ARAŞTIRMA / RESEARCH

Readiness for Nursing Practice Scale for New Graduate Nurses: A Validity and Reliability Study

Yeni Mezun Hemşireler İçin Hemşirelik Uygulamalarına Hazır Oluş Ölçeği: Geçerlik ve Güvenirlik Çalışması

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ÖZET

Bu çalışmada Yeni Mezun Hemşireler için Hemşirelik Uygulamalarına Hazır Oluş Ölçeği'nin Türkçe'ye uyarlanması, geçerlik ve güvenirlik çalışmalarının yapılması amaçlanmıştır. Araştırmanın örneklemini Türkiye'de altı devlet üniversitesinde öğrenim gören 401 son sınıf hemşirelik öğrencisi oluşturmuştur. Veriler Ocak-Mayıs 2023 tarihleri arasında yüz yüze ve çevrimiçi (Google form) olarak toplanmıştır. Veriler SPSS 26 ve LISREL 8.7 paket programları kullanılarak değerlendirilmiştir. Ölçeğin geçerliliğini kontrol etmek için içerik yapı ve yakınsak geçerlilik çalışmaları yapılmıştır. Güvenilirlik çalışmasında Cronbach alfa iç tutarlılık güvenilirlik katsayısı, toplam madde korelasyonu ve bileşik güvenilirlik katsayısı hesaplanmıştır. Çalışma, kapsam geçerliliğini belirlemek için ölçek maddeleri üzerinde uzman görüşleri arasında yüksek derecede uyum olduğunu ortaya koymuştur. Yapı geçerliliği için yapılan açımlayıcı faktör analizi sonucunda yazarlar, ölçeğin toplam varyansın %66,87'sini açıklayan iki faktörlü bir yapıya sahip olduğunu belirlemişlerdir. Ayrıca, bu iki faktörlü yapıyı doğrulayıcı faktör analizi ile de teyit etmişlerdir ($\chi 2=408.78$, df =118). Çalışma, ölçek puanları için Cronbach alfa güvenilirlik ve bileşik güvenilirlik katsayılarını .96 olarak hesaplamıştır. Ayrıca, yazarlar açıklanan ortalama varyansın .50'den yüksek ve bileşik güvenirlik katsayısından düşük olduğunu ve böylece yakınsak geçerliliğin sağlandığını tespit etmişlerdir. Yazarlar, hazırbulunuşluk ölçeğinin geçerlilik ve güvenilirlik kontrolleri sağlanarak Türkçe'ye uyarlandığı sonucuna varmışlardır.

Anahtar Kelimeler: eğitim, hemşirelik, hemşirelik uygulaması, güvenilirlik, geçerlilik.

ABSTRACT

This study aimed to adapt the Readiness for Nursing Practice Scale for New Graduate Nurses into Turkish by conducting validity and reliability studies. The study sample consisted of 401 senior nursing students studying at six state universities in Turkey. The data were collected face-to-face and online (Google form) between January and May 2023. The data were evaluated using SPSS 26 and LISREL 8.7 package programs. To check the scale's validity, content construct, and convergent validity studies were conducted. The reliability study calculated the Cronbach alpha internal consistency reliability coefficient, total item correlation, and composite reliability coefficient. The study found a high degree of agreement among the expert opinions on the scale items, indicating content validity. As a result of exploratory factor analysis for construct validity, the authors determined that the scale had a two-factor structure explaining 66.87% of the total variance. Furthermore, they confirmed this two-factor structure with confirmatory factor analysis ($\chi 2=408.78$, df =118). The study calculated Cronbach's alpha reliability and composite reliability coefficients for the scale scores as .96. In addition, the authors found the explained mean-variance to be higher than .50 and lower than the composite reliability coefficient, thus ensuring convergent validity. The authors concluded that the readiness scale was adapted to Turkish by ensuring validity and reliability checks.

Keywords: education, nursing, nursing practice, reliability, validity.

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Gönderilme Tarihi: 30.06.2025, **Kabul Tarihi:** 30.01.2026

INTRODUCTION

The nursing profession plays a central role in health service delivery and constitutes one of the largest professional groups within healthcare systems (Li et al., 2021). Nurses are the health professionals who interact most frequently with patients and healthy individuals across all healthcare settings, making their professional competence critical to the quality of care (Choi et al., 2020). In recent years, population growth, the increasing prevalence of chronic diseases, and the emergence of epidemics have significantly increased the global demand for nurses (Koornneef et al., 2017).

In response to this growing demand, the number of nursing programs and student quotas has steadily increased worldwide, including in Turkey. While expanding educational capacity is necessary, it is equally important to ensure that nursing students develop the professional skills required for effective clinical practice. Nursing education combines theoretical knowledge with the acquisition of practical skills, and students are expected to graduate with competencies aligned with professional standards (Baker et al., 2021). Accordingly, the educational process plays a crucial role in fostering nursing students' knowledge, clinical skills, and professional values (Baker et al., 2021; O'Connor, 2022).

However, several factors may negatively influence the effectiveness of nursing education. These include the transition to distance education during epidemics or natural disasters, shortages of academic staff, high student numbers, insufficient physical infrastructure, and limited clinical practice areas (Rush et al., 2014; Wildermuth et al., 2020). Such challenges raise concerns about whether nursing students receive adequate preparation to develop nursing practices at the desired level prior to graduation. In this context, evaluating students' perceptions of satisfaction, confidence, and comfort related to their educational experiences may provide valuable insights for improving nursing education outcomes.

Insufficiently developed nursing practices may lead novice nurses to experience difficulty applying theoretical knowledge in clinical settings and to feel stressed due to limited experience (Gardiner & Sheen, 2016; Kim & Shin, 2022). These challenges can contribute to interpersonal difficulties, emotional fatigue, and intentions to leave the profession (Duchscher, 2009). Moreover, a lack of readiness for professional practice among newly graduated nurses increases the risk of clinical errors and poses potential threats to patient safety (Huston et al., 2018). For this reason, strategies that support novice nurses' educational and professional development are essential to enable them to function independently and competently in clinical environments (Walker et al., 2015).

Research examining graduate nurses' transition experiences indicates that many new graduates feel inadequately prepared for professional practice due to difficulties adapting to complex healthcare environments and assuming new responsibilities (Missen et al., 2014; Watt & Pascoe, 2013). As nursing students move from academic settings to clinical practice, they must manage both professional expectations and role adaptation. Identifying the needs of nursing students during their first year of professional practice is essential to facilitate successful integration into the profession. Addressing these needs through targeted theoretical and practical training may help reduce competency gaps and enhance clinical adaptation (Walker et al., 2015).

Within the Turkish context, nursing students are expected to develop professional competencies that enable them to function effectively in complex healthcare environments; however, previous research indicates that newly graduated nurses may experience difficulties in transferring educational knowledge into clinical practice (Yıldız & Aslan, 2021). There is a need to examine nursing students' readiness for practice from a multidimensional perspective reflecting their educational experiences. Assessing satisfaction, self-confidence, and

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comfort related to clinical competence can provide context-specific evidence on educational effectiveness. As pre-graduation perceptions—especially in Turkey—are underexplored, this study aims to fill this gap and offer a practical, reliable scale to support competency-based nursing education.

Research Questions

1. Is the Turkish version of the Readiness for Nursing Practice Scale for New Graduate Nurses a valid measurement tool?
2. Is the Turkish version of the scale a reliable measurement tool?
3. Does the factor structure of the original scale fit the Turkish sample?
4. Do the construct validity indices of the scale indicate an acceptable model fit?

MATERIALS AND METHODS

Research design

This study employed a quantitative methodological research design aimed at adapting an existing measurement instrument. The study was conducted as a methodological scale adaptation study, in which the Readiness for Nursing Practice Scale for New Graduate Nurses was translated into Turkish and its validity and reliability were evaluated. Data were collected using a survey method, which refers to the administration of the adapted scale to a defined sample to assess its psychometric properties.

Population and sample

The authors obtained institutional permission from sixteen state universities in Central Anatolia and received approval from six. The study included 1,220 fourth-year nursing students from universities in Kayseri, Ankara, Nevşehir, Yozgat, and Konya. Using convenience sampling, data were collected from 401 students (32.8%), meeting recommended criteria for scale validity and reliability studies. All questionnaires were complete and included in the analysis. Although no a priori power analysis was conducted, post-hoc analysis showed sufficient statistical power (>0.80), supporting the adequacy of the sample size.

In this study, cluster sampling was used due to difficulties in listing all eligible students. Universities in Kayseri, Ankara, Nevşehir, Yozgat, and Konya were defined as clusters and selected based on accessibility and permission. All fourth-year nursing students in these clusters were invited, and volunteers formed the sample. Fourth-year students were chosen due to their proximity to graduation. The mean age was 21.94 (±1.34), 86% were female, and 6.7% had graduated from health vocational high schools.

Data collection instrument

The authors used the items from the original scale that they determined for this purpose, since this study aimed to adapt a data collection tool into Turkish. Therefore, they created a draft scale by translating the original items of the Readiness for Nursing Practice Scale for New Graduate Nurses into Turkish and preferred this draft scale as a data collection tool. In this context, the study used the items of the "Descriptive Characteristics Information Form" in the first section of the draft scale and the items of the "Readiness for Nursing Practice Scale for New Graduate Nurses" in the second section. The Descriptive Characteristics Information Form consists of three questions, including age, gender, and high school graduation. The second section of the draft scale is explained in further detail below.

Original scale of readiness for nursing practices

The Kim and Shin (2022) Readiness for Nursing Practice Scale was selected for adaptation because it provides a comprehensive assessment of readiness outcomes for newly graduated nurses. The original English scale consists of 35 items across five factors: clinical judgment and nursing performance, professional attitudes, patient-centeredness, self-regulation, and collaborative interpersonal relationships. It is a 4-point Likert scale ranging from strongly disagree (1) to strongly

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agree (4), with total scores from 35 to 140; higher scores indicate greater readiness for nursing practice. In the present study, the response format was modified to a 5-point Likert scale by adding an "undecided" option to allow respondents to express neutral perceptions and reduce forced responses without altering the conceptual structure of the scale.

The original scale was developed using data from 430 new graduate nurses in South Korea. Factor analysis confirmed the five-factor structure, and internal consistency was high, with a Cronbach's alpha of .89 for the overall scale, demonstrating strong psychometric properties and suitability for cross-cultural adaptation.

Data collection process

Data were collected both face-to-face and online (via Google Forms) between January and May 2023. A preliminary administration with a small group confirmed item clarity, and no changes were required. The first and second authors conducted face-to-face data collection in Kayseri, while collaborating researchers assisted in other provinces. Completing the scale took about 20 minutes. Online responses showed similar completion times. To minimize bias, administrators had no evaluative relationship with participants, and the online survey allowed only one response per participant. No identifying information was collected to ensure anonymity.

Research implementation stages

Stage 1- Language validity: Stage 1 focused on language validity and was conducted using the translation–back translation method. The initial translation was performed independently by four experts, including two nursing academicians with experience in scale development and two bilingual experts proficient in both English and Turkish. These experts were selected based on their academic background, language proficiency, and familiarity with nursing terminology.

The translated Turkish items were subsequently reviewed by two Turkish language experts with academic expertise in linguistics, who evaluated the items in terms of clarity, grammatical accuracy, and semantic appropriateness. Revisions were made in line with their recommendations to improve comprehensibility and linguistic consistency. The revised Turkish draft was then back-translated into English by two professional translators who were native speakers of Turkish and fluent in English and had no prior knowledge of the original scale. The original and back-translated versions were compared by an additional nursing academician with expertise in scale adaptation to assess semantic equivalence. No major discrepancies in meaning were identified; minor wording differences were noted and resolved through consensus among the research team. Following expert feedback, the necessary adjustments were made, and the finalized Turkish version was prepared for the content validity phase.

Stage 2- Content validity: Stage 2 focused on content validity, which was assessed using the Davis technique. A four-point rating form was distributed to four nursing faculty members with academic expertise in nursing education and scale development to evaluate the relevance and appropriateness of each item. Although the number of experts was limited to four, this number is considered acceptable and methodologically sufficient for content validity assessment, as recommended in the literature (Davis, 1992). Experts rated each item as appropriate, slightly revised, revised, or inappropriate. Items rated as appropriate or slightly revised were used to calculate the content validity index (CVI). The item-level CVI values ranged from 0.80 to 1.00, and the mean CVI of the scale was 0.94, indicating a high level of content validity. Since the CVI value of each item exceeded the recommended threshold of 0.80 (Davis, 1992), no modifications were made to the draft scale items based on expert feedback.

Stage 3- Construct Validity: The authors conducted an exploratory factor analysis (EFA) to understand under which construct/dimension the items in the draft scale were grouped. They conducted a confirmatory

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factor analysis (CFA) to understand the accuracy of the constructs of these items (Pallant, 2020). Therefore, the third author used SPSS 26 for EFA and LISREL 8.7 for CFA to ensure construct validity.

Stage 4- Reliability study: Cronbach's alpha was used to assess the reliability of the scale and its sub-dimensions, based on the items retained after construct validity analysis. Item-total correlations were also examined to determine internal consistency. All coefficients were interpreted in line with the commonly accepted threshold of 0.70 (Pallant, 2020). Finally, the third author calculated composite reliability (CR) coefficients based on Fornell and Larcker's (1981) factor loading and error variance values (Bacon et al., 1995; Fornell & Larcker, 1981). The authors expected this value (CR) to be higher than 0.70 to ensure CR for the whole scale and each sub-dimension (Hair Jr et al., 2021).

***Stage 5- Convergent validity*:** The average variance explained (AVE) value is expected to be 0.50 and above (Hair Jr et al., 2021). At the same time, all CR values related to the scale are expected to be greater than AVE values for convergent validity (Hatcher & O'Rourke, 2013).

Data analysis

Statistical analyses for construct validity and reliability were conducted using IBM SPSS Statistics and LISREL. Data normality was assessed using skewness and kurtosis values. The suitability for factor analysis was evaluated with the Kaiser–Meyer–Olkin test and Bartlett's test of sphericity. Exploratory factor analysis (EFA) was performed to determine the factor structure, and items with low loadings, cross-loadings, or poor conceptual fit were removed. As a result, 17 items were retained. Confirmatory factor analysis (CFA) was then conducted to test the final model. Reliability was assessed using Cronbach's alpha for the overall scale and its subdimensions. Detailed factor and reliability results are presented in the Findings section.

Ethical aspects of the research

Before the initiation of the study, approval number 28, dated 28.04.2022, was obtained from the local ethics committee. Permission to adapt the scale was obtained via e-mail from the authors who developed the original scale. Participants were informed about the purpose and procedures of the study, and informed consent was obtained before participation. For face-to-face data collection, written informed consent was obtained using a printed consent form. For online data collection conducted via Google Forms, an electronic informed consent process was implemented; participants were required to read the consent statement and actively indicate their agreement by selecting the "I agree to participate" option before accessing the questionnaire. The study was conducted in accordance with the principles of the Declaration of Helsinki throughout the research design, data collection, and publication processes.

RESULTS

Content validity

After a comprehensive review of the national and international literature, Kim and Shin's (2022) scale was selected as the most comprehensive instrument for assessing readiness for nursing practice. The scale consists of five sub-dimensions: clinical knowledge and skills, professional attitudes and management, empathy, emotional control, and interprofessional communication. Content validity of the translated scale was evaluated using the Davis technique by four nursing faculty experts with experience in nursing education and scale development. Each item was rated on a four-point scale (appropriate, slightly revised, revised, inappropriate), and item-level content validity indices (I-CVI) were calculated based on the proportion of experts rating the item as appropriate or slightly revised. All items achieved an I-CVI value of 1.0, indicating that all experts rated each item as either appropriate or slightly revised. Given the limited number of experts, this result reflects

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complete agreement among the experts rather than an unusually large panel effect. The average scale-level CVI (S-CVI/Ave) was also calculated as 1.0, and the expert agreement rate across items was 100%. These findings indicate a high level of consistency between the translated items and the conceptual scope of the original scale, supporting strong content validity (Kim & Shin, 2022).

Construct validity

Construct validity was evaluated using exploratory factor analysis (EFA) followed by confirmatory factor analysis (CFA). The data were suitable for factor analysis (KMO = 0.96; Bartlett's test $\chi^2 = 5178.40$, $p < .001$), indicating excellent sampling adequacy and factorability (Field, 2024; Pallant, 2020). Multiple extraction methods were tested, showing similar results, with total variance explained ranging from 58.89% to 66.87%.

Method	Factor	Eigenvalue	Variance %	Cum. Variance %	Eigenvalue after rotation	Variance after rotation %	Cum. Variance %
PCA	1	10.03	59.01	59.01	10.03	59.01	59.01
	2	1.34	7.86	66.87	1.34	7.86	66.87
FA	1	10.03	59.01	59.01	9.67	56.85	56.85
	2	1.34	7.86	66.87	.97	5.70	62.56
ML	1	10.03	59.01	59.01	9.66	56.81	56.81
	2	1.34	7.86	66.87	.98	5.74	62.55
ULS	1	10.03	59.01	59.01	9.67	56.85	56.85
	2	1.34	7.86	66.87	.97	5.71	62.56
GEK	1	10.03	59.01	59.01	9.72	57.15	57.15
	2	1.34	7.86	66.87	1.05	6.15	63.30
AF	1	10.03	59.01	59.01	9.66	56.84	56.84
	2	1.34	7.86	66.87	.97	5.71	62.55
IF	1	10.03	59.01	59.01	9.31	54.78	54.78
	2	1.34	7.86	66.87	.70	4.11	58.89

Table 1. Variance explained according to factor extraction methods

Given the expected relationships among dimensions, direct oblimin rotation was applied. During iterative EFA procedures, 18 items were removed due to low loadings, cross-loadings, or conceptual inconsistency. The final structure consisted of 17 items and two factors, explaining 66.87% of the total variance (59.01% for Factor 1 and 7.86% for Factor 2), indicating a strong factor structure (Scherer et al., 1988).

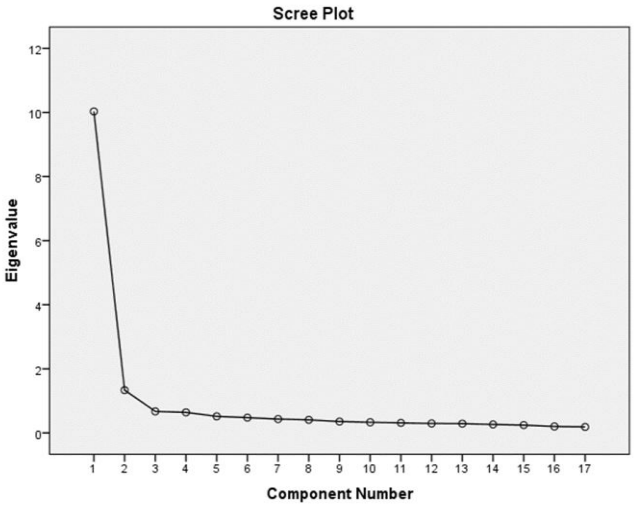

Figure 1. Scree-Plot

This reduction from the original five-factor, 35-item structure may reflect contextual differences and the modified response format. CFA supported the adequacy of the two-factor model, with factor loadings ranging from 0.71 to 0.86, exceeding the recommended threshold and indicating strong item–factor relationships (Pallant, 2020). The final model is presented in Table 3, and the path diagram is shown in Figure 2.

Factor and items	X±SS	Item number
Adequacy of knowledge and skills (Factor 1)		
I know the basic duties of the ward.	3.89±.95	3
I have the necessary nursing	3.56±.95	5
I can prioritize nursing practices according to the situation.	3.68±.94	6
I can use scientific evidence to identify changes in the patient's condition.	3.56±.93	8
During nursing care, I can determine when it is necessary to request help for abnormal situations.	3.66±.92	9
I can realize all planned nursing practices within a certain period.	3.71±.96	12
I can apply the knowledge and skills acquired from major and elective courses in an integrated manner.	3.65±.96	13
I can use the electronic medical record system skillfully.	3.25±1.00	15
I can collect the necessary information for patient care from various scientific sources.	3.75±.90	16

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I can perform patient care on my own without the help of team members.	3.50±.98	27
Self-regulation and sensory control (Factor 2)	**X±SS**	**Item number**
I believe in my skills and potential.	4.05±.89	26
I think I am needed in the ward.	3.89±.91	28
I can professionally respond to patients and relatives.	3.80±.90	30
I can positively deal with stress.	3.60±.94	31
I can find a balance between my work and personal life.	3.89±.89	32
I can ask for help from a colleague or specialist in stressful situations.	4.00±.90	33
I can control impulsive behavior in stressful situations at work.	3.73±.95	35

Table 2. Two sub-dimensions and items

Reliability and convergent validity

The study assessed the reliability of the scale scores using Cronbach's alpha, item-total correlation, and CR coefficients. The third author calculated Cronbach's alpha as .96 for the overall 17-item scale, .94 for the first subscale, and .91 for the second subscale. Item-total correlations, which indicate how well each item aligns with the overall construct, were all above the acceptable threshold of .30 (Hair Jr et al., 2021), as shown in Table 4.

Fit index	Acceptable limit	Perfect fit limit	Value of the scale	The scale's fit decision
NNFI	=.90 and up	.95 and up	.98	Perfect
CFI	=.95 and up	.97 and up	.98	Perfect
IFI	=.90 and up	.95 and up	.98	Perfect
RFI	=.90 and up	.95 and up	.97	Perfect
SRMR	Between =.05 and =.08	Between =.00 and <.05	.04	Perfect
GFI	.85 and up	.90 and up	.89	Acceptable
AGFI	.85 and up	.90 and up	.86	Acceptable
RMSEA	between .50 and =.80	=.000 and < .050	.078	Acceptable
χ2/df	It must be less than 5	It must be less than 3.	3.46	Acceptable

Table 3. The Goodness of fit indexes of the scale.
Fit indices were obtained using confirmatory factor analysis (CFA)

CR values for the total scale and each subscale exceeded .70, demonstrating internal consistency. Additionally, the average variance extracted (AVE) values were greater than .50, and all CR values exceeded the AVE values, confirming convergent validity (Hatcher & O'Rourke, 2013).

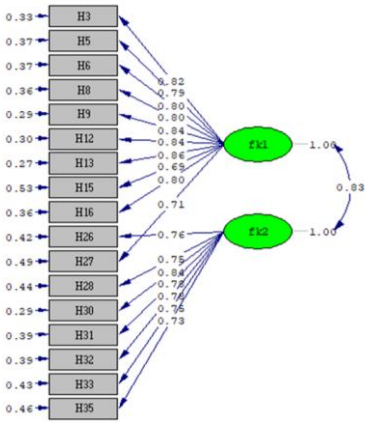

Figure 2. Path diagram

Factor 1 item number	X±SS	Item total correlation
3	3.89±.95	.77
5	3.56±.95	.74
6	3.68±.94	.75
8	3.56±.93	.74
9	3.66±.92	.79
12	3.71±.96	.78
13	3.65±.96	.81
15	3.25±1.00	.67
16	3.75±.90	.79
27	3.50±.98	.71
Factor 2 item number	**X±SS**	**Item total correlation**
26	4.05±.89	.70
28	3.89±.91	.71
30	3.80±.90	.79
31	3.60±.94	.71
32	3.89±.89	.69
33	4.00±.90	.65
35	3.73±.95	.67
Factor number	**CR**	**AVE**
1	.94	.63
2	.90	.57
Total	.96	.60

Table 4. Item total correlation values and composite reliability and convergent validity findings

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DISCUSSION

The Turkish version of the Readiness Scale for Nursing Practices demonstrated strong reliability and a high content validity index (1.0), exceeding the recommended threshold of .80 (Casanova et al., 2015). However, as also acknowledged in the discussion, the adaptation process was conducted across institutions with differing educational structures and through both face-to-face and online data collection methods. When combined with the substantial reduction in item number and the modification of the Likert response format, this process may be interpreted as challenging for preserving the original structure of the scale.

The reduction of the scale from 35 items and five factors to 17 items and two factors raises important questions regarding the suitability of the original scale for direct adaptation within the Turkish nursing education context. This reduction does not merely reflect a decrease in item numbers but also a narrowing of conceptual coverage. In particular, readiness dimensions related to patient-centeredness, collaborative interpersonal relationships, and broader psychosocial competencies—explicitly represented in the original scale by Kim and Shin (2022)—were not retained as distinct factors in the adapted version. Therefore, the adapted scale may be limited in its ability to comprehensively capture all aspects of readiness for nursing practice originally intended to address complex nursing challenges.

Several factors may explain why the original five-factor structure could not be confirmed through confirmatory factor analysis. Cultural and educational differences between newly graduated nurses in South Korea and nursing students in Turkey may have influenced how readiness-related competencies are perceived and structured. Additionally, although the translation process followed established methodological steps, subtle semantic differences may have affected item interpretation. Differences in sample characteristics are also noteworthy, as the original scale was developed with practicing new graduate nurses, whereas the present study involved students who had not yet entered active professional roles. Similar structural reductions have been reported in other adaptation studies, indicating that such outcomes are not uncommon in cross-cultural scale adaptations.

Implementation-related issues may have further contributed to the observed factor structure. Some face-to-face data collection procedures were conducted without direct supervision by the authors, potentially leading to inconsistencies in instruction delivery and completion conditions. In addition, online administration may have affected response quality due to reduced participant engagement, a limitation frequently reported in the literature (Gelinas et al., 2021; Hardy et al., 2020). Response bias and reliance on self-reported data also remain important limitations. Despite these challenges, the participation of 401 students represents a considerable and heterogeneous sample. The high KMO value (.96) indicated excellent sampling adequacy (Shrestha, 2021; Tabachnick et al., 2013), supporting the robustness of the factor analytic procedures.

It should be clarified that Bartlett's test of sphericity was used to assess the suitability of the data for factor analysis rather than to evaluate normality. The significant Bartlett's test result indicated sufficient correlations among items to justify factor analysis. Based on EFA results, the adapted scale explained 66.87% of the variance using PCA and 58.89% using image factoring, values that reflect a strong factor structure (Scherer et al., 1988).

Confirmatory factor analysis supported a two-factor, 17-item structure, whereas the original five-factor structure could not be replicated. Although two- and three-factor solutions with a larger number of items initially emerged, these models failed to demonstrate acceptable fit indices, even after splitting the sample to reduce chi-square sensitivity related to sample size (Shi et al., 2018). Con-

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sequently, overlapping items and those with weak statistical or conceptual alignment were removed, resulting in a parsimonious and robust two-factor model.

The first factor reflects competencies related to clinical knowledge and skills required for patient care, including clinical judgment, nursing performance, patient assessment, and technical skills. This factor corresponds largely to the "Clinical Judgment and Nursing Performance" dimension of the original scale and shares nine common items with Kim and Shin's (2022) model. One item (Item 27) shifted from the original second factor to the first factor in the adapted scale. This shift may be explained by the strong emphasis placed on clinical competence and practical skills in Turkish nursing education, particularly in addressing the theory–practice gap for newly graduated nurses.

The second factor represents professional attitudes related to stress management, self-regulation, emotional control, and maintaining work–life balance. Most items in this factor were originally included in the professional attitudes dimension of the original scale, while one item was previously classified under self-regulation (Kim & Shin, 2022). Kim and Shin (2022) suggested that nurses with low scores in this domain may benefit from interventions such as mentoring and counseling to improve psychosocial well-being. Accordingly, the adapted scale may be useful for identifying Turkish nurses who could benefit from similar support programs.

The modification of the response format from a 4-point to a 5-point Likert scale by adding an "Undecided" option represents another important methodological consideration. The literature suggests that the inclusion of a neutral response option may influence factor structures by increasing indecision or response centrality (Broadbent et al., 1982; Eser et al., 2020). In the present study, higher proportions of "Undecided" responses were observed for items related to psychosocial and professional role dimensions, which may have contributed to weaker factor differentiation and the inability to retain the original five-factor structure.

The reliability findings further support the psychometric strength of the adapted scale. The Cronbach's alpha coefficient for the overall scale was calculated as .96, indicating excellent internal consistency (Field, 2024). This finding suggests that the scale yields highly consistent and stable scores across applications. The results are also consistent with previous studies that developed or adapted readiness-related scales (Almaiah et al., 2022; Masso et al., 2022; Rohayani, 2015). Composite reliability values were similarly high (Hair Jr et al., 2021), and item–total correlation coefficients exceeded the recommended threshold of .30 (Özdamar, 2017). In addition, the AVE values exceeded .50, and all CR values were greater than AVE values, supporting convergent validity (Hatcher & O'Rourke, 2013).

Strengths and limitations

This study has several strengths, including a large and diverse sample and rigorous psychometric analyses to evaluate the adapted scale. Participation from multiple universities also increased the robustness of the findings. However, several limitations should be noted. The scale was reduced from 35 items and five factors to 17 items and two factors, which may limit comprehensive measurement. Data were collected both face-to-face and online, which may have affected response consistency. The use of a self-report scale and the change from a 4-point to a 5-point Likert format may also have influenced responses. Finally, the sample included only fourth-year nursing students, limiting generalizability. Future studies should use more standardized data collection procedures and longitudinal designs including students at different educational stages.

CONCLUSION

This study concludes that the adapted Readiness for Nursing Practice Scale is a valid and reliable tool with two sub-dimensions: adequacy of knowledge and skills

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and self-regulation and sensory control. The first dimension assesses clinical judgment, nursing performance, patient assessment, and technical skills, while the second focuses on professional self-regulation, emotional control, and stress management in clinical settings. The scale can help educators identify areas where nursing students or new graduates need additional support, particularly in applying theoretical knowledge and managing professional demands.

It may also guide the development of targeted educational interventions and support programs to strengthen clinical competence and facilitate the transition to professional nursing practice.

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