDY

A pilot study is a small version of a full scale study (Polit and Beck, 2010). The researchers used two other nurses who were in the exchange program for the pilot study. This helped the researchers to develop and test adequate research instruments, which were helpful in designing a research protocol and assess whether it is realistic and workable. It also helped them recognize logistical problems that would arise from the use of the proposed methods such as adjusting the questionnaire by removing questions that were irrelevant and adding those that helped to capture relevant data from the respondents. Furthermore, gave the researchers an experience of how they would conduct themselves in the interviews.

3.5 TRUSTWORTHINESS

According to Rolfe. G., (2004), trustworthiness is divided into credibility, which corresponds roughly with the positivist concept of internal validity; dependability, which relates more to reliability; transferability, which is a form of external validity; and confirmability, which is largely an issue of presentation. Our research was credible because collected data from respondents were not altered in any way and the findings are a true representation of the responses. Dependability was maintained in our research by using the same interview guide to collect data from Norway and Zambia. Transferability was ensured by describing the research context and the assumptions that were central to the research, while confirmability was done when the researchers checked and rechecked the data throughout the study, while maintaining objectivity.

4.0 DATA ANALYSIS

Data analysis is a process of organizing and integrating narrative, qualitative information according to emerging themes and concepts (Polit and Beck, 2010). The authors used a coding process which involved colour coding the raw data and putting them in groups. Rossman and Rallis in Creswell, J., (2009), define **coding** as the process of organizing the material into chunks or segments of text before bringing meaning to information. The four groups that emerged from this particular coding process were: *Intra-personal level; Inter-personal level; organizational level; and structural level*. Thereafter, the authors coloured the raw data into two groups of blue, red, yellow and green for each country according to similarity, which represented the four categories that emerged. The authors assigned each other duties; one was working with data collected from Norway while the other was organizing the data collected from Zambia. They also ensured that they counter-checked what the other was working with to maintain objectivity and neutrality of the collected data. The next step involved cutting pieces of the responses so that each response could be grouped by colour under the main categories, a process which the researchers had never worked with before but it was quite helpful in analyzing the raw data and it covered all the aspects of the questionnaire.

4.1 PRESENTATION OF DATA

A total of 16 respondents participated in this study, 10 from Zambia and 6 from Norway. The respondents were aged between 23 and 41 years with working experience of 4 months to 21 months. Only four respondents, two from each country, had between 8 and 14 years of working experience and were aged between 36 and 46.

INTRA-PERSONAL LEVEL

This involved data that consisted of personal attributes of the newly qualified nurses. A lot of similarities were extracted from the data collected from both Norway and Zambia on

this aspect. Three sub aspects emerged from this, which were: *Caring for patients; strengths; and weaknesses.*

Caring for patients: The most common response for the respondents was that they were interested and engaged in looking after their patients because they were able to identify and meet their needs to help them recover. One newly qualified nurse from Norway said:

“I like working with people and caring for patients, and I'm quite patient. I Want to do the best for patients, and following them up.”

Similarly, another newly qualified nurse from Zambia said:

“I am always ready to help my patients meet their daily needs and carry out all needed nursing care to help them recover fully.”

Additionally, newly qualified nurses from both Norway and Zambia perceived nursing as a noble career, which involved caring for the ill and always having apathy. One newly qualified nurse said:

“Nursing is a noble career and people practicing it should always have apathy”.

Strengths of the newly qualified nurses: Both in Norway and Zambia, the respondents expressed that they were motivated and self -driven to carry out nursing care. Most of them also showed that they were interested in learning new things. One newly qualified nurse from Norway indicated that:

“I am Interested and engaged in learning new things, procedures, diagnosis and treatments.”

While another newly qualified nurse from Zambia said:

“I am a person with keen interest to learn new things.”

Weakness of the newly qualified nurses: However, most of the respondents from both Norway and Zambia stated that they were not sure on which areas they needed to develop hence they said they had to improve in all aspects of their care since they were newly qualified. A few of them identified specific nursing procedures such as wound care, catheterization and naso-gastric tube insertion that they needed to develop.

INTER-PERSONAL LEVEL

This was about the newly qualified nurses' relationship with colleagues, patients and/or relatives.

Team work: Both respondents from Norway and Zambia expressed appreciation that they had good team work and they felt they were welcomed and accepted into the profession by the longer serving nurses. They also mentioned that their colleagues expected them to perform basic nursing care, be responsible and cooperative. Additionally, the respondents also pointed out that even if they still had a lot to learn, their opinions were still valued and appreciated. A newly qualified nurse from Norway appreciated this by saying:

“The relationship is good, they have all been welcoming since I started working there, and very helpful.....a lot of nurses that have worked there for more years know much more about diagnosis and good observation, but they are very open to newly graduates' new knowledge and research.....they know that I am a newly graduate but they expect me to have basic knowledge as a nurse”.

Another newly qualified nurse from Zambia similarly said:

“We have a good working relationship.....when I suggest something, the other nursing staff support my idea if it is genuine.....they expect me to put in the best I can to meet the needs of the patient”.

On the other hand one respondent from Norway said she did not like seeing nurses not performing their duties as expected.

“It is bad to see some nurses not following through with their responsibilities, and therefore, not providing good patient care”.

Handling Patients and/or relatives: Newly qualified nurses from Norway and Zambia had some similar and different responses towards handling patients and/or their relatives. The respondents, both Norway and Zambia pointed out that though some patients and/or relatives were difficult and more demanding than others, they felt this was easy to handle because each patient was treated as a unique individual. However, the respondents also acknowledged that they would refer difficult situations. One respondent said:

“I find talking and good communication to be the most important thing, listening and finding their needs and what they are worried about. But some patients and families are more difficult to communicate and associate to than others, and some again can be very demanding and have very high expectations..... I choose to believe that the patients think I am caring and that I am genuinely interested in their treatment and wellness, which makes it easier for them to talk to me about different situations..... I always inquire when I am not sure of what should be done”.

On the other hand, some respondents from Zambia felt they did not enjoy working with uncooperative patients and/or their relatives because they were insulted at times. One said:

“I do not enjoy dealing with patients or relatives who are uncooperative....I had a bad experience when I was insulted by a patient..... I don't like patients and relatives shouting at me even when I have done my level best in nursing them”.

ORGANIZATIONAL LEVEL

This part involves how newly qualified nurses felt about hierarchy and decision making. According to the responses, it was rare for the newly qualified nurses in Zambia to be involved in management issues while in Norway the respondents said management was a huge part of their nursing tasks that they felt they had to improve on. One nurse in Zambia said:

“Nurses do not have a say when it comes to decision making.....I am expected to do my duties as assigned by my supervisors”.

On the contrary one respondent from Norway said:

“I know I need to improve with leadership and delegation.....I need to develop in my duties as a nurse in charge”.

STRUCTURAL LEVEL

Structural level refers to the availability of human resource, medical supplies and equipment. The newly qualified nurses in Zambia shared that there was a shortage of nurses, medical supplies and equipment. In Norway however, the respondents indicated that though there was some shortage of nursing staff, the nurses were enough to look after the patients.

“I don't like the shortages on the wards, which leads to nurses' inability to render adequate nursing care.....I don't like shortage of things like drugs and stationary”. Said one of the respondents from Zambia. They also added that:

“We work in difficult conditions with a lot of improvisation.....I once lost a patient because of lack of supplies and assistive machines such as oxygen concentrators in my department, which was a sad scenario.”

On the other hand, a Norwegian respondent indicated that:

“We need to be 2 nurses for each patient in my ward to help them turn around in bed, sit, or help from bed to chair and if I am insecure with something, I will ask for help”.

The researchers also included nurses who had served longer than the target sample, two from each country. The respondents indicated they had a lot of experience with dealing with situations. One nurse who had served 10 years said:

“It is was quite difficult when I was a newly qualified nurse but now it is a lot easier to prioritize nursing care because I have had a lot of experience in my nursing career.”

Similarly, one newly qualified nurse who had had prior experience with handling different people in her previous job before she became a nurse found it easy to work with patients due to her past experience.

In the same vain, some newly qualified nurses who had trained at the same institution as a student stated that it was easier to adapt to working as a qualified nurse because they had worked there before as students. One nurse said:

“I did not have a colleague to guide when I started work because I already had been working there as a student, and assistant during weekends and summertime”.

4.2 CONTEXTUAL DESCRIPTION

According to the authors' observation during their practical placement in Norway, the nurses on the wards communicated freely with one another. It was difficult to notice who was superior and who was a newly qualified nurse. All the staff referred to each other by their first names. Additionally, one or two nurses were assigned to each patient who were responsible to care for the patient throughout the shift. Furthermore, the wards in Norway were well equipped with state of the art equipment such devices for lifting patients and computers plus drugs and other medical equipment were readily available. On the other hand, in Zambia nurses in authority are respected and addressed by their official names such as Nursing Officer or Charge nurse. It is also preferable to use titles like Mr or Mrs. Failure to use the official titles usually attracts disciplinary action. Newly qualified nurses are often found at the bottom of the hierarchy. In Zambia nurses are assigned to a unit of patients usually performing collective tasks, while attending to a lot of patients. There is also shortage of equipment and drugs such that nurses sometimes have to improvise things to use.

5.0 DISCUSSION

This study is a comparative study to explore the challenges faced by newly qualified nurses in their first year of practice. A cultural perspective of Norway and Zambia. The findings of this study revealed that the challenges facing newly qualified nurses were in four categories namely: *Intra-personal level*; *Inter-personal level*; *Organizational level*; and *Structural level*.

INTRA-PERSONAL LEVEL

Caring for patients and strengths of the Newly qualified nurses: The researchers' findings on the intra-personal level were that newly qualified nurses in their first year of practice from both countries were interested and engaged in looking after their patients because they were able to identify and meet their needs to help them recover. They also mentioned that they were motivated and self-driven to learn new things and carry out nursing care. This is supported by study done in Norway by Bjercknes and Bjørk, (2012), who found that nurses generally enter the field with empathy for their patients, enthusiasm for the profession, and readiness to learn more about being a good nurse. The findings also indicated that newly qualified nurses perceived nursing as a noble career that required one's empathy and commitment to the patient. This concurs with the authors' observation as nurses that indeed newly qualified nurses have the enthusiasm to learn more and perform better nursing care. They enter the profession with nobility and willingness to work with different situations regarding patient care. On the contrary, Tseng, (2009), suggests that the transition of becoming an independent nurse may cause newly qualified nurses stress and anxiety, but may also be a positive experience as not every individual experiences the same psychological changes when they undergo this process.

Weaknesses of the newly qualified nurses: However, the findings also revealed that most of the newly qualified nurses did not know which areas they needed to improve. Only a

few could specify areas of their nursing care that needed improvement. This may be because everything was still new to them and they needed time or rather a transition period to get used to the situations and the meaning of their re-occurrences. Benner, (1984), reaffirms the same point when she stated that novices and advanced beginners can take in little of the situation: it is too new, too strange and besides, they have to concentrate on remembering rules they have been taught. Kramer, (1974), also supports this with her classic 'reality shock' term which is defines reactions of new workers when they find themselves in a work situation for which they have spent several years preparing, for which they thought they were going to be prepared, and then suddenly find they are not. Furthermore, the researchers found that nurses who had been serving longer understood the meaning of different situations because they had more experience, which verifies that newly qualified nurses need to go through the stages of clinical competency to be able to appreciate the meaning of recurring situations.

INTER-PERSONAL LEVEL

Team work: According to the findings, the newly qualified nurses from both Norway and Zambia felt welcome and accepted by the longer serving nurses. They expressed that they enjoyed a good working relationship and the other staff were very supportive and cooperative. They said even though they had a lot to learn, their opinions were still valued and appreciated. This is in line with Samovar et al, (2007), who states that one of the most important responsibilities of any culture is to assist its members in forming their identities. It assigns roles to the various players' expectations about how individuals will behave. Furthermore, literature tells us that staff development departments have a significant role in creating the environment in which a new version of nursing can be nurtured (Benner, 1984). In support of this, Whitehead and Holmes, (2011) suggest that introducing a mandatory preceptorship programme would offer support to newly qualified nurses. The findings of this study solidify this by indicating that an environment where newly qualified nurses felt welcome and accepted by their colleagues smoothed their transition into the

profession. This also reduced the number of mentors assigned to newly qualified nurses because the colleagues were always available to guide them. However, Bjerknes and Bjørk, (2012), argue that more experienced colleagues seemed to neither respect nor nurture the attitude of enthusiasm for the profession that the newly qualified nurses had.

Handling patients and/or their relatives: The findings of this research suggested that some newly qualified nurses from both Norway and Zambia found handling patients and/or their relatives easy because they treated each patient as an individual. However, they added that they would refer situations that were difficult for them to handle to more experienced staff. On the other hand, some respondents from Zambia shared a number of experiences when they were insulted by patients and/or their relatives. It was interesting to note that none of the Norwegian respondents had had such an experience. This may mirror back to the fact that Zambia, being a collectivistic type of culture, which pertains to societies in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty (Hofstede 1991). Furthermore, the ideology of ubuntu is so deep rooted in Zambia such that relatives are more likely to be involved in the care of the patients than they are in Norway making it more common to have encounters where patients and/or their relatives insult nurses. Additionally, the authors' observations were that usually the patients who were more likely to speak out or utter insulting remarks are those with a high status in society. This is typical of a Hierarchal cultural orientation, where people with high social status voice out more than those with low social status.

ORGANIZATIONAL LEVEL

Our study revealed that in Zambia, there is a hierarchal system that is followed strictly in the nursing fraternity and newly qualified nurses are at the bottom of this structure. The respondents said they were not considered in decision making and had to do tasks as delegated by their supervisors. This verifies the authors' observation that newly qualified

nurses are not fully involved in decision making even though their opinions are valued. Seniority usually goes with authority, such as nursing officer position, and by virtue of who has served longer. For example, junior nursing staff rise on their feet to show recognition of the presence of a senior staff. Failure to do so usually attracts disciplinary action. This may mean that newly qualified nurses from Zambia are oppressed because they are not part of decision making and conform to a rigid hierarchical system. Freire, (1970) makes the same point when he stated that the major characteristics of an oppressed group arise from a dominant group's ability to control a lower, submissive group. This is supported by Schwartz, (2006), who states that people are socialized to take the hierarchical distribution of roles for granted, to comply with the obligations and rules attached to their roles, to show deference to superiors and expect deference from subordinates. Values of social power, authority, humility, and wealth are highly important in hierarchical cultures. In the same vein, Samovar et al, (2007), found that in high power distance cultures, organizations place more importance on status and rank, a larger proportion of supervisory personnel, a rigid value system that determines the worth of each job, and subordinates adhering to a rigid hierarchy. The individuals accept power as part of society. As such superiors consider their subordinates to be different from them and vice versa. They believe that power and authority are facts of life.

On the other hand, in Norway, management was a huge part of the newly qualified nurses' responsibility and the respondents felt they needed to improve on it. Burton and Ormrod, (2011), confirm this when they stated that the newly qualified nurse will encounter many challenging situations where she or he must lead care delivery. This includes dealing with care management within the team. This is in line with the researchers' observation that every nurse was involved in management and decision making such that it was difficult to notice who was superior and who was a newly qualified nurse. Everyone referred to each other by their first names and moreover, student nurses, nurses and other staff wore the same uniform, this is confirmed by Schwartz (2001) that Norway is an Egalitarian type of

society where there is a belief that all people are of equal worth and should be treated equally in society.

STRUCTURAL LEVEL

The findings of this research showed differences on the availability in human resource, medical supplies and equipment between Norway and Zambia. The respondents from Zambia shared that there was shortage of staff; drugs and medical equipment which meant them work alone on a shift with a huge number of patients and a lot of improvised equipment. This is confirmed in Whitehead and Holmes, (2011), that “shortages were a major contributor to the lack of support given to newly qualified nurses once in post, rather than unwillingness from established members of staff. This implies that newly qualified nurses may have a hard time adjusting in an environment that has staff shortages because they would lack much needed guidance from other experienced staff.

However, in Norway though the respondents reported that there was some shortage of staff, the nurses were enough to look after the patients. Usually patients had nurses to whom they were assigned and these nurses provided individualized care. During their practical placement in Norway, the authors observed that there was adequate availability of drugs, medical supplies and state of the art equipment such as lifting devices, which made a lot easier to carry out the tasks. According to the World Bank, (2013), Zambia is ranked among the Lower Middle Income countries meaning it may struggle to provide adequate human resource and medical supplies, including advanced state of the art technology to the health sector. On the other hand, Norway has undergone a substantial socio-economic transformation during the last four decades, and is now among the wealthiest nations in the world. This development has of great significance to the health status of the nation. (Norwegian Directorate of Health, 2009). This implies that the nurses in Norway have the latest technology at their disposal and all essential drugs and medical equipment is

available due to the country's economic status. Newly qualified nurses find transition in such an environment to be much easier than it is for their counterparts in Zambia

5.1 STRENGTHS AND WEAKNESSES

The data collection process allowed the researchers to reach saturation such that there was no new information that was relevant to the research. Furthermore, the inclusion criteria was nurses in the first year of practice in Norway and Zambia but it even extended to as far as nurses who had 8 to 14 years working experience. This was not the initial target population for the researchers but it brought out various data that were relevant for the research. In addition, the researchers cooperated and progressed so well despite it being new to them.

However, the research experienced some weak points which include; the data collection period was much longer than the researchers had planned. This was due to difficulties in having the transcribed questionnaires scanned and sent back to Norway from Zambia, which delayed the data analysis process. The other challenge the researchers faced was that most of the data were collected through electronically sent questionnaires even to respondents in Norway. This was because the practical placement areas did not have enough respondents who could fit the inclusion criteria. This also meant that the researchers could not carry out enough face to face interviews, which could have given more data for the research through probing and observation. Additionally, the other weakness was that the researchers did not focus on potential gender differences and how they might have affected newly qualified nurses, which may have presented more data.

5.2 CONCLUSION

The aim of this research was to explore the challenges of newly qualified nurses in their first year of practice and compare them in two different cultural perspectives namely, Norway and Zambia. According to the findings, challenges facing newly qualified nurses in their first year of practice are in four categories namely intra-personal, inter-personal, organizational and structural levels. In a comparative cultural perspective, respondents from both Norway and Zambia expressed similarities on the intra-personal level. They perceived nursing as a noble career and they were enthusiastic to practice as nurses. This showed that newly qualified nurses in a cultural perspective of Norway and Zambia have the same perceptions about nursing in their first year of practice. However, on the interpersonal level the respondents from Norway and Zambia had some differing views. This is linked to the fact that Zambia embraces a collectivistic type of culture based on the ideology of Humanism called 'Ubuntu'. Relatives are much more involved in the care of patients than they are in Norway, which is mainly an individualistic type of culture. On the Organizational level, Zambian nurses follow a strict hierarchical structure and newly qualified nurses are at the bottom of this. In Norway this is quite different because newly qualified nurses involved in management and decision making. Finally, the Structural level revealed that Norway, being a wealthy nation, has advanced and state of the art technology compared to Zambia, which is a Lower Middle Income nation. The respondents from Zambia expressed that shortage of drugs, medical equipment and shortage of nursing staff made their transition into the nursing profession quite difficult. On the contrary, the respondents from Norway did not find this a challenge because the nursing staff were enough to care for patients and had advanced medical equipment at their disposal.

FUTURE RESEARCH

More research is needed on how potential gender differences may have an impact on the challenges facing newly qualified nurses in their first year of practice.

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APPENDICES

Appendix i

Høgskulen i Sogn og Fjordane

Faculty of Teacher Education and Sport

6856, Sogndal

The Head Nurse

Home Care Service

Årdal Kommune

Årdal

Dear sir/madam,

RE: PERMISSION TO CONDUCT A STUDY AT ÅRDAL KOMMUNE

We are Zambian nurses on an exchange program in Global Knowledge at Høgskulen i Sogn og Fjordane between Norway and Zambia. The program requires that we undertake a research project. Our research topic is “To explore challenges facing newly qualified nurses in the first year of practice. A comparative cultural perspective of Norway and Zambia”.

We are requesting for permission to interview nurses in their first year of practice at the facility from 13th March to 17th March 2013.

For further details and clarifications, please contact our supervisor Randi Jepsen at the Faculty of Health Studies on telephone number +4799375399, email Randi.Jepsen@hisf.no

We would be grateful if our request was considered favourably.

Yours faithfully,

Eddie Milimo and Mirriam Nchimunya

Appendix ii

Høgskulen i Sogn og Fjordane

Faculty of Teacher Education and Sport

6856, Sogndal

NORWAY.

The Medical Superintendent

Livingstone General Hospital

P.O. Box 60091

Livingstone

ZAMBIA.

Dear sir/madam,

RE: REQUEST TO COLLECT DATA FOR RESEARCH AT YOUR INSTITUTION

We are Zambian nurses on an exchange program in Global Knowledge at Høgskulen i Sogn og Fjordane between Norway and Zambia. The program requires that we undertake a research project. Our research topic is “To explore challenges facing newly qualified nurses in the first year of practice. A comparative cultural perspective of Norway and Zambia”.

We are requesting for permission to issue out questionnaires to nurses in their first year of practice at the institution from 13th March to 20th March 2013. We will have a contact person to oversee the data collection process.

For further details and clarifications, please contact our supervisor Randi Jepsen at the Faculty of Health Studies on telephone number +4799375399, email Randi.Jepsen@hisf.no

We would be grateful if our request was considered favourably.

Yours faithfully,

.....

Eddie Milimo

.....

Miriam Nchimunya