



EXPLORING THE CLINICAL ACCOMPANIMENT CHALLENGES  
SECOND-YEAR STUDENTS EXPERIENCE AT A NURSING  
EDUCATION INSTITUTION IN NORTH WEST

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Submitted in accordance with the requirements for the degree

**Magister Curationis (Education)**

in the

**Department of Nursing Science**

School of Health Care Science

Faculty of Health Sciences

University of Pretoria

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February 2015

## Declaration

Student number: 21312517

I, Pelegamotse Tabea Motsilanyane, declare that **Exploring the clinical accompaniment challenges second-year students experience at a nursing education institution in North West**, is my own work and that all sources that have been used or quoted have been indicated and acknowledged by means of complete references. I further declare that this work has not been submitted for any other degree at any other institution.

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Pelegamotse Tabea Motsilanyane

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Date

## Acknowledgements

I give all the glory to the Almighty for giving me the courage and the strength to complete my study.

I wish to thank the following people:

- My supervisor, Dr T Heyns, and co-supervisor, Dr IM Coetzee, for their support, encouragement and guidance throughout the period of my study.
- Mr M Volschenk, information specialist at the University of Pretoria, for training me on how to access articles from different scientific journals.
- The Head of Department of Nursing Science Dr A.M. Rakhudu, for her encouragement and for allowing me to take study days to work on my project.
- Dr A van der Wath for conducting the focus group interviews and her role as an independent coder in the data analysis phase of the study.
- The third-year nursing students for participating in the study and sharing valuable information relating to their second-year experiences.
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- Mr I Mokgaole and N Zulwayo for teaching me how to use reference works and training me on the Windows computer program.
- Ms M Mosang who was always there to support me and for taking the field notes during the data collection.

## Abstract

**Aim:** The aim of the study was to explore the nursing students' challenges of clinical accompaniment in a clinical learning environment (CLE).

**Method:** A qualitative, explorative and descriptive design was used to conduct the study. Three focus group interviews were conducted and consisted of 31 participants. Focus group 1 had 9 participants and focus groups 2 and 3 comprised of 11 participants each. All interviews were audiotaped and transcribed and then analysed using content data analysis

**Results:** Three main themes with categories and sub-categories emerged from the question that was asked from the nursing students. The identified challenges related ineffective communication, inconsiderate attitudes, insufficient resources, and inadequate planning.

**Conclusion:** The guidelines should specify the annual authorised (by SANC) period of clinical accompaniment a nursing student should receive as well as the objectives for the particular level. Clinical facilitators should be provided with the necessary support and training to allow them to function according to the expectation of the Nursing Education Institution (NEI).

**Key words:**

Clinical accompaniment; clinical facilitator; clinical learning environment; nursing student.

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### List of Abbreviations

CLE	Clinical Learning Environment
FGI	Focus Group Interview
NDoH	National Department of Health
NEI	Nursing Education Institution
SA	South Africa
SANC	South African Nursing Council
WHO	World Health Organization

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# 1 ORIENTATION TO THE STUDY

## 1.1 INTRODUCTION AND BACKGROUND

Nursing is a practice-based discipline and therefore clinical education is an essential part of a nursing programme (Henderson, Twentyman, Heel & Lloyd 2006:564; Midgley 2006:337). Clinical education takes place in the clinical learning environment (CLE) where clinical learning is facilitated through clinical accompaniment by a clinical facilitator. The CLE is the environment in which nursing students participate in the actual observation and management of patients (van Rooyen, Laing & Kotze 2005:32). Clinical accompaniment is a purposeful activity structured by a clinical facilitator to enable nursing students to overcome their need for assistance and support, ensure theory-practice integration and links the “know what” and the “know how” (Di Prospero & Bhimji-Hewitt 2011:e-61; Kotzé 2008:198; Failender & Shafranske 2003:3; Moleki 2008:1; Midgley 2006:338). Clinical accompaniment is therefore a vital component of a nursing programme to educate and train competent nurse practitioners.

Competent nurse practitioners are required to maintain quality healthcare for all citizens. This statement is consistent with the aims of the National Policy for Quality Health Care in South Africa (National Department of Health [NDoH] 2007:2). Quality education and training is required to ensure competent nurse practitioners, thus it is imperative for nurse educators to “improve programme effectiveness and demonstrate accountability” through continuous programme evaluation (Dillard & Sitkberg 2009:86).

The World Health Organization (WHO) (2008:4) states Nursing and Midwifery Education Institutions are expected to provide quality education and must develop mechanisms to ensure quality in education and training. Quality education will produce qualified graduates who will meet the needs and expectations of society (WHO 2008:4; NDoH 2007:14). During the National Nursing Summit held by the NDoH in April 2011, clinical accompaniment emerged as a national concern and nurse educators were asked to commit to produce clinical competent nurse practitioners. The relationship between clinical accompaniment and clinical competent nurse practitioners was also emphasised during the summit (NDoH 2014:3).

As nurse educators we have a responsibility to evaluate the theoretical component as well as the clinical component of the programmes that we are involved in to ensure quality education and training. The purpose of programme evaluation is to judge the merit or worth of the total programme or individual component of the programme, such as the clinical component (Billings & Halstead 2013:543). Armstrong (2008:138) makes a valid suggestion regarding evaluation of programmes by proposing that nurse educators should listen to “the students as customers”; in this way, students would be involved in the evaluation process. Giving nursing students the opportunity to give input relating to the challenges experienced in the theoretical and clinical component of the nursing programme is therefore important and necessary to enhance their training. In this study the researcher will discuss the clinical component of the pre-graduate programme, specifically on clinical accompaniment.

The Nursing Education Institution (NEI) in the North West offers a four-year comprehensive nursing programme which includes both a theoretical and clinical component (South African Nursing Council [SANC] R425:1985). As stipulated in Regulation R425 of 1985, learning opportunities should be provided in both these components. During the clinical component of the programme the SANC recommends that each nursing student should be exposed to the CLE for not less than 4000 hours within a period of four years. These hours are distributed among general, psychiatric and community nursing and midwifery (SANC R425 guide, 1994:21). Emphasising the importance of the clinical component of the four-year comprehensive programme, the NEI in the North West re-focused their attention to clinical accompaniment. Ten (10) clinical facilitators have been appointed mainly for accompaniment of the nursing students in the CLE. The researcher is responsible for coordinating the clinical accompaniment of approximately 90 second-year nursing students when rotating through the CLE.

The proposed study will enable the researcher as a nurse educator to explore the clinical accompaniment challenges second-year nursing students experience at a NEI in one of the provinces in South Africa (SA), namely North West, and make recommendations to enhance clinical accompaniment.

## **1.2 PROBLEM STATEMENT**

The clinical component of the four-year comprehensive programme which takes place in the CLE is a significant component of the curriculum as it provides the student opportunities to apply theory to



practice (Stokes & Kost 2009:283). In the view of Henderson, Twentyman, Eaton and Creed (2010:179) the quality of clinical learning in the CLE depends largely on the interaction between the nursing students and the clinical facilitators.

Nursing students at the NEI in North West are experiencing challenges relating to clinical accompaniment that affect their learning in the CLE. The researcher, as coordinator of the clinical accompaniment of the second year students, has listened to a number of challenges regarding clinical accompaniment in the clinical learning environment voiced by these students. During the researcher's day to day interaction with the second-year nursing students, they reflected on challenges they experienced in the clinical learning environment. Some of the challenges mentioned included:

- "... we [nursing students] are expected to be able to perform skills independently in the hospital ... we [nursing students] do not know how ... they [clinical facilitators] do not help us [nursing students]..."
- "... they [clinical facilitators] do not come to the hospital on a regular basis ... we [nursing students] do not know when they [clinical facilitators] are coming..."
- "... they [clinical facilitators] check if we [nursing students] are on duty and have the correct uniform ... they [clinical supervisors] do not help us with our questions..."

The evaluation of programmes is important to ensure quality education and training (O'Donoghue, Doody & Cusack 2011:170). At present the clinical accompaniment, although a vital aspect of the clinical component of the four-year programme, has not formally been evaluated. The challenges may be experienced as insurmountable obstacles by the nursing students. If this is the case, it can impact negatively on the quality of the nurse practitioners produced by the NEI once the nursing students have completed the four-year comprehensive programme. In addition, the nursing students have not been afforded the opportunity to give inputs regarding the challenges they experience with the clinical accompaniment.

As mentioned, the magnitude of the challenges experienced by the second-year nursing students is currently unknown. Therefore, the researcher decided to explore the challenges relating to clinical accompaniment in depth in order to make recommendations based on the findings from the nursing students to enhance clinical accompaniment. Through exploring and describing the challenges experienced by nursing students the researcher can make recommendations that will address such

challenges and enhance the quality of clinical accompaniment. This will enable the researcher as nurse educator to enhance quality education and training in the CLE utilised by second-year students in future.

### 1.3 RESEARCH QUESTION

The following research question guided this study:

What are the challenges second-year nursing students experience pertaining to clinical accompaniment at a nursing education institution in the North West?

### 1.4 AIM OF THE STUDY

The overall aim of the study was to explore the clinical accompaniment challenges second-year nursing students experience at an NEI in North West.

### 1.5 SIGNIFICANCE

Nursing students will be provided an opportunity to give feedback regarding the clinical accompaniment challenges they experience in the CLE. Based on the feedback obtained from them, the researcher will have a better understanding of the challenges students experience regarding clinical accompaniment during their second year of training. In her role as clinical facilitator, the researcher will share the voiced challenges with nurse educators and clinical facilitators involved in the clinical accompaniment of second-year students.

The NEI can use the study findings and suggested recommendations to guide them in planning and implementing strategies to address the challenges. Addressing the challenges, coming up with solutions and attending to them can enhance the current clinical accompaniment practices. Other NEIs countrywide may also benefit by adopting the recommendations of this study thus improving the quality of clinical accompaniment in general. Increasing the quality of clinical accompaniment will lead to an increased 'product' (better trained and skilled nurse practitioners) at the end of the four-year programme.

Continuous comprehensive in-service programmes related to clinical accompaniment may be developed for both the clinical facilitators and the nurse educators. Such programmes may assist the clinical facilitator to provide quality clinical accompaniment while at the same time enabling nursing students to integrate theory and practice.

The ward staff involved in a CLE can also benefit by involving the hospital management to address issues of shortages of staff and equipment, thus improving the quality in healthcare service. The findings of this study may furthermore assist the ward staff to maximise the nursing students' clinical learning opportunities for accompaniment.

Finally, by conducting this study a more student-centred approach in clinical teaching and learning may be promoted that may increase the nursing students' satisfaction in a CLE and decrease the absenteeism rate in the clinical services. The researcher will also disseminate the study findings through publication in different national scientific journals.

## 1.6 SETTING

A study setting is defined by Polit and Beck (2010:568) as the physical location and the conditions in which data collection take place when conducting a research study. Qualitative data collection is usually done in a real-world, naturalistic setting because the researcher may deliberately strive to study phenomena in a variety of natural contexts (Polit & Beck 2010:568). Conducting a study in a natural setting therefore means that the researcher does not make any effort to change or manipulate the environment for the study (Burns & Grove 2011:40).

In this study the setting was a level two government hospital, which is also a general and referral hospital, situated 13 kilometres from the NEI. At the time of the study, the hospital consisted of 18 wards with a bed capacity of 392. The hospital employed only full-time staff members, namely, 202 professional nurses, 202 enrolled nurses and 108 nursing auxiliary nurses (auxiliaries). In the medical ward, for example, seven professional nurses were allocated for approximately 60 patients with four nurses on day duty and three on night duty. Having four professional nurses on day duty meant that two of them were off duty, leaving the medical ward with only two or one registered nurse for 60 patients. The nursing students rotated through the following wards: gynaecological, surgical, medical,

the outpatient department and casualty. It is the norm that the nurse educators together with the clinical preceptors are responsible for the clinical accompaniment of the nursing students.

There are also three other institutions that usually allocate their students to the hospital for clinical learning: two nursing institutions and one institution for emergency medical practitioners.

## 1.7 PARADIGM

The interpretivist paradigm was used to guide this study. It provided this researcher with the opportunity to have “a way of looking at natural phenomena that encompasses a set of philosophical assumptions and that guides one’s approach to inquiry” (Polit & Beck 2008:761; Burns & Grove 2009:713). The researcher took the participants’ (second-year nursing students’) subjective experiences as the “essence of what is real for them” (Terre Blanche, Kelly, Durrheim & Painter 2006:274) in an attempt to “enter another’s world and to discover the practical wisdom, possibilities and understandings found there” (Polit & Beck 2008:229). The researcher was committed to understand and rely on the participants’ views pertaining to the challenges they experienced regarding clinical accompaniment as it occurred in the CLE as described by Terre Blanche et al. (2006:276).

Using the interpretivist paradigm allowed the researcher to form a circular relationship with the second-year nursing students in which she attempted to understand the “whole text in terms of its parts, and the parts in terms of the whole” as viewed by the students (Polit & Beck 2008:229). Throughout the study, the researcher continuously questioned the meaning of the feedback obtained, looking for “frames that shape meaning” as suggested by Henning, van Rensburg and Smith (2004:20) in an attempt to understand the nursing students’ challenges relating to clinical accompaniment.

## 1.8 ASSUMPTIONS

Polit and Beck (2008:748) define assumptions as “[a] principle that is accepted as being true based on logic or reason, without proof”. The paradigms of human inquiry are categorised according to the ways they respond to the three basic philosophical questions (Polit & Beck 2008:13).

**Table 1.1: Summary of the assumptions**

Assumption	Application
<i>Ontological:</i> What is the nature of reality?	<ul style="list-style-type: none"> <li>○ Reality is multiple, subjective and is mentally constructed by individuals.</li> </ul>
<i>Epistemological:</i> How is the inquirer related to those being studied?	<ul style="list-style-type: none"> <li>○ The researcher interacted with those being studied.</li> <li>○ Knowledge creation was a collaborative, inductive process.</li> </ul>
<i>Methodological:</i> How is evidence best obtained?	<ul style="list-style-type: none"> <li>○ Sought in-depth understanding and information was narrative.</li> <li>○ Emerging insight was grounded in participants' experience.</li> <li>○ Context bound and contextualised.</li> <li>○ The methodology was a flexible and emergent design with qualitative data analysis.</li> <li>○ The aim of the research was to make recommendations to address the challenges with regard to clinical accompaniment.</li> </ul>

**Source: Adopted from Polit and Beck (2008:14)**

The constructivist paradigm is referred to as the naturalistic paradigm, which is based on specific assumptions (Polit & Beck 2008:15). Table 1.1 provides the assumptions on which this study was based as well as the application of these assumptions to the study as derived from the constructivist paradigm.

## 1.9 CLARIFICATION OF KEY CONCEPTS

Key concepts are defined to ensure that the meaning is clear and to enhance the simplicity and consistency throughout the study.

### 1.9.1 Clinical accompaniment

'Clinical accompaniment' means a structured process at an NEI to facilitate assistance and support to the learner by the nurse educator in the clinical facility to ensure the achievement of the programme

outcome as defined by the Nursing Act (Act 33 of 2005:2). In this study the term 'clinical accompaniment' refers to the planned process and involvement of a clinical facilitator in accompaniment and guidance of a second-year nursing student in a CLE.

### **1.9.2 Clinical facilitator**

Uys and Meyer (2005:12) define a 'clinical facilitator' as a registered professional nurse who provides professional guidance and academic leadership to nursing students, mainly in the clinical field. For the purpose of this study a 'clinical facilitator' is a nurse educator, a preceptor and a clinical registered nurse who accompanies the second-year nursing students in a CLE to provide guidance during the integration of theory and practice.

### **1.9.3 Clinical learning environment**

Lambert and Glacken (2005:665) define the 'clinical learning environment' (CLE) as an environment in which clinical learning takes place or the focal point of nurse education. Vallent and Neville (2006:1) add that the 'clinical learning environment' is an interactive network of forces within the clinical setting that influence the students' clinical learning. In this study the 'clinical learning environment' refers to a clinical area where nursing students are placed on rotational bases to do their clinical learning during the second year of a four-year comprehensive programme presented at an NEI in North West. The clinical areas are wards in an academic hospital to provide the nursing students learning opportunities for medical and surgical nursing. The second-year nursing students rotate within different wards, namely, the medical, surgical, gynaecological, outpatient department and casualty for their clinical learning.

### **1.9.4 Nursing education institution**

According to the *Nursing Act, 33 of 2005* a nursing education institution (NEI) is an institution of which the intent is to conduct a nursing education and training programme to prepare persons for practice as a professional nurse, midwife and auxiliary nurse. In this study the 'nursing education institution' (NEI) refers to an institution in North West where nursing students enrol for a comprehensive programme and are educated and trained for a period of four years to become professional nurses. The NEI also offers masters and doctoral degrees for nurses.

### 1.9.5 Nursing student

The *Nursing Act, 33 of 2005* defines a 'nursing student' as a person who is following a programme of study in a nursing education and training institution. For the purpose of the study the term 'nursing student' refers to an individual who is enrolled for the pre-graduate comprehensive nursing programme in the NEI in North West and is in the second year of study.

## 1.10 RESEARCH DESIGN AND METHODS

The research design is defined as a systematic plan for a research project (Flick 2014:542) or the overall plan for addressing the research question (Polit & Beck 2008:765). As suggested by Jooste (2013:297) the chosen design should be appropriate and applicable for the identified problem statement and, in the view of Flick (2014:132), should be applied according to the methodological element and targets.

Green and Browne (2011:9) define a research method as a particular strategy for answering a research questions and it is influenced by the aim of research, that is, what the researcher is trying to find out. A qualitative approach, using an explorative and descriptive design, was used to conduct this study. The researcher chose this approach to achieve the purpose and objective of the study which was to explore the clinical accompaniment challenges second-year nursing students experience at an NEI in North West.

### 1.10.1 Qualitative approach

Polit and Beck (2008:763) define qualitative research as the investigation of a phenomenon, typically in an in-depth and holistic fashion, through the collection of rich narrative material using a flexible research design. The qualitative method in this study consisted of a focus group interview (FGI) and thematic content analysis (view Section 3.3.3.2). The researcher chose the qualitative approach because it allowed her to conduct in-depth interviews and to classify the phenomenon investigated, namely, the experiences of challenges among the nursing students with their clinical accompaniment in the CLE (Green & Browne 2011:13).

### 1.10.2 Explorative design

Johnson and Christensen (2008:23) describe an exploratory design as an attempt to generate ideas about phenomenon which is important at the early phase of the research because the researcher must generate ideas about the phenomenon before additional research can progress. Exploratory research begins with a “phenomenon of interest and investigates the full nature of the phenomenon, the manner in which it is manifested and the factors to which it is related” Polit & Beck 2008:20). The researcher used the exploratory design in order to explore the challenges related to clinical accompaniment as perceived by the nursing students.

### 1.10.3 Descriptive design

The purpose of descriptive research, according to Polit and Beck (2008:274), is to observe, describe and document aspects of a situation as it naturally occurs; it can also serve as a starting point for theory development. A descriptive design focuses on the richness and depth of the experience with the researcher being the tool for data collection and listening to individual descriptions of quality of life through the interview process (Streubert & Capenter 2011:81) The researcher described the challenges nursing students experience relating to clinical accompaniment in the current study.

In this study the challenges relating to the clinical accompaniment as perceived by the second-year nursing students were fully described to bring a clear meaning to the study. The independent facilitator was used as a tool for data collection. The researcher then studied the data as they had been transcribed verbatim and reviewed repeatedly what the participants had described as the challenges they encountered regarding accompaniment in a CLE.

**Table 1.2: Summary of the methods**

Population	Sampling	Data collection	Data analysis	Trustworthiness
Third and repeating second-year pre-graduate nursing students (view section 3.3.1)	Purposive sampling (view section 3.3.2.1)	Focus group interview	Content analysis	<b>Strategies utilised included:</b> Credibility Dependability Transferability Authenticity



An in-depth discussion of the research design and methods is provided in Chapter 3.

## 1.11 ETHICAL CONSIDERATIONS

Ethical considerations are important in nursing research because human beings are used as study participants (view Annexure A). The researcher must ensure that the human rights of these participants are protected at all times during the research study (Polit & Beck 2008:167). Three primary ethical principles have been identified which influence the conduct in nursing research: beneficence, respect for human dignity, and justice (Polit & Beck 2008:170).

The Nuremberg Code, as described by Burns and Groove (2005:177), reflects the three notions most appropriate to this study and which the researcher upheld. These include the principles of beneficence, respect for human dignity and justice.

### 1.11.1 Beneficence

According to Maltby, Williams, McGarry and Day (2014:348), the principle of beneficence is based on the requirement to benefit the individual which includes the requirement to safeguard the welfare of the participant. Moule and Goodman (2009:57) view this principle as the principle of “doing good” to both the participants and the society, and the expectation thereof being to benefit both the participants and the society. In this study the society that would benefit was all the nursing students at the NEI in North West including the participants. Beneficence requires from the researcher to ensure that harm is minimised and benefits are maximised. The principle of beneficence includes: the right to freedom from harm and discomfort and the right to protection from exploitation (Polit & Beck 2008:170). The participants were informed (view Annexure B1) that the study intended not only to benefit them as participants but also the entire nursing student population regarding clinical accompaniment.

#### 1.11.1.1 *The right to freedom from harm and discomfort*

No unnecessary risks for harm or discomfort should be imposed on participants participating in research studies and their participation must be essential in achieving the research objectives (Polit & Beck 2008:170). In the current study there were no known risks for physical, psychological, emotional or social harm. However, it was expected that participants might experience slight discomfort in terms of the time required for participation in the focus group interview. The researcher strived to minimise

this discomfort by adhering to the scheduled time for the interview. She did not extend the timeframe without the permission of the participants and then only if it was truly necessary.

### **1.11.1.2 The right to protection from exploitation**

Participation in a research study must not put the participants in a “disadvantage or expose them to situations for which they have not been prepared” (Polit & Beck 2008:171). In this study the researcher assured the participants that their participation and the data they provided would not be used against them in any way and neither would it influence their academic performance in any manner, whether they chose to participate or not. The researcher furthermore strived to adhere to any agreement made between her and the participants and did not exploit the researcher-participant relationship. For this reason, she chose the third-year nursing students to give inputs based on their experience as second-year students so that they could freely deliberate because they had already completed their second year.

### **1.11.2 Respect for human dignity**

The principle of respect for human dignity involves the right to self-determination and the right to full disclosure (Polit & Beck 2008:171). The right to self-determination means that an individual has the right to decide whether or not he or she wants to participate in a study with no risk of penalty or prejudicial treatment (Polit & Beck 2008:172). The right to self-determination also implies that the participant has the right to withdraw from the study at any time if the need arises, to refuse to give information they do not feel comfortable to give, and to ask for clarification about the purpose of the study if it is not clear to them (Brink, van der Walt & van Rensburg 2006:32). In this study the researcher ensured verbally as well as in writing that participants understood that their participation was of their own free will and that they could choose to withdraw from the study at any time they wished to do so (view Annexure B1). The researcher made sure that the participants were not coerced to participate.

For the participants to make informed, voluntary decision regarding participation in this study, it was necessary to discuss the following information with them: the nature of the study, their right to refuse participation, the researcher’s responsibilities, and the risks and benefits involved in the study (Polit & Beck 2008:172). There was no reason for deception or concealment of this information. Full disclosure of the information was done on the information leaflet (view Annexure B1) they received which also

served as the consent form. The researcher made herself available to clarify any uncertainties or answer questions related to the study.

### 1.11.3 Justice

The principle of justice involves the right to fair treatment and the right to privacy (Polit & Beck 2008:173). The principle of justice is concerned with fairness and the participants are not obliged to take part in the research study by virtue of any pre-existing relationship (Maltby et al. 2014:348). Benefits and burdens of research must be equally distributed, and study participants must be selected based on the requirements of the study and “not on vulnerability or compromised position” (Polit & Beck 2008:173). The principle of justice not only focuses on a fair selection of participants, but also involves the fair treatment of people who decline to participate in the study or who withdraw from the study. In this study the researcher obtained a fairly selected group of participants through purposive sampling. She ensured that she treated all prospective participants, including those who declined participation as well as those who withdrew during the course of the study, equally and without prejudice.

The researcher further ensured that strict confidentiality was maintained throughout the study. According to Moule and Goodman (2009:57), confidentiality is the ethical principle of safeguarding the personal information which was gathered during data collection. No information was (or will be) used in such a manner that it reveals the participants identities. The study was not more intrusive than required to achieve its objectives and the participants’ privacy was maintained at all times during the study as well as thereafter. In addition, an independent facilitator was used to collect the data which further enhanced confidentiality.

**Table 1.3: Summary of the application of the principles of the Nuremberg Code**

Principles of the Nuremberg Code	Application to this study
Voluntary consent is essential	Completion of the informed consent form constituted voluntary consent for participation in the study.
Study should yield fruitful results for the good of the nursing students	The results of this study were used to develop recommendations on the clinical accompaniment of nursing students that can be implemented in the clinical learning environment where the students are placed.  The researcher regarded this study as an essential step in ensuring quality clinical accompaniment of the nursing students in the NEI in North West

Principles of the Nuremberg Code	Application to this study
Previous results should justify the study	The researcher conducted an in-depth literature control on the topic to ensure trustworthiness.
Study should avoid all unnecessary physical and mental suffering and injury	There were no perceived risks or harm to participants in this study, as there were no planned interventions or potentially harmful activities included.
No study should be conducted if it is believed death or disabling injury will occur	Participants received an information leaflet explaining the aims and objectives of this study. There were no perceived risks that could have led to disability or death.
The degree of risk should never exceed the potential benefits of the study	In this study there were no risks for the participants involved in the data collection process.
The study should only be conducted by qualified persons	The researcher is a qualified registered nurse and has successfully completed a research methodology module. In addition, the supervisors are both recognised researchers.
Participants were free to withdraw participation at any time	It was explicitly explained to participants that they may withhold consent or withdraw from the study at any time during the data collection without risk of penalty or prejudice.
The researcher undertaking the study was prepared to stop the study if a continuation was likely to cause harm	Approval for this study was provided by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.

**Source: Adopted from Burns and Grove (2005:177)**

## 1.12 DISSEMINATION

Dissemination of research refers to the publishing of the research findings to selected audiences. Stommel and Wills (2004:111) note that the research dissemination phase of the research process is a key step in the research utilisation process.

The information on the findings and the recommendations of this study will be disseminated by the researcher by using the following strategies:

- publish an article on clinical facilitation in an accredited nursing journal
- present the findings and recommendations to colleagues at the NEI who are involved in clinical accompaniment of second-year nursing students
- present the research findings at a national conference.

### 1.13 LAYOUT

The layout of this study is represented in Figure 1.1

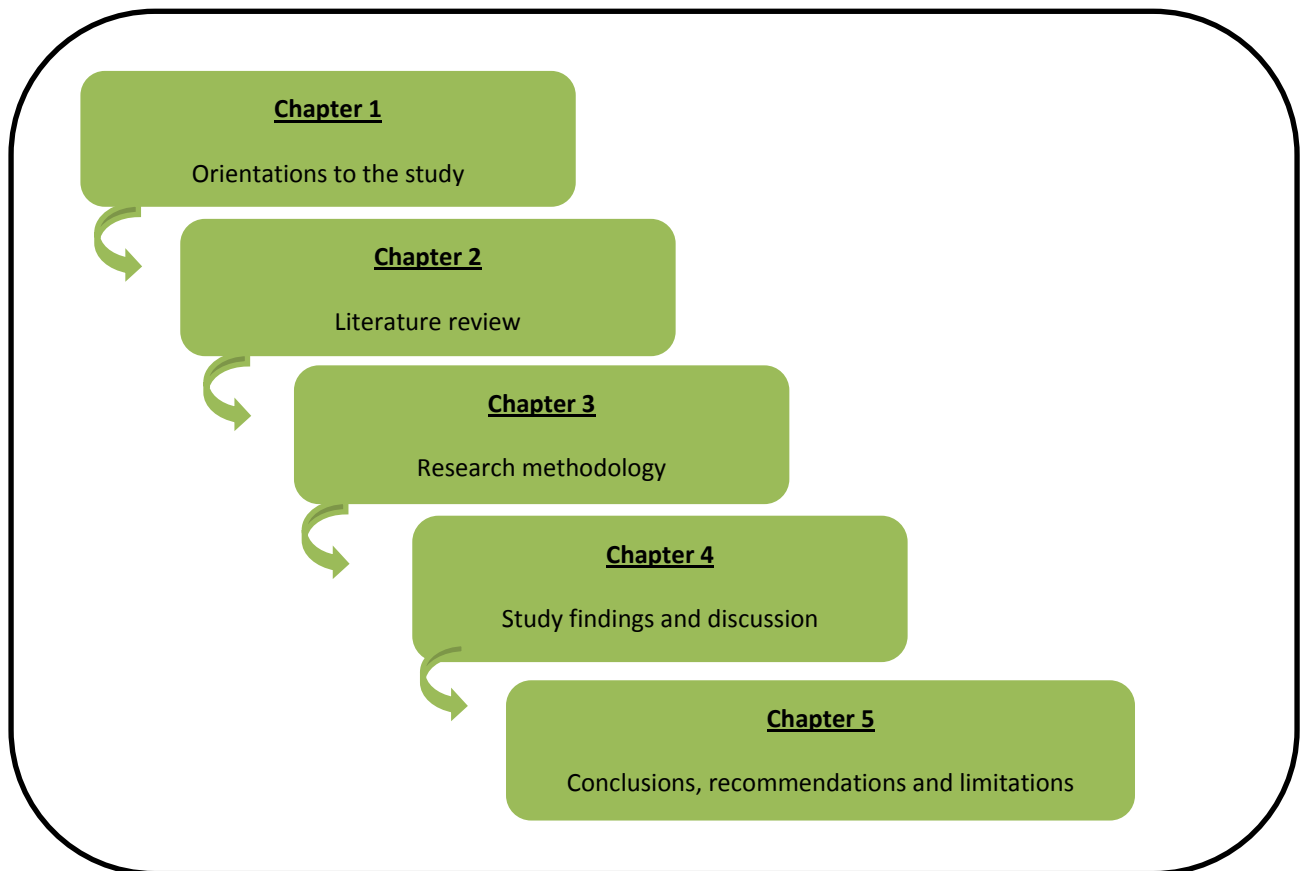


Figure 1.1: Layout of the study

### 1.14 SUMMARY

Chapter 1 provided an orientation to the study which gave the background of the study, problem statement and aim and objectives on clinical accompaniment. The chapter also outlined the significance, setting, paradigm and assumptions. Working with an interpretive paradigm the researcher

used qualitative, descriptive, and explorative FGI research methods to address the study aim and objectives. Ethical consideration was briefly discussed and a layout of the entire dissertation was given.

In Chapter 2 an in-depth literature review is provided with regard to the clinical accompaniment and CLE.

## 2 LITERATURE REVIEW

### 2.1 INTRODUCTION

Chapter 1 orientated the reader to the study. Chapter 2 provides an in-depth discussion of the nursing programme, the clinical learning environment (CLE) clinical facilitation as well as clinical accompaniment done by the clinical facilitators in the CLE.

### 2.2 NURSING PROGRAMMES

Uys and Gwele (2005:22) define a programme as a coherent set of courses leading to a certain degree, diploma or certificate which may consist of compulsory (core) or elective (optional) courses. Programmes consist of a course, which is the building block of the programme, a subject which is the identifiable area of the knowledge, a module which is a unit within the programme, and a level which is a period during which the subject or courses taken are at the similar level of difficulty. Pre-registration programmes are those that nursing students take to become professional nurses. In accordance with the Nursing Act (no. 33 of 2005) the South African Nursing Council (SANC) defines “programme” as a purposeful and structured set of learning experiences that leads to a qualification, which may be “disciplined-based, professional, career-focused, trans-, inter- or multidisciplinary in nature” (SANC 2005:4). The SANC Regulation (R425) on the Education and Training of a nursing and midwife course leading to registration as a nurse (general, psychiatric and community) and midwife is in line with the approval of and the minimum requirements for the education and training of a nurse as stipulated in the Act (2005:4). The training includes modules in general, psychiatric and community nursing and midwifery.

In the SANC regulation (R425) (SANC 1985:20) an ‘academic year’ is defined as a period of at least 44 weeks in any calendar and the ‘course of study’ as a programme of education and training approved in terms of Section 15(3), leading “to the obtaining of qualification which confers on the holder thereof the right to registration as a nurse (general, psychiatry, community) and midwife.

The SANC regulation R425 (1985:21) prescribe 4 000 hours clinical experience for the four-year nursing programme. Although the prescribed hours do not guarantee the competencies, this was seen as the only measure to ensure that the desired programme outcome is achieved. The clinical hours are appropriately distributed in respect of the sub-disciplines (General Nursing, Psychiatric Nursing Science, Community Nursing Science and Midwifery).

**Table 2.1: Specific allocation of clinical hours according to SANC Regulation R425**

Module	Clinical hours
Nursing Practice ( <i>general, psychiatric and community</i> )	1 000 hours
Preventive and promotive health:	1 500 hours
Curative health:	500 hours
Midwifery Practice:	1000 hours

In the United Kingdom (UK) the Nursing and Midwifery Council (2010:8), stipulates that in the pre-registration nursing programme not less than 4 600 hours over a period of at least three years must be completed. All nursing students must complete it within a period of five years for full-time students and seven years for part-time students according to the new Standards for pre-registration nursing education. Half of the hours of the programme are spent in practice while the remaining half (2 300 hours) at the nursing institution for theory. The Nursing and Midwifery Council in Nigeria has a new standard of general nurse training; the current duration of three years of general nurse training was reduced from the previous three-and-a-half years (Dolamo & Olubiyi 2013:18).

Unlike the 4-year curriculum for both diploma and bachelor's degree nursing science, programmes in South Africa (SA), the United States of America (USA) and China presents baccalaureate programmes which stretches over a five-year timeframe, which is equal in duration to most of the medical programmes in China (Xu, Xu & Zhang (2000:210). According to Midgley (2006:3) the key component of courses leading to registration as professional nurse is the mastery of clinical skills. For a nursing student to work towards mastering all these skills, a clinical learning environment that is conducive to learning is required. Chan and IP (2006:677) state the CLE is a vital element of nursing education and therefore investigations on the central role that the CLE plays in nursing students' experience and learning need to be extensively studied.



## 2.3 CLINICAL LEARNING ENVIRONMENT

Nursing as a practice-based profession uses the CLE to provide experience with real patients and real problems. In this environment nursing students are able to use knowledge in practice, develop skills in problem solving and decision making and develop critical thinking and clinical reasoning skills (Reilly & Oermann 1992:115; Meyer & Van Niekerk 2008:17). This view is supported by D'Souza, Venkatesaperumal, Radhakrishnan and Balachandran (2013:26) who state that CLE provides an opportunity for nursing students to combine their cognitive, psychomotor and affective skills.

According to Papastavrou, Lambrinou, Tsangari, Saarikoski and Leino-Klipi (2010:176) and D'Souza et al. (2013:26), the CLE is a complex social entity that influences nursing students' learning outcomes in the clinical setting. The quality of a CLE is viewed by Hosoda (2006:481) as an essential factor in determining the quality of nursing students' clinical experience. Consequently, Ranse and Grealish's (2007:173) statement that the CLE allows nursing students to become immersed in practice and provides them with the opportunity to repeat experiences, supports Hosoda's (2006:187) view regarding the quality of a CLE. Ranse and Grealish (2007:173) add that such experiences assist the nursing student to develop clinical judgement skill through opportunities to differentiate between the 'usual' and the 'unusual'. In the CLE the nursing student is given the opportunity to learn about the norms of practice which include the processes on care delivery.

### 2.3.1 Characteristics of the CLE

Midgley (2006:3) identifies the characteristics of CLE firstly as an "organisation of work unit" and, secondly, as a pattern of interaction which contributes to this environment. Each of these two characteristics is discussed briefly in sections 2.3.1.1 and 2.3.1.2.

#### 2.3.1.1 Organisation of work unit

It is important to identify the views of students regarding CLE to enhance the learning experience. The "organisation of work unit", according to Papastavrou et al (2010:177), refers to "the unit premises" being the CLE that includes the nature of care delivery, the unit nursing philosophy and the delivery of care. The unit must be organised in such a manner that the flow of information related to patient care is maintained; there must be accuracy in documentation of nursing records such as a nursing care plan and clear recordings of nursing procedures. "Organisation of the unit" also includes teaching

programmes and daily delegation of duties for nursing students. Hosoda (2006:481) suggests that the CLE should stimulate reflective learning in clinical practice.

### 2.3.1.2 Pattern of interaction

The “pattern of interaction” involves encouraging nursing students to participate in the discussions during ward rounds or case presentation or patient care in a CLE and that a spirit of solidarity reigns among the clinical facilitator and the nursing students (Papastavrou et al. (2010:177).

**Table 2.2 Summary of characteristics of CLE**

Characteristics	Application to this study
Individualisation	<ul style="list-style-type: none"> <li>○ This refers to the extent to which students are allowed to make decisions and are treated differently according to their ability and interests. The students are generally allowed to work at their own paces.</li> </ul>
Innovation	<ul style="list-style-type: none"> <li>○ The extent to which the clinical facilitator plans new, interesting and productive clinical experiences, teaching techniques and learning activities.</li> <li>○ New ideas are seldom tried out in this ward (the CLE).</li> </ul>
Involvement	<ul style="list-style-type: none"> <li>○ The extent to which the students participate actively and attentively in hospital ward activities.</li> <li>○ There are opportunities for students to express opinions in this ward.</li> </ul>
Personalization	<ul style="list-style-type: none"> <li>○ Emphasis on opportunities for individual students to interact with the clinical facilitator as well as concern for a student’s personal welfare.</li> <li>○ The clinical facilitator considers the student’s feeling(s).</li> </ul>
Task orientation	<ul style="list-style-type: none"> <li>○ The extent to which clinical activities are clear and well organised, for example, daily delegation of tasks.</li> </ul>
Satisfaction	<ul style="list-style-type: none"> <li>○ The extent to which nursing students enjoy learning in a CLE.</li> </ul>
Placement	<ul style="list-style-type: none"> <li>○ The extent to which nursing students are looking forward to clinical placement.</li> </ul>

**Source: Adopted from Chan and Ip (2006:680)**

### 2.3.2 Clinical placement

The clinical placements of nursing students in a CLE is pivotal in providing an opportunity for skills development as well as an opportunity for active participation in patient care (Newton, Jolly, Ockerby & Cross 2010:1372). The clinical placement of nursing students is done according to the expected outcomes for the particular level or year of training. Delany and Molloy (2009:84) state clinical placement is fundamental to the educational experience of entry level professionals where nursing

students are expected to demonstrate the application of clinical skills in a specific context under direct supervision. Clinical placement should be planned in such a way that the clinical skills performed during the placement are aligned to the theoretical content. As stated by Jackson, Hutchinson, Everett, Mannix Peters, Weaver and Salamonson (2011:108), clinical placement can help nursing students to reinforce and further develop a sense of professional identity; a characteristic that will enable them to withstand possible harmful and hostile behaviour from the ward staff in the CLE. The NEI engages clinical facilitators to ensure there is support for the nursing students during clinical placement.

When the clinical placement of nursing students is planned, it is important that the number of students is verified and the clinical area and the length of clinical placement are determined to ensure that the clinical area is not saturated with too many students. It is further important that the spreading a greater number of the nursing students more evenly in clinical areas is borne in mind (Barnett, Cross, Jacob, Shahwan-Akl Welch, Caldwell & Berry 2008:57). The clinical placement of nursing students can never occur in isolation from the context of the CLE in which it takes place.

### **2.3.3 Integration of theory and practice**

Thistlethwaite (2013:180) explains the integration of theory and practice as the translation of classroom-based learning and theory into the clinical setting. The theory-practice gap occurs when there is disparity between what has been learned in the classroom setting and what is practiced in the CLE (Kaphagawani & Useh 2013:182). The main goal of effective CLE is to therefore integrate theory and practice.

Papastavrou et al. (2010:177) state nursing education is characterised by a close relationship between theory and practice which means that nursing cannot be learned through either theory or practice only; thus, the integration of theory and practice forms the core of successful nursing practice. According to Henderson et al. (2006:8), the integration of theory and practice is an important component of nursing education that is maximised through effective clinical placement. A highly effective theoretical input in the classroom setting will never be considered to singularly cater for the complexities that can be encountered in a clinical situation. Beukes, Nolte and Arries (2010:1) support the idea that theory-practice integration encapsulates the facilitation and development of professionalism in nursing students as future health care professionals.

## 2.4 TEACHING STRATEGIES

Billings and Halstead (2013:154) define teaching strategies as “teacher centered strategies” that are used to describe the kind of activities the clinical facilitator engages in when teaching the nursing students in a CLE. These authors further state that the clinical facilitator needs to select strategies that match the objectives and the outcome of the curriculum so that the nursing students have the opportunity for maximum learning. It is very important for the clinical facilitators to make use of different teaching strategies in different clinical situations so as to enhance learning and to motivate the nursing students to become eager to learn more during their clinical accompaniment. The teaching strategies used during clinical accompaniment in a CLE are discussed next. These strategies are problem solving, critical thinking, concept mapping, observation, demonstration and reflection.

### 2.4.1 Problem solving

Problem solving is the most important teaching strategy that is used by the clinical facilitator during clinical accompaniment. Alfaro-LeFeVre (2007:12) asserts that understanding problem solving strategy is a key part of critical thinking. As a teaching strategy, for example, when they are caring for patients with different conditions nursing students must know how to prevent and manage complications of such conditions. In other words, nursing students must be taught how to prevent problems before they happen.

The approach to problem solving in clinical practice that Kinnell and Hughes (2009:171) highlight to identify a clinical problem, search the literature, critically evaluate the evidence and determine the appropriate interventions. The clinical facilitator is responsible for helping the nursing student to define a clinical problem and to ascertain that the student has already learned the concept and the rules that will be needed to solve the problem. Harris (2007:55) suggests that clinical facilitators should allow the nursing student to “discover” the answer rather than providing all the solutions, and to accommodate the nursing student’s style of operating and thinking. Harris (2007:54) further states the clinical facilitator points the way, leaves the nursing student alone when necessary and helps her or him to find the courage within her- or himself. Trust and support from the clinical facilitator also allow the nursing students to manage problems on their own and to learn to become more independent.

### **2.4.2 Critical thinking**

Critical thinking, according to Benner and Sutphen (2010:67), has become an important teaching strategy for all forms of thinking required in nursing practice. Teaching clinical reasoning and thinking in multiple ways (using different strategies) during clinical accompaniment is beneficial to the nursing student. These authors suggest that thinking like a nurse requires clinical reasoning as well as critical scientific and creative thinking. Velde, Wittman and Vos (2006:50) define an ideal critical thinker as an “inquisitive, flexible, open minded and a well-informed person who is honest in facing personal biases, prudent in making judgment and willing to reconsider”. Critical thinking is the ability to solve problems by using highly cognitive thinking processes whereby information is implemented in a creative, logical analytic and scientific manner (Uys & Meyer 2005:13).

### **2.4.3 Concept mapping**

Concept mapping is defined by Conceição and Tailor (2007:268) as a strategy that allows a learner to interrelate isolated concepts through visual representation of what they understand. In nursing, concept mapping helps the student to synthesise data such as diagnoses, signs and symptoms, health needs, assessment and nursing intervention (Hill 2006:36). The author adds that concept mapping encourages the nursing student to organise information and understand complex relationships.

Lee, Chiang, Liao, Lee, Chen and Liang (2013:1219) support the use of concept mapping as a tool for enhancing a nursing student’s critical thinking skill by encouraging the student to process information deeply for understanding. Emerson (2007:224) states concepts mapping can also be used to link theory and practice whereby the nursing students select and organise concepts so that contextual perspectives become apparent as relationships emerge. Emerson (2007:225) suggests that, if the approach of concept mapping to clinical preparation is to be successful, nursing students must be taught how to create them and their potential value to the students in learning. Concept mapping can be used in case studies designing a nursing care plan and may provide fodder for clinical questioning.

### **2.4.4 Observation**

Costley, Elliott and Gibbs (2010:121) define observation as “looking, listening and being aware of your surroundings, noting what is interesting, strange, seemingly important or significant, amusing shocking

or telling”. Observation is important teaching strategies that can help the nursing student to learn before working directly with the patient in the CLE. According to Billings and Halstead (2013:311), the foundation of the nursing skill is grounded in observational learning whereby behaviour must be retained so that the student can imitate it. The authors ascertain that behaviour can be learned by observation of a model and subsequent imitation. This is referred to as the true observational learning of clinical skills of which the critical factors thereof are attention, retention, production and motivation. Production can be facilitated when the nursing student is afforded an opportunity to give immediate and accurate feedback in practice of clinical skills.

#### **2.4.5 Demonstration**

Demonstration is one of the teaching strategies commonly used in the CLE. It is an attempt to enhance learning and to reduce the nursing student’s anxiety and is also the traditional method for skill teaching whereby the clinical facilitator will be demonstrating the clinical skill to a student or group of nursing students in a CLE. Löfmark, Thorkildsen, Råholm, and Natvig (2012:1) state if nursing students are to acquire knowledge and skills in a CLE, someone must be there to demonstrate how theoretical knowledge can be integrated into practice.

Using demonstration is important and, as suggested by Billings and Halstead (2013:309), should be demonstrated more than once to ensure that students benefit from the skill demonstration whilst return demonstration with continuous practice can increase nursing students’ competence of skill performance. Kelly, Lyng, McGrath and Cannon (2009:293) believe that single skill demonstration is not sufficient and nursing students would benefit from being able to see the skills repeatedly. Bloomfield and Jones (2013:1606) add that demonstration videos as a multimedia feature are an effective means of clinical skill education.

#### **2.4.6 Reflection**

Reflection is defined by Stalmeijer, Dolmans, Wolfhagen and Scherpbier (2009:537) as ways of stimulating the nursing students to deliberately consider their strengths and weaknesses. Tanner (2006:208) mentions that reflection enhances learning from experience; it helps nursing students expand and develop their clinical knowledge and improves their judgement in complex situations as well as with clinical reasoning. Reflection enables the nursing student to look for flaws, gain better

understanding, double-check their thinking and correct and improve their thinking (Alfaro-LeFevre 2007:16). In a CLE nursing students can demonstrate reflection in two ways, namely, reflection *on* action and reflection *in* action.

#### **2.4.6.1 Reflection on action**

According to Emerson (2007:135), one of the ways in which the clinical facilitators can help the student learn from their clinical experience, is to assist the students to reflect on their experiences. Reflection on action, according to Costley et al. (2010:122), describes the process of reflecting on experience after the drawing out lessons, implications and understandings (that will inform future action) have been done. The nursing students should thus be encouraged by the clinical facilitators to reflect on their own reasoning and make careful consideration of findings by using a good decision making skill (Delany & Molloy 2009:116).

#### **2.4.6.2 Reflection in action**

Reflection in action is perceived by Tanner (2006:209) as the nursing student's ability to "read" the patient; in other words, how the patient is responding to nursing intervention and the student's ability to adjust the intervention based on the assessment. According to Costley et al. (2010:122), reflection in action involves the ability to "draw on comparable memories and experiences to construct a frame that guides the present action and response".

### **2.4.7 Addressing nursing students' needs**

It is crucial to emphasise nursing students' needs in a CLE and making sure that these needs are met if they are to achieve their learning objectives. Four specific needs of nursing students in the CLE will be discussed, namely, orientation, delegation of clinical skills, and learning and learning outcomes.

#### **2.4.7.1 Orientation**

The nursing workplace is regarded as the most significant CLE for nursing students. With its unique social identity, culture and behaviour each workplace is a highly complex environment that provides invaluable experience for student learning (Smedley & Morey 2010:77). Nursing students become vulnerable in this environment because they are inexperienced and new to it; they have to put learned theory into practice and therefore effective communication through clinical facilitation and the design of their orientation is imperative. Orientation is an ongoing process which can be used as a strategy to

create a CLE that is conducive for nursing students. If done properly, specific learning outcomes can be achieved.

The CLE can be extremely influential in determining students' attitude and learning outcomes. To include the nursing students in a CLE it is important that they receive orientation to the specific CLEs where they are placed. Task orientation is also extremely important to the nursing student and should be clear and well organised (Smedley & Morey 2010:82). Orientation to the clinical learning environment is seen by Hutchings, Williamson and Humphreys (2005:946) as one of the most important characteristics of a good learning climate.

#### **2.4.7.2 Delegation of clinical skills**

Delegation is defined by Jooste (2013:81) and Ulrich (2011:205) as the transfer of responsibility; it is the performance of transferring a task from one person to the other but taking into account the right person, the right circumstances, the right task with the right education and the right supervision and evaluation. Nursing students need to be aware of the specific skills they are expected to perform every day in the specific CLE to which they have been allocated. A formal written allocation of tasks for nursing students empower them to take more control over the learning environment by enabling them to practise the learned skills under supervision and to ensure that the environment remains conducive for learning. Tasks need to be allocated to the nursing students according to their level of training and also according to the learning outcomes. The clinical facilitator should maintain continuous supervision of nursing students as they perform their allocated tasks (Jooste 2013:81).

#### **2.4.7.3 Learning**

Learning is defined by Billings and Halstead (2013:190) as a "process of understanding, clarifying and applying the meaning of knowledge acquired". The SANC Circular No 8/2013 (2013:3) defines learning as the "acquisition of knowledge, understanding, values, skill, competence and experience". Croxon and Maginnis (2009:237) view learning as a result of an activity in the context and culture in which it occurs. Effective clinical accompaniment is a critical part of clinical learning. Beukes and Nolte (2013:1) assert that the significance of clinical learning as an integral part of nursing education lies therein that it facilitates theory-practice integration. However, a constructive CLE where the focus is on meeting nursing students' learning needs with adequate opportunities for them to develop confidence is essential (Löfmark et al. 2012:1).



#### **2.4.7.4 Learning outcomes**

Nursing students' learning outcomes should be explained to the staff in the clinical area (Löfmark et al. 2012:1) since the CLE remains the most important domain for the development of nursing students' confidence to fulfil learning outcomes. Löfmark et al. (2012:2) further state the clinical facilitator has a responsibility that is directed at helping the students to achieve the learning outcomes whereby in the daily care of patients planning and evaluating is done to achieve these outcomes.

The clinical learning outcome should be relevant to the theoretical component and in accordance to the nursing students' level of training. Tanner (2010:351) advises that during clinical accompaniment the focus should be on the learning outcome by considering competencies such as the development of clinical judgement, inter-professional teamwork and the competencies required in professional practice rather than for the reason of completing clock hours.

#### **2.4.8 Feedback to the nursing students in a clinical learning environment**

Delany and Molloy (2009:130) define feedback as "a key to learning, offering information on actual performance in relation to the intended goal of performance". These authors further describe feedback as a "hard to give" and "hard to take" feature because the one who provides the feedback have to negotiate "considerable social tension" in the attempt to modify students' learning. Clynes and Raftery (2008:405) views feedback is "an interactive process which aims at providing nursing students with insight into their performance". Feedback should include opinion and judgement about current performance and explore options for improved practise (Clynes & Raftery 2008:406).

Feedback is discussed below under the sub-headings communicating feedback effectively; presenting a balanced feedback; methods of delivering feedback, and benefits of feedback.

##### **2.4.8.1 Communicating feedback effectively**

Kotzé (2008:217) states the demonstration of honesty when communicating feedback is essential to build positive relationship between the clinical facilitator and the nursing student; if the clinical facilitator is being honest it will show the nursing student that the former cares and is considerate. This means the clinical facilitator should monitor his or her emotional tone, and pay specific attention to nonverbal behaviours and pacing while communicating feedback to the nursing student in a CLE.

Emerson (2009:162) observes that verbal feedback delivery encompasses more than just the words themselves but it includes the emotional tone embedded in the words as well as the nonverbal cues. Verbal feedback should therefore be in line with the nonverbal behaviour. If it is not, the nursing student can perceive it as a mixed message; such mixed messages can distract the nursing student, leave them demotivated and undermine their learning. Conversely, if the nursing student is demonstrating the expectation of the clinical facilitator, nonverbal encouragement by the latter can be shown by nodding and maintaining eye contact with the student. Delany and Molloy (2009:130) advocate for clinical facilitators to understand the positions they are adopting and projecting when giving feedback to students.

#### **2.4.8.2 Presenting balanced feedback**

The quality of feedback provided by a clinical facilitator should be a balance of positive and negative and should be presented in a caring and respectful manner (Emerson 2009:162). This statement is supported by Billings and Halstead (2013:289) who state one method of giving feedback regarding clinical performance is to point out positive aspects of the nursing student's performance as well as areas that require improvement. It must be noted also that Plakht, Shiyovich, Nusbaum and Raizer (2013:1266) found that a high quality of negative feedback could lead to students becoming more accurate in their evaluation of their own performance in the CLE while a too high quality positive feedback could cause the student to overestimate his or her performance.

#### **2.4.8.3 Methods of delivering feedback**

Feedback given to nursing students can be delivered in either an informal or a formal manner.

##### ***Informal feedback***

There are two methods of delivering informal feedback (Clynes & Raftery 2008:406). The one is an immediate comment which is made by the clinical facilitator while observing the practice. This method is situation specific and its advantage is that the most important elements are not forgotten by the nursing student. The second informal method is a general discussion of the performance away from the clinical environment which is sometimes given consciously. The disadvantage of this method is that the nursing student may not regard it as feedback per se.

According to Stuart (2013:179), giving immediate feedback on a particular performance or highlighting where "the desired improvement has to be made assists the student to extract more learning from the

clinical events” and also prevents errors of care delivery from happening. Praising an event of exceptional caring may also motivate the nursing student to reflect on the action taken and care given.

### ***Formal feedback***

Formal feedback sessions provide a safe forum because it is removed from the immediate demand of the patient. In a formal feedback situation the clinical facilitator can disclose aspects of the student’s clinical practice and provide information to improve practice (Delany & Molloy 2009:137). It is important that the clinical facilitator should start the feedback session by allowing the nursing students to first critique their own skill performance. A formal feedback approach allows the nursing students to acknowledge aspects of their own performance before it can be pointed out by the clinical facilitator during her or his turn to give feedback.

#### **2.4.16 Benefits of feedback**

Feedback can be beneficial to both the clinical facilitator and the nursing student.

##### ***2.4.16.1 Benefits to the nursing student***

According to Clynes and Raftery (2008:406), feedback is essential for the nursing students’ growth because it provides direction and helps to boost their confidence; it also increases their self-esteem and promotes motivation. Feedback can also help the nursing student to rate her or his clinical practice in a realistic way. Sharples and Elcock (2011:31) add that feedback can be used as a means of developing a nursing student’s self-awareness. In the opinion of Delany and Molloy (2009:130), face to face feedback is beneficial as it provides both learning and an evaluative function and also helps the students to identify their strengths and weaknesses in performance thereby promoting learning and behavioural change. One other benefit of feedback to the nursing students is that it can help them improve their ability to reflect themselves more accurately (Plakht et al. 2013:1264)

##### ***2.4.16.2 Benefit to the clinical facilitator***

Feedback to the clinical facilitator promotes personal and professional growth and development and enhances their communication and interpersonal skills (Delaney & Molloy 2009:130). The clinical facilitator may also achieve a sense of personal satisfaction by facilitating the development of a nursing student, sharing practice and enhancing learning. As outlined by Ulrich (2011:182), feedback increases

the success rate of the clinical facilitators' ability to influence the nursing students to change and also augments the facilitators' behavioural assessment skills.

## **2.5 CLINICAL FACILITATOR**

In the past, the teaching of nursing students was regarded as part of the responsibilities of professional nurses. They were also the major role players in providing clinical support to nursing students. However, in modern times the reality in hospital nursing is that the role of professional nurses has changed due to the many and varied pressures that included the additional demands placed on them by their managerial responsibilities. A repercussion was that clinical teaching became fortuitous and the theory-practiced gap simply widened (Lambert & Glacken 2005:666). Additionally, nurse teachers do not seem to fulfil their clinical role but seems to prioritise theory which may also be due to numerous obstacles such as theoretical workload, meetings and the pressure of professional development. Lambert and Glacken (2005:666) further state in an attempt to alleviate the nurse teacher workload and address a long debated theory-practice gap clinical facilitators were employed around 1980s with mixed views upon the effectiveness of the clinical teacher role.

Lambert and Glacken (2005:669) did a literature study on clinical facilitators and found that clinical facilitators were introduced to support the nursing students in the clinical setting with the aim of bridging the theory-practice gap. However, as indicated by Di Prospero and Bhimji-Hewitt (2011:61), it is essential for clinical facilitators to be familiar with the theory that nursing students learn in the classroom to ensure the successful integration of theory and practice; this means clinical facilitators have to tailor their learning activities in the CLE in accordance with the learnt theory. According to Lostus-Hill, Rycroft-Malone, Titchen Kitson, Mc Cormack and Seer (2002:579), facilitation is achieved by an individual carrying out the specific role which aims to help others.

### **2.5.1 The role of the clinical facilitator**

The role of a clinical facilitator is unique and focuses on the ability to guide the student through his or her own learning thus enabling the process of facilitation. Di Prospero and Bhimji (2011:61) note that the clinical facilitator's role requires a plethora of tasks with some being more easily acquired than others. The authors further suggest that clinical facilitators should undergo training that focuses on creating a safe environment and using learner-centred teaching methods facilitated within small groups.

Roles of the clinical facilitator will be discussed individually in Sections 2.5.1.1 to 2.5.1.10

### **2.5.1.1 Clarify role**

It is the responsibility of the clinical facilitator to clarify the tasks, terminologies, values, concepts and to encourage nursing students to become precise in their communication so that all members of the group understand each other (Löfmark et al. 2012:1). In their study findings, Walker, Dwyer, Sander, Moxham, Broadbent and Edwards (2014:94) highlight the need for role clarity with regards to the nursing students' learning needs and goals by the clinical facilitator. The clinical facilitator has to clarify students' needs and goals to both the clinical staff working with the nursing students as well as the nursing students so that the learning opportunity is not lost.

### **2.5.1.2 Creating a conducive environment for learning**

For learning to be effective, the CLE should be conducive to learning. The clinical facilitator is the key figure in creating a CLE that furthers a nursing student's learning. Therefore, during accompaniment the clinical facilitator has to create a climate where the nursing students are continuously encouraged to analyse, evaluate and act when confronted with problematic situations.

The clinical facilitator, according to Di Prospero and Bhimji-Hewitt (2011:62), is responsible for creating a safe and comfortable CLE for nursing students. An effective facilitator "creates, monitors and maintains a stimulating, meditative and cooperative environment that enhances the intellectual growth of all involved in learning" in an organisation. Löfmark et al. (2012:1) agree that a constructive CLE with adequate clinical learning opportunities is essential for a nursing student to develop confidence and competence.

Clinical facilitators are also responsible for creating an empowering environment for nursing students. According to Eaton-Spiva, Buitrago, Trotter, Macy, Lariscy and Johnson (2010:36), nursing students who feel their CLE is empowering are more satisfied, more committed to their work and demonstrate a high quality of nursing care in such an environment.

### **2.5.1.3 Mentoring**

Myall, Levett-Jones and Lathlean (2008:1836) define a mentor as "a practitioner who facilitates learning, supervises, assesses and evaluates nursing students in a CLE." Myall et al (2008:1838) view a mentor as someone who gives a nursing student an opportunity to perform, observe and participate in

a wide variety of skills. A mentor should also be able to support and guide the students, give them constructive feedback and encourage them to engage in a reflective practice. Beukes and Nolte's (2013:305) view is that clinical accompaniment in nursing involves a one to one mentoring process by a skilled clinical facilitator within the context of the CLE with the purpose of developing a specific professional competency and specific socialisation in the learning environment. A mentoring relationship is based on trust, respect, caring, mutuality, compatibility and personal attraction which mean that the relationship is reciprocal (Kotzé 2008:219).

In a study conducted by Webb and Shakespeare (2008:566) the overall finding was that the nursing students experienced effective mentors as those who were enthusiastic about their own work and about passing on their knowledge to students; those who will "*be there*" and prepare them for new experiences. Effective mentors have a positive attitude towards nursing students and are experienced willing to bring a wealth of knowledge and skill to the mentor-student relationship. Amstrong (2013:16) clinical facilitators mentoring younger nursing students empower the latter and support them towards effective practice as well as personal and professional development.

An effective mentor is able to be flexible and adapt to ever changing situations, quick to illuminate accomplishments that result from processes and strategies employed to produce satisfactory results (Webb & Shakespeare 2008:76). They should also be able to create a relationship of trust with the nursing student and to display a warm, open and honest approach towards one another. Armstrong (2013:16) share that an ideal mentor-student relationship resembles the typical therapist-client in a counselling relationship where the therapist demonstrates empathetic and supportive behaviour.

The role of a mentor is pivotal to the nursing students' clinical experience because the student needs to receive adequate support and be sufficiently prepared to become a confident and competent practitioner.

#### **2.5.1.4 Role modelling**

Williams (2008:ix) expects clinical facilitators to model trust; they have to assume that all in a learning situation are trustworthy. They further model the belief that people have their own inner resources to achieve excellence. To Woolley and Jarvis (2007:75), role modelling involves that the expert performs the skill so that the learner can observe and build a conceptual model of the process required to accomplish it. As role models, the clinical facilitators have to acknowledge the nursing students as

human beings and must address them by their names as they discuss with them their learning needs (Beukes & Nolte 2013:310). As a role model for the nursing students, the clinical facilitator has to pay attention to their own attitude towards patients as well as it is the clinical facilitator's responsibility to serve as a role model for nursing students in a CLE in order to enhance the nurses' clinical competency.

#### **2.5.1.5 Clinical skill trainer**

Clinical skill training comprises assisting nursing students to increase their experience as well as providing them with the tools to achieve consensual decision making (Williams 2008:34). The clinical facilitator offers direct face to face teaching and demonstration of skills in a CLE and then gives the nursing student an opportunity to practice the same skills (Lambert & Glacken 2005:668). Di Prospero and Bhimji-Hewitt (2011:61) state the skill of being able to facilitate is integral to the delivery of interprofessional curricula. The creation of an environment conducive for facilitation is highly dependent on the skill of the facilitator. The delivery of group managing skills, according to Di Prospero and Bhimji-Hewitt (2011:61), is the key to successful interprofessional education.

#### **2.5.1.6 Supervisor**

Clinical supervision is defined by Cummins (2009:117) as a process that seeks to create an environment in which participants have an opportunity to evaluate, reflect and develop their own clinical practice and provide a support system. Cummins (2008:215) observes that clinical supervision is becoming progressively established. General supervision is identified as an important challenge for measuring effectiveness through the educational, supportive and administrative function it fulfils (Bruijn, Burari & Wolf 2006:1002). These authors further sees the CLE in which supervision take place an important aspect of supervisory practice.

Part of being a clinical facilitator is to supervise nursing students who are learning different techniques, skills and attitudes relevant to nursing. The clinical facilitator should motivate the nursing student to be an active participant in the learning process rather than them being passive recipients of information. Nursing students should not only be observers but needs to be encouraged by the clinical facilitators to participate hands-on in the activities under supervision. During the supervision process the nursing students should be recognised for a job well done and be encouraged to continue doing even better.

According to Saarikoski, Warne, Kaila and Leino-Kilpi (2009:275), supervision allows for the nursing student to go through a process of “self-recovery, uncovering and discovery and to be creative and self-transfiguring both personally and professionally”. These authors state supervision can enhance and advance clinical practice and sees the potential facilitating role of supervision as giving new tools to supervisees to handle and cope with different kinds of clinical experiences. Effective supervision by the clinical facilitator allows the nursing students an opportunity to evaluate and develop their own clinical experience.

#### **2.5.1.7 Guidance**

According to Berntsen and Bjork (2011:18), the guidance of nursing students by the clinical facilitators who use innovative teaching methods and sound pedagogical principles has a positive influence on the students’ learning outcome. Di Prospero and Bhimji-Hewitt (2011:61) state the role of the facilitator is unique when compared to the traditional role of a teacher because it focuses less on content expertise and more on the ability to guide the students through their own learning.

The clinical facilitators are responsible for guiding learners through a constructive process of learning; by sharing and exploring knowledge and asking questions the nursing students are guided to have a more in-depth understanding of knowledge that can translate to clinical practice (Di Prospero & Bhimji-Hewitt 2011:61). It is, however, important that clinical facilitators provide the nursing student with what to learn and how to learn (Dornan, Hadfield, Brown, Boshuizen & Scherpbier 2011:61). These authors thus propose that the CLE is more effective when there are clear objectives (Dornan et al. 2011:61).

#### **2.5.1.8 Coaching**

In the study conducted by Stalmeijer, et al (2009:540), coaching was perceived by the nursing students as being observed by the clinical facilitator; this observation was followed by suggestions as to what and how the nursing students could do better in the CLE. Alleyne and Jumma (2007:537) identify three types of coaching: feedback, in-depth development of content, and content coaching. Feedback and in-depth development of content focus on the development of the nursing student in a CLE and it requires a one-on-one relationship with the clinical facilitator whereas content coaching provides the clinical facilitator an opportunity to develop students’ knowledge and skill in a specific content area.



### **2.5.1.9 Teaching**

According to Kotzé (2008:201), teaching and facilitating clinical learning refers to what the clinical facilitator gives of him- or herself; this means that the content given is what the clinical facilitator as an individual understands of the knowledge and skill. The clinical facilitator must also have an in-depth knowledge and understanding of the area of the curriculum that he or she is responsible for and its application in a clinical practice. This author adds that the clinical facilitator as a teacher must be a confident and competent manager of the area he or she takes responsibility for. Stuart (2013:152) outlines that the teaching role of a clinical facilitator includes the ability to guide in problem solving, setting priorities and to assist in the development of new skills.

As a teacher the clinical facilitator must be a resourceful person who is capable of creating a conducive CLE, who is able to select and direct learning activities and demonstrate how the crisis circumstances can be utilised as a learning situation (Kotzé 2008:201). Resourcefulness also means that the clinical facilitator must stimulate the nursing students' interest and encourage them to find answers. The author further states the clinical facilitator as a teacher should set a good example, be well-groomed, neat and clean with good posture and movement and suitable use of language and voice.

#### **2.5.1.10 Assessor**

The SANC Circular No. 8/2013 (2013:2) defines assessment as "a systematic evaluation of the learner's ability to demonstrate the achievement of the learning goal intended in the curriculum". Covic and Jones's (2008:75) stance is that the quality of learning is influenced by the way it is assessed, meaning to what degree it provides the students with the opportunity to learn how to progress.

The clinical facilitator's role is seen Löfmark et al. (2012:2) as including the assessment and grading of nursing students. The assessment of nursing students' clinical performance can be done by the clinical facilitator in different ways and can be either summative or formative. Duers and Brown (2009:654) define formative assessment as the 'assessment *for* learning' and summative assessment as being 'assessment *of* learning'.

- **Formative assessment (assessment *for* learning)**

Formative assessment is explained by Delany and Molloy (2009:150) as the assessment that mimics the summative assessment to familiarise the nursing students with both the expected performance and their current skill level. The SANC (2013:3) defines the formative assessment as a type of assessment

used to improve learning and give feedback to learners on progress made – the formative assessments thus serves the needs intrinsic to the educational process. Formative assessments reduce the anxieties associated with summative assessments and assist the nursing student by creating an opportunity to improve their performance. Delany and Molloy (2009:155) assert that the formative assessment provides the clinical facilitator with an important opportunity to also reflect on their own biases that might work for or against the nursing student.

The formative assessment of the clinical component in nursing education training in the CLE is done in the form of an Objective Structured Clinical Examination (OSCE) or practical examination; a checklist or a global rating scale is used during the assessment. The formative assessment has the potential to prepare a student not only to succeed in a summative assessment but also in the world beyond clinical learning (Duers & Brown 2009:654).

- **Summative assessment**

The summative assessment is described by Emerson (2007:277) as a student's final examination carried out at the conclusion of the clinical teaching process of the course whereby all clinical work should be completed, reviewed and incorporated into the summative assessment. The SANC Circular 8/2013 (2013:4) defines a summative assessment as "a formalised assessment which is used to certificate the attainment of certain level of education". Nursing students' strengths and limitations are identified during this assessment. A summative evaluation of the clinical learning outcome, according to Billings and Halstead (2013:393), usually results in assigning of final grades to the nursing student. However, the disadvantage thereof is that nothing can be done to alter the results.

#### **2.5.1.11 Leader**

For a clinical facilitator to be successful, she or he needs to be effective leaders. Kinnell and Hughes (2009:203) describe the qualities of an "effective leader" as someone who is knowledgeable in her or his own clinical area, approachable, honest and able to demonstrate effective interpersonal communication skills. Kotzé (2008:51) states there are leadership styles that are dictated by the situation. Each of these leadership styles depends on the circumstances and has a place in decision making. Leadership styles can impact negatively or positively on the nursing student; therefore, it is important for a clinical facilitator to understand the impact of the chosen style used during clinical accompaniment.

The different leadership styles that can be used by the clinical facilitator in a CLE during accompaniment of nursing students and how they were applied in this study are shown in Table 2.3.

**Table 2.3 Summary of leadership styles**

Leadership styles	Application to this study
Directive leadership	<ul style="list-style-type: none"> <li>○ Appropriate when the nursing student lacks knowledge and skills for the task.</li> <li>○ Approach and strategies for the clinical facilitator to equip the nursing students if it is required.</li> <li>○ This style requires close supervision and feedback. This is done until the clinical facilitator is satisfied that the nursing student is competent.</li> <li>○ In this study directive leadership was upheld.</li> </ul>
Coaching leadership	<ul style="list-style-type: none"> <li>○ The style is used as a follow-up when the nursing student still lacks confidence and is hesitant to undertake a task.</li> <li>○ Students need encouragement, support, acknowledgement and praising for progress and the clinical facilitator being alongside them at all times.</li> <li>○ This was done in this study.</li> </ul>
Supportive leadership	<ul style="list-style-type: none"> <li>○ This is an ongoing leadership that is maintained by the clinical facilitator on a daily basis irrespective of the nursing student's level of competence.</li> <li>○ The degree of direction is low because of the level of confidence.</li> <li>○ This was noted and adhered to in this study.</li> </ul>
Delegating leadership	<ul style="list-style-type: none"> <li>○ This style is used by the clinical facilitator where the level of confidence of the nursing student when on the site is high.</li> <li>○ When this style is used for the nursing students it is used in combination with the supportive one as the student cannot be held completely liable for patient care.</li> <li>○ In this study delegating leadership was also upheld.</li> </ul>

**Source: Adoped from Kotze (2013:51)**

### 2.5.3 Clinical facilitation

In a study conducted by Lekhuleni, Van der Wal and Ehlers (2004:15) in Limpopo on student nurses' perceptions regarding their clinical accompaniment, the authors define clinical facilitation as a goal-directed and dynamic process in which professional nurses and nursing students interact in a CLE with genuine mutual respect. Lambert and Glacken (2005:667) explain clinical facilitation as a holistic student-centred approach of which a "genuineness, acceptance, trust and empathic understanding are fundamental qualities". They expand on the concept by adding that it involves the clinical facilitator as a teacher who is in a collaborative clinical learning relationship with a nursing student.

### **2.5.3. Developing knowledge and skills of clinical facilitator**

In the view of Lindahl, Dagborn and Nilsson (2009:9), clinical facilitators should participate in clinical seminars, examinations and in the supervision sessions provided for all clinical facilitators as it will encourage and empower them to plan their work to assist the nursing students to achieve their educational goal. Sharples and Elcock (2011:36) are for the opinion that clinical facilitators need a personal development plan that will allow them to focus on developing the competencies to facilitate the clinical practice and also be able to identify opportunities for professional development. The authors also advise clinical facilitators to be honest with themselves regarding their own development needs. By achieving the competencies expected, the clinical facilitator will be able to make consistent effort and stay committed to clinical accompaniment of the nursing student (Sharples & Elcock 2011:36).

### **2.5.4. Nurse educator**

The nurse educator should ensure various practice opportunities for nursing students by putting emphasis on the thinking skill and the ability to apply this skill to a diversity of course-related issues and problems (Meyer & van Niekerk 2008:84). Working in collaboration with colleagues, cooperating with other healthcare professional to identify thinking skills common to all the courses, and building assignments into the courses will reinforce learners' ability to use the skills in a variety of academic and clinical situations (Meyer & van Niekerk 2008:84). The nurse educators are also responsible for clinical accompaniment of the nursing students.

## **2.6 CLINICAL ACCOMPANIMENT**

Clinical accompaniment is defined by Beukes and Nolte (2013:305) as "a planned and deliberate intervention" whereby the nursing student interacts with the clinical facilitator to achieve a specific outcome which can be orientated towards personal and professional development. According to the Nursing Act No. R. 174 (2005:1), clinical accompaniment means "a structured process by a nursing education institution to facilitate assistance and support to the learners by the nurse educator at the clinical facility to ensure the achievement of the program outcomes". Accompaniment in a clinical learning environment is aimed at enabling the nursing students to overcome their need for help and support.

During clinical accompaniment the nursing student interacts with the clinical facilitator in the CLE to facilitate the development of knowledge and skill. Vallant and Neville (2006:2) observe that the

interactions between nursing students and the clinical facilitator have a critical influence on student learning. Therefore, it was important for the purpose of this study to take note of the types of relationships that exist between the nursing students and the clinical facilitator.

### **2.6.1 Advantages of clinical accompaniment**

Uys and Meyer (2005:12) ascertain that an important advantage of clinical accompaniment is that it enables the nursing students to achieve a high level of cognitive thinking, reasoning, problem stating and problem solving. Nursing students are able to meet their objectives through the ongoing guidance and support from the clinical facilitators. These assertions are supported by Beukes and Nolte (2013:305) who add clinical accompaniment is beneficial because it facilitates knowledge and skill development; it further socialises and makes nursing students aware of the values of nursing as a profession.

Beukes and Nolte (2010:2) further state clinical accompaniment provides the nursing student with an opportunity to develop the necessary sensitivity to the value of those they interact with. During clinical accompaniment nursing students do not only interact with the clinical facilitator but also with the clinical staff who also offer support and guidance.

### **2.6.2 Process of clinical accompaniment**

According to Kotzé (2008:210), the process of clinical accompaniment features four dimensions: establishing a relationship; developing a relationship into a functional relationship; actualisation inputs towards self-empowerment; and the pursuit of goals for empowered professional practice.

#### **2.6.2.1 Establishing a relationship**

Establishing a relationship of trust, understanding and acknowledgement is achieved through meaningful contribution from both the clinical facilitator and the nursing student (Kotzé 2008:210). According to this author, it includes the acknowledgement of other's professional knowledge, experience and commitment as well as creating an awareness of other's privacy and dignity. For the clinical facilitator and the nursing student to engage effectively during clinical accompaniment they need to understand and demonstrate respect for one another (Beukes & Nolte 2010:2).

Ali and Panther (2008:38) identifies strategies to establish a good relationship between the clinical facilitator and the nursing student. These strategies include offering support to the nursing student, organising introductory meetings, and the orientation of the student to a CLE as well as offering an environment that is conducive to clinical learning.

#### **2.6.2.2 Development of functional relationship**

This includes continuous observation of the nursing student's activity and progress for identification of need for assistance and guidance (Kotzé 2013:210). In Ali and Panther's (2008:39) opinion, if the expectation of the nursing students is met during accompaniment, it can influence the development of a positive functional relationship between the clinical facilitator and the student. Kotzé (2008:210) believes that, when the nursing student has gained, or then regained, the courage, confidence and ability to cope and shows a positive, sensitive and willing attitude, the clinical facilitator can then take distance.

#### **2.6.2.3 Actualisation inputs towards self-empowerment**

For the nursing student to achieve the goals towards self-empowerment, he or she needs to be willing to take risks, accept responsibility, acknowledge his or her need, accept challenges and consider alternatives. Additionally, nursing students need to participate in exploring possibilities and in making decisions (Kotzé 2008:210). In return, the clinical facilitator needs also to be willing to offer alternatives and encouragement appeals in order to reach and maintain standards. They have to participate in exploring possibilities, demonstrate availability and be accessible.

#### **2.6.2.4 Pursuit of goals for empowered professional practice**

With this strategy Kotzé (2008:212) says the aim is to reach the outcomes that include developing an integrated nursing student into a professional identity. Evidence of a nursing student's professionalism, commitment and conduct will be mirrored by the ability to make decisions, work ethics portraying a developed commitment and social conscience, and the actualisation of exemplary adult and professional behaviour under all circumstances.

## 2.7 SUMMARY

In Chapter 2 the literature review on which this study was based was presented. The main focus of the chapter was on the nursing programme, clinical learning environment, clinical facilitator and clinical accompaniment.

Chapter 3 provides an in-depth discussion on the research design and methodology used in this study.

## 3 RESEARCH DESIGN AND METHODS

### 3.1 INTRODUCTION

In Chapter 2 the literature review was discussed in detail. Chapter 3 outlines the research design and methods, target population, sampling methods and the approach to data collection and data analysis. Furthermore, the strategies to ensure trustworthiness are presented.

### 3.2 RESEARCH DESIGN

The research design is defined by Polit and Beck (2010:567) as the overall plan for addressing a research question and it includes the strategies for enhancing the integrity of the study. According to Birks and Mills (2011:175), the research design is a plan that accounts for the philosophical and methodological aspects of the study and the methods to be used in the study. The design also serves as a logical plan which involves the links among the research question, the data to be collected and the strategies for analysing the data so that the study findings will address the intended research question (Yin 2011:76).

A qualitative research approach using an explorative and descriptive design was used to conduct this study. The researcher chose this approach to achieve the purpose and objective of the study which was to explore the clinical accompaniment challenges second-year nursing students experience at an NEI in North West.

#### 3.2.1 Qualitative approach

Polit and Beck (2008:763) define qualitative research as “the investigation of phenomena, typically in an in-depth and holistic fashion through the collection of rich narrative material using a flexible research design”. Qualitative research is an aspect of the research process that may be “estimated by meaning or language and the results thereof are expressed in non-numerical terms” (Maltby, Williams, McGarry



and Day 2014:363). The process of qualitative research as outlined by Creswell (2014:246) involves emerging questions and procedures, collecting data from the participants, the setting, analysing the data by building from particular to general themes and making interpretations in the meaning of data. This researcher chose the qualitative approach based for the reasons that follow.

With a qualitative approach the researcher tend to collect data in a natural setting at the site where participants experience the issue or problem under study. Information is gathered by actual talking directly to people and seeing them behave or act within the context (Creswell 2014:185). In this study data were collected at the hospital setting where the nursing students are usually placed during their second year of clinical learning.

Face to face interaction is an important aspect during data collection. As outlined by Yin (2011:8), the events and ideas emerging from qualitative research can represent the meaning given to real life events by the people who live them, not the values, preconceptions or meanings held by the researcher. In this study the real life situation in a CLE was given by the third-year nursing students concerning the challenges with clinical accompaniment as experienced during their second year of training.

With qualitative research narrative data can be obtained by having conversation with participants and by making detailed notes about how participants behaved in a natural setting (Polit & Beck 2008:60) Using a focus group interview (FGI) rich and narrative data were provided regarding the challenges of clinical accompaniment as experienced by the second-year nursing students. Yin (2011:8) points out qualitative research covers contextual conditions such as social, institutional, and environmental conditions within people's lives that may strongly influence all human events. The approach in this study covered the accompaniment of second-year nursing students in a CLE by the clinical facilitators that can influence the learning of the nursing students.

A qualitative approach, according to Green and Browne (2011:13), is best used for questions that relate to the variation in the meaning of experiences for different people such as starting with the questions "Why?" or "What?" In this study the approach was relevant to the intended question: "What are the challenges of clinical accompaniment as experienced by the second-year nursing students in a CLE?"

A qualitative approach is used to classify events or phenomena such as barriers to the situation or nature of dissatisfaction (Green and Browne 2011:13). Using a qualitative approach provided the researcher in this study to arrive at a better understanding of the nursing students' dissatisfaction related to clinical accompaniment.

### **3.2.2 Explorative design**

Johnson and Christensen (2008:23) define an exploratory design as an attempt to generate ideas about phenomena which is important at the early phase of the research because the researcher must generate ideas about the phenomena before additional research can progress. Exploratory research "begins with a phenomenon of interest and investigates the full nature of phenomenon, the manner in which it is manifested, and the factors to which it is related" (Polit & Beck 2008:20). The researcher used an exploratory design to discover the challenges related to clinical accompaniment as perceived by the third-year nursing students during their second year of training and made some recommendations to address such challenges.

The purpose of exploratory design as outlined by Buckingham and Saunders (2008:44) is to gather as much relevant information as possible so that the researcher can begin to identify and specify what is being studied. These authors further state an exploratory design allows the researcher to use less structured methods such as focus group interviews (FGIs) or documentary analysis from which themes emerge.

A focus group interview was conducted with the third-year nursing students. They were required to respond to an open-ended question which allowed them to communicate freely on their experiences relating to clinical accompaniment. The independent facilitator was used to facilitate the data collection. The researcher then studied the data after it had been transcribed. She reviewed it repeatedly to gain more knowledge on what the participants had described as the challenges regarding accompaniment in a CLE.

### **3.2.3 Descriptive design**

The purpose of a descriptive study, according to Polit and Beck (2008:274), is to observe, describe and document aspects of a situation as it naturally occurs and can also serve as a starting point for theory

development. A descriptive design focuses on the richness, breadth and depth of the experience with the researcher being the tool for data collection and listening to individual descriptions of quality of life through the interview process (Streubert & Carpenter 2011:81) This is the step whereby the researcher should become totally immersed in the phenomenon under investigation and avoid all criticisms, evaluations, and opinions and pay attention to the phenomenon under discussion.

According to Fade and Swift (2011:112), thick descriptions in qualitative data are those that “present detail, context, emotions and the webs of social relationships that joins persons to one another”. These authors further stated in thick description the voices, feelings, actions and meanings of interacting individuals are heard and the significance of an experience is established. In this study the voices of the third-year nursing students were heard as they described their challenges regarding clinical accompaniment as well as their interactions with the clinical facilitators during their second year of training.

### **3.3 RESEARCH METHODS**

Research methods are the techniques used to structure a study and to gather and analyse information in a systematic fashion (Polit & Beck 2010:567) as well as the interpretation that the researcher proposes for his or her study (Creswell 2014:247). According to Green and Browne (2011:9), the research method is a particular strategy for answering a research questions and it is influenced by the aim of research, that is, what the researcher is trying to find out.

#### **3.3.1 Population**

Somekh and Lewin (2005:347) define a population as the entire people or phenomena under study from whom a sample will be selected for the research study. The target population is the entire population which a researcher is interested in and to which she or he would like to generalise study results (Polit & Beck 2008:767). In the context of this study the target population should therefore have consisted of all the nursing students following a four-year comprehensive nursing programme and who received clinical accompaniment in a CLE. However, the target population could not be used in this study because of the large numbers which could not be used in FGI, therefore the accessible population was the most appropriate sampling for FGI. Ellis (2013:53) advises between 6 and 12 people as an appropriate number of participants for a target group whereby a minimum number of 6

participants will enable a significant discussion and a maximum of 12 participants will allow the whole group to participate in a meaningful discussion.

The accessible population is defined by Polit and Beck (2008:338) as “the aggregate of cases that conform to designated criteria and that are accessible as subject for a study.” The accessible population for this study included both second- and third-year students. Second-year students who were repeating their second year of the comprehensive nursing programme had to be included as it was possible they could have had similar and/or different challenges to students who had passed their second year successfully. Therefore, it was the assumption that both second- and third-year students who received clinical accompaniment in a CLE during their second year of study possessed important knowledge about their experience of clinical accompaniment during the second year of the four-year comprehensive nursing programme.

Inclusion criteria for the study were as follows:

- second-year nursing students who were repeating the second year
- current third-year nursing students
- all participants had to be registered for the four-year comprehensive nursing programme
- they had to rotate through the medical and/or surgical wards in the academic hospital utilised as the CLE during the second year.

### **3.3.2 Sampling**

Sampling is defined by Polit and Beck (2008:764) as “a process of selecting a portion of the population to represent the entire population” or the process of selecting participants that will be involved in the study (Whittaker & Williamson 2011:11). The selection of participants, according to Yin (2011:311), is based on the anticipated richness and relevance of information in relation to the study’s research question and not the researcher’s thinking about the research question. Purposive sampling was used.

#### **3.3.2.1 Purposive sampling**

Purposive sampling is a non-probability sampling method in which the researcher selects participants based on personal judgement about which ones will be most informative (Polit & Beck 2008:763). Green and Browne (2011:122) explain a non-probability sampling as any sample that is not drawn randomly from any known population; the limitation thereof is that it is impossible to know how

representative the survey sample is. The idea behind qualitative research as pointed out by Creswell (2009:178) is to purposefully select participants that will best help the researcher understand the problem and the research question.

According to Green and Browne (2011:122), purposive sampling involves the deliberate choice of respondents, subjects or settings to reflect some features or characteristics of interest. Yin (2011:88) suggests when selecting the participants the researcher should deliberately interview some people whom he or she suspects might hold different views related to the topic under study. Participants were recruited for this study based on their exposure during the second year to clinical accompaniment in the CLE.

The researcher considered purposive sampling as the most appropriate approach in which the participants selected were most likely to yield useful information. The selection was based on the participants' knowledge and experience (Whittaker & Williamson 2011:62). The participants are selected for the purpose of describing an experience in which they have participated (Streubert & Carpenter 2011:28) and the selection is based on the anticipated richness and relevance of information in relation to the study's research question (Yin 2011:311). In this study the participants were selected for the purpose of describing the challenges of clinical accompaniment as experienced by the second-year nursing students in a CLE as they already had been exposed to the area for a reasonable period of time.

### **3.3.2.2 Sample size**

Burns and Grove (2011:548) define a sample size as the number of subjects, events, behaviour or situations that are examined in the study. In total there are 20 students repeating the second year and 50 third-year students who had successfully completed the second year. These students were provided an opportunity to voluntarily participate in the study to reflect on the challenges they experienced pertaining to clinical accompaniment during the second year.

The sample size is usually determined based on informational needs and data saturation (Polit & Beck 2010:321). A total of 31 students participated in the three focus group discussions. Focus group 1 had 9 participants and focus group 2 and 3 had 11 participants each. De Vos (2011:305) is of the opinion that a focus group should include six to ten participants. Green and Browne (2011:65) suggest between eight to 12 participants. The size of the group allows all members to participate in an interview. In

addition, Liamputtong (2012:44) suggests three to five focus groups may be enough for each variable of investigation to ensure adequate coverage in one research project. In Table 3.1 an overview of the participants in each of the three focus groups is given.

**Table 3.1: Overview of the study participants in each of the focus groups**

FOCUS GROUP	PARTICIPANTS		TOTAL
	Repeating 2 <sup>nd</sup> year	3 <sup>rd</sup> years	
1	2	7	9
2	1	10	11
3	2	9	11
		<b>TOTAL</b>	<b>31</b>

### 3.3.3 Data collection

Birks and Mills (2011:174) define data collection as the process of gathering data in which the researcher has limited influence on the data source, as occurs when data is extracted from static material such as documents and the literature. In this study data were collected by means of FGIs.

#### 3.3.3.1 Invite participants

The researcher invited the participants to participate in the study based on their experience and involvement related to the research topic as suggested by Wong (2008:257) and Jayasekara (2012:414). The participants were contacted four weeks before the FGI just after their practical session at the simulation laboratory and were reminded a day before to ensure a sufficient number of students would participate. An FGI should include approximately six to 12 participants as suggested by Green and Thorogood (2013:127). Three focus FGIs were held giving each participant three options for participation with regard to the times the FGIs were scheduled for. The interviews were held at three different times because some of those who wanted to participate might have been busy in the CLE during the hour one FGI was scheduled for, but would be available to attend an FGI held during one of the other scheduled hours.

The researcher discussed and agreed with the head of the nursing department as well as the unit managers on the three dates because the FGI was conducted during the period when the nursing students were in the clinical setting. Participants from the same ward did not participate in the same

FGI to ensure that service delivery was not compromised and, as agreed with the participants, the hour spent in the FGI was considered to be their lunch break and a meal was prepared for them. The three FGIs were all conducted on the same day. There was no need to schedule an additional FGI as data saturation was reached at the end of the third interview.

### **3.3.3.2 Focus group interview**

A focus group is defined by Green and Browne (2011:165) as a group of people brought together to discuss a topic with one or more facilitators who introduce and guide the discussion and record it in some way. A focus group can also be defined as a group of individuals assembled to take part in a group interview with the purpose of collecting data and observing the effect of group interaction. Gerrish and Lacey (2010:529) as well as De Vos (2011:360) describe focus group interview as means of better understanding how people feel or think about an issue. Webb and Doman (2011:51) explain the focus group as a form of interview used in qualitative research consisting of a small number of people brought together by the researcher to discuss a specific topic. The interviews in this study were introduced by the researcher and guided by the independent facilitator and the note-taker. Focus groups are next discussed related to advantages and limitations.

- **Advantage**

The researcher chose the FGI method because focus groups are “inexpensive, flexible, stimulating, cumulative, elaborative, assistive in information recall and capable of producing rich data” (Streubert & Carpenter 2011:38). In this study data were collected to explore the challenges viewed by nursing students regarding clinical accompaniment during the second year of the four-year comprehensive nursing programme. The nursing students did not have to travel to the venue as they were interviewed around their CLE; some during their lunch break and some during their substituted lunch break, thus no travel costs were involved.

The main strength of FGI as outlined by Holloway and Wheeler (2010:133) is the production of data through social interactions which stimulates the thoughts of participants and remind them of their feeling about the research topic. Being in their third year of the nursing programme, the participants were able to relate the experiences with regard to the clinical accompaniment they had had during their second year by interacting in a focus group.

The FGIs enabled the researcher to gather large amounts of information in a minimum amount of time (De Vos et al. 2011:360). In addition, the group dialogue tends to generate rich information as the participants' insights may trigger others in the group to share their personal experiences and perspectives. Also, in and FGI brainstorming may lead to a better understanding of the topic because group dynamics are not present during one on one interviews. Therefore, data saturation in this study was reached within a reasonable amount of time.

Focus groups are less intrusive than participant observation and a more efficient method of collecting data on a topic, as the facilitator can set the agenda and prompt for a particular area to be discussed in more detail (Green & Browne 2011:66). The questions were prepared before the commencement of the FGIs and probing was used for some of the questions that necessitated further in-depth discussion in order to obtain rich data. An FGI allows for participants to express their experiences and consider their own thoughts and views in the context of others' views in a way that may enhance data quality and produce deeper and richer data more rapidly than individual interviews (Kristiansen, Hellsen & Asplund 2010:428). In this study participants were able to express their views regarding clinical accompaniment during the second year of their four-year comprehensive nursing course.

Gerrish and Lacey (2010:36) assert participants can feel comfortable within a group because they are not required to read and write before attending the focus group interview. Participants can query and explain themselves to others in the group; they can react and build upon the responses of others thus allowing the researcher to track consensus and diversity around issues and get feedback directly on comparisons. Subsequently, data can be quickly analysed (Belzile & Öberg 2012:463). Focus group interviews are seen by Whittaker and Williamson (2011:68) as more democratic in that there may be six to eight participants with only one facilitator who is thus outnumbered. The power differential between the facilitator and the participants is less than in a one-to-one setting. The number of participants who took part in the three FGIs ranged between eleven and nine with one facilitator and the note-taker who was only listening and writing.

The facilitator is able to probe and observe the non-verbal responses (Belzile & Öberg 2012:463). In this study the facilitator used probing as one of the skills to obtain rich data during the FGIs.



### ○ **Limitations**

According to Green and Browne (2011:63), a focus group does not provide any access to how people talk to each other in a more natural setting. Facilitation is difficult, the location of the group can also affect the ability to participate and exclude some potential participants (Gerrish & Lacey 2010:365).

Gerrish and Lacey (2010:367) state although the right to withdraw consent has been discussed, it is sometimes very difficult for an individual within the group to withdraw their consent to participation; these participants usually stay silent throughout the discussion. This will mean that there is no contribution reported from the specific participant. Therefore, the facilitator's responsibility is to offer them an opportunity to withdraw the consent if she is sure that her or his silence is not wrongly interpreted. Small groups, according to Wong (2008:257), can easily be dominated by one or two members. Green and Browne (2011:67) state groups may be inhibiting for some participants. They may feel unable to give their opinion, particularly if it differs from that of the majority of the group members. It is therefore pivotal to have an FGI conducted by a highly experienced facilitator.

Recording and transcribing can be time consuming and complex, for example, identifying the contributions of different participants from an audio-tape when they have similar voices (Whittaker & Williamson 2011:68). In this study it was difficult to hear the contributions from some participants as their voices were quite too soft. According to Doody, Slevin and Taggart (2013:173), FGIs require considerable planning which include inviting the participants, the venue, the duration of the interview, the roles of the researcher, the facilitator, and the note-taker, and the formulation of questions.

### ○ **Duration of the interview**

Specific dates and a timeframe of approximately 1½ to 2 hours was negotiated with the students as suggested by Holloway and Wheeler (2010:130). Liamputtong (2012:46) indicates less time may be needed if the examined issues have been effectively covered. The duration of the FGI also depends on whether the topic is broad or specific as well as on the number of questions to be asked (Doody et al. 2013:171). In the current study the three FGIs were conducted on one day, starting in the morning and ending at night. As discussed with the head of the department, on the day of the FGIs all the participants on day duty participated either between 09h30 to 10h25 or, alternatively, between 11h30 to 12h30. The third FGI was conducted from 20h00 to 20h52 because the participants were all on night duty. Table 3.2 provides an overview of the dates and duration of the three FGIs.

**Table 3.2: Summary of dates and times of the FGIs**

FOCUS GROUP	DATE	TIMES		DURATION
		FROM	TO	
1	26 June 2013	09h30	10h25	55.05 min
2	26 June 2013	11h30	12h30	1hr 14 min
3	26 June 2013	20h00	20h52	52.05 min

- **Venue**

s advised by Burns and Grove (2009:99), providing a secure environment ensures that the participants can discuss their experiences without fear of criticism from outsiders and to enhance in-depth discussions. Adhering to this advice, the researcher arranged the use of a classroom downstairs away from the wards at the provincial hospital where the nursing students were placed. The classroom was big enough to accommodate all the participants in the separate three FGIs (Holloway & Wheeler 2010:130) with adequate lighting and a cool temperature as suggested by Doody et al. (2013:171). The venue selected was in a quiet area of the provincial hospital with little disturbance from outside, for example, telephones ringing (Pope & Mays 2006:26). The participants, the facilitator and the note-taker were seated in a U-shaped arrangement of desks and comfortable chairs. Snacks and beverages were provided to create a pleasant and relaxed atmosphere as suggested by Packer-Muti (2010:1025) and Bowling (2002:396).

- **Researcher's role**

The researcher arranged for and prepared the venue and made sure that the focus group members were comfortably seated. The researcher welcomed the participants and introduced the independent facilitator and the note-taker and briefly described their roles. She then explained the purpose and objectives of the research project as well as the ethical considerations. She made a point of assuring the participants that the ethical considerations would be maintained throughout the study process.

- **Independent facilitator and note-taker**

A skilled independent facilitator as well as a note-taker was used during the FGIs. The rationale for this decision was based on the fact that the researcher is involved in the clinical accompaniment of second-year nursing students and therefore did not want to influence their feedback during the FGIs. The researcher discussed the proposal, aim and objectives of the study with the independent facilitator before commencing with the interviews. The independent facilitator who was identified to conduct the

FGIs had conducted many such group interviews in the past. Hence, she had professional interview skills such as flexibility and open-mindedness to elicit in-depth information as suggested by Holloway and Wheeler (2010:131).

- **Independent facilitator's role**

The independent facilitator created an open and non-threatening group climate to ensure that the nursing students felt comfortable and at ease. The independent facilitator discussed the rationale for the study by reading out loud the information leaflet. The participants were ensured that participation was voluntary and that their participation and feedback during the FGI would not affect their academic performance in any way. The participants were provided with an opportunity to read through the information leaflet, ask questions, and sign the informed consent document (view Annexure A) as suggested by Streubert and Carpenter (2011:62).

The independent facilitator requested permission from the participants to audiotape the FGI; she also explained the interview would be transcribed and the data would then be analysed. Ground rules were established so that all the participants knew how to proceed. The ground rules outlined included switching off their cellular telephones, respecting others' opinions, no interference when one participant was talking. The researcher requested the note-taker to take the field notes during the FGIs and audiotape the discussion with the permission of the participants (Creswell 2009:190).

Liamputtong (2012:60) identifies characteristics of an effective independent facilitator as including appropriate leadership skills, respect for the participants, being open-minded, having adequate knowledge about the topic, possessing effective observation and listening skills as well as being sensitive to the needs of the participants.

### **Asking the FGI question**

Green and Browne (2011:56) suggest the use of the next five rules of thumb when asking the FGI question: starting with the general question, asking open questions, using neutral questions, using appropriate vocabulary, and making use of concrete rather than abstract question.

- **Start with the general question**

The above authors are for the opinion that beginning with the general question is necessary for orientating the participants to the topic. In fact, the question can be related to general matters such as the weather or the transport used by the participants even though it has nothing to do with the topic (Doody et al. 2013:171). Such question can make the participants feel more comfortable In the study, the facilitator began each FGI by asking general questions pertaining to clinical accompaniment: “Do you all know what clinical accompaniment is?” and “What do you understand about clinical accompaniment?”

- **Ask open questions**

These are questions that require more than a “yes” or “no” answer. Guion, Diehl and McDonald (2011:1) state the question needs to be worded so the participants expound on the topic by having the freedom to use their own words. The above authors note further the open question allows the facilitator to deeply explore the participants’ feelings and perspectives on a subject.

- **Ask neutral questions**

The neutral question refers to the use of “how” instead of “why” when asking questions during the FGI. It is supported by Doody et al. (2012:31) who state the use of a “why” question may cause participants to feel defensive thus inhibiting their responses to the asked question and future questions. The facilitator used neutral questions, for example: “How does that make it difficult and how does that interfere with your learning in the clinical environment?”

- **Use appropriate vocabulary**

Vocabulary used by the facilitator was understandable to the third-year nursing students as observed from data obtained and how the participants responded to the questions being asked.

- **Use concrete rather than abstract questions**

This is about questions that refer to specific incidents rather than abstract ones. The facilitator avoided questions like the following: “What do you like about clinical accompaniment?” and “What do you dislike about clinical accompaniment?” The facilitator used the following questions: “Anything else that you would like to discuss?”; “Anything else?”; “Have we covered everything?”; “Any other feelings or experiences?” These questions were used at the end of the FGI as closing questions.

**The main question asked to the participants of the FGI was:**

*What are the challenges you as a second year student experience during clinical accompaniment?*

The facilitator used probing, reflection, clarification, listening skills, and paraphrasing during the FGIs (De Vos 2011:290).

○ **Probing**

Probing is defined by Buckingham and Saunders (2008:294) as “the instructions to the interviewer to delve deeper into the informant’s initial answer to get richer information”. The purpose of probing is to elicit more useful or detailed information from a research participant during an interview (Polit & Beck 2008:792). In this study probing helped the facilitator to explore the challenges second-year nursing students faced regarding clinical accompaniment. Probing persuaded the participants to provide additional information about the issue (clinical accompaniment) that was explored (De Vos 2011:290). As stated by Liamputtong (2012:77), the participants may provide incomplete or irrelevant responses to the question being asked during the FGI and therefore the facilitator used the following probing techniques for fuller and clearer responses from the participants:

- repeated questions to provide the participants with more time to think about the question; a repeated reply from the participants was encouraged as hearing the reply for a second time was seen as stimulating the conversation and also to ensure the participants’ experiences were real and truthfully shared
- the participants were asked to provide more specific details if some responses were unclear
- waiting and pausing for the answer with an expectant look on her face which conveyed the message that the facilitator required a fuller answer; it also indicated to the participants the facilitator was really interested in what they had to say which, in turn, helped them to share further experiences on the aspect touched on by the question
- asking the participants to return to an aspect previously mentioned and to discuss it in more detail, provided a clearer understanding of the topic being examined (Liamputtong 2012:77)

The facilitator avoided asking leading questions as they could have reflected her opinion and assumptions about the topic. Leading questions may also result in the participants giving answers they think the researcher expects to hear rather than providing honest answers about how they feel about

the topic under discussion. The participants may also want the researcher to look at them in a favourable way; thus, matching the researcher's opinion rather than sharing what they truly believe or have experienced (Liamputtong 2012:77). The facilitator refrained from asking dichotomous questions that could lead to answers like "yes" or "no" by asking about attributes or influences, that is, features of the topic and things that prompted or caused the action. As advised by (De Vos 2011:290), the facilitator made a follow-up on important points, asked for an example of a vague aspect that had been mentioned by a participant, and avoided asking leading questions.

- **Reflection**

Repetition provided the participants with an opportunity to think deeply about the question asked; giving them time to consider it allowed them to respond to a question they had understood (de Vos 2011:290). when the independent facilitator repeated the participants' views relating to the challenges regarding clinical accompaniment to make sure that she as well as the participants had understood the information shared correctly and similarly.

Two processes can be used to facilitate reflection, namely, reflective critique and dialectical critique. Reflective critique is based on the understanding that all statements made during data generation, including the participants' and researcher's verbal and written language, are subject to reflexivity. Reflexivity, according to Holloway and Wheeler (2010:8), is the critical reflection of what has been done and thought. Another process that can assist in reflection is dialectical critique which allows facilitators "to make explicit their internal contradictions rather than complementary explanation" (Streubert & Carpenter 2011:157). The ultimate goal of the two processes is to ask important questions and reveal biases about data as they reflect it.

- **Clarification**

Clarification is a technique that was used during the FGIs to gain clarity on statements made by participants. This technique ensured that both the independent facilitator and the note-taker interpreted and understood the information shared correctly. According to Doody and Noonan (2013:30), the interviews involve the use of predetermined questions whereby the researcher is free to seek clarification. The facilitator must avoid making assumptions at all costs; the facilitator should take small steps in questioning by using simple questions as this will prevent her or him assuming they know what the participants' opinions, ideas or views about the topic are. Both the facilitator and the participants should ask for clarification of what has been said so as to meet the goal of the interview.

Doody et al. (2013:172) state when the facilitator asks a participant to clarify what was said, it shows the facilitator did not understand what the participant meant. Clarifying questions and answers are the most important part of interviewing to obtain more detailed information on the topic of interest. Certain type of responses may impede the discussion if not clearly phrased, thus the facilitator may ask the participant to clarify the statement so that it is understood by all. The facilitator may also need the participant to give examples or be a little more specific by giving more details of what he or she meant.

In this study the facilitator made sure she interrupted the participants as little as possible when asking for clarification and did not rush them with their answers. Instead, she kept them focused by making use of the interview guide (see annexure B1). Sometimes the participants may also need some kind of clarification from the facilitator. Clarifications may give participants clues as to how specific the facilitator wants their answers to be (De Vos 2011:305).

- **Listening skills**

One of the critical interview skills relating to FGI is “being a good listener” and it is vital not to interrupt the participants, but allow them to give their views (Polit & Beck 2008:792). Making use of listening skills enables the facilitator to maintain continuous interaction with the participants and to obtain clarity and meaning regarding the views voiced by the participants (Terre Blanche, Kelly, Durrheim, & Painter 2006:306). While listening to the participants, the facilitator should remain neutral by using phrases such as “*thank you very much*” and “*that can really help*”. Comments such as “*do you really think so?*” or “*I cannot believe that*” were avoided. It might have made the participants feel as if they, or their opinions, were judged by the facilitator or that she disagreed with their view and if such feelings were experienced by the participants it could have closed down the discussion.

One of the critical interview skills relating to FGI is “being a good listener”; it is vital not to interrupt the participants but to allow them to give their views as suggested by Polit and Beck (2008:400). The use of listening skills enables the facilitator to “maintain continuous interaction with the participants and to obtain clarity and meaning regarding the views voiced by the participants”. (TerreBlanche et al. 2006:307). According to Gravett and Geyser (2013:50), the quality of listening is important because the “listener will always make sure that the essence of the person’s contributions is clearly conveyed and that the rest of the group has understood it”.

Doody et al. (2013:172) suggest the facilitator should be able to listen actively, pick up on cues from the participants, and be sensitive to what the group of participants consider important. Both the facilitator and note-taker should listen for notable codes and listen carefully for phrases that are particularly enlightening or express a particular point of view. In most cases it is difficult to pick up the entire quote so it is important for the facilitator to concentrate on hearing what parts of the discussion are emphasised by the participant. They may raise their voice, speak in a softer tone of voice or even sound emotional.

Listening also entails showing the participant that the researcher (in this case the facilitator) is 'hearing' what is shared. In this study the facilitator acknowledged that she understood and 'heard' the participants by sometimes nodding her head as suggested by Doody et al (2013:172)

- **Paraphrasing**

Paraphrasing is explained by Doody et al. (2013:172) as restating what was said. The facilitator restates the essence of the participant's response to the answer; restating therefore indicates the facilitator understands what the participant means and verifies her understanding is correct by restating what she had heard. This is supported by Guion et al. (2011:2) who state paraphrasing what the participant has said confirms to the participant that the facilitator is "actually listening and that the message conveyed is the message received". Paraphrasing also encourages the participant to focus wholly on the conversation thus limiting distractions. From the transcripts and the field notes read the researcher it is noted that the facilitator also used paraphrasing by restarting what the participants were saying, for example, "for 30minutes only?"

At the end of the FGI the facilitator briefly summarised the main challenges identified during the discussions. The facilitator thanked all the participants for their valued contribution as well as their time and cooperation. As Terre Blanche et al. (2006:300) state, it is the researcher who indicates when the session is over. In this study it occurred when data saturation had been achieved and no new data emerged in the FGIs.

Researchers must also inform the participants that, should the need arise to contact them for reasons relevant to the study, the researcher would do so (Terre Blanche et al. 2006:300). This was done after each FGI. In the case of all three FGIs, after the participants had all left, the researcher and the facilitator had debriefing sessions and discussed the outcome of each of the FGIs.



### 3.3.3.3 Recording of FGIs

The discussions with the three focus groups were all recorded by means of an audiotape and field notes.

#### ○ **Audiotape**

The note-taker is typically not able to record everything discussed (Liamputtong 2012:84). In the study this challenge was overcome by using an audiotape with the permission of all the participants. According to Brenner (2006:357), an audiotape (tape recorder) allows the facilitator to focus on the conversation with the participants and it provides a more complete record of the participants' actual words. Liamputtong (2012:84) suggests when recording the researcher has to make sure the room does not have too much background noise as it may be difficult to hear the discussion on the audiotape when transcribing it. Also, it is best if the audiotape is of good quality because the audible sound on the recorded interview has been a problem for many researchers. It has resulted in bad transcripts or having no transcripts at all because of poor recording or bad audiotape quality (Liamputtong 2012:84).

In the current study the facilitator tested the audiotape before starting with the interviews to make sure it was in working order and would record the audio properly and clearly (Guion et al. 2011:1). As suggested by Liamputtong (2012:84), the participants were made aware of the presence of the audiotape. It was explained to them the purpose of the audiotape was to capture the discussions as accurately as possible. The audio recordings were complemented by written field notes taken by the note-taker. This ensured that, should a problem occur with the recorded data, the field notes would also serve as a backup during the data analysis.

#### ○ **Field notes**

Polit and Beck (2010:555) define field notes as the notes taken by the researcher "to record the unstructured observation made in the field and the interpretation of those observations". Field notes are described by Polit and Beck (2010:354) as broader and more interpretive notes representing the observer's efforts to record information and to synthesise and understand the data. Field notes can be categorised according to their purpose. According to Birks and Mills (2011:78), field notes should be made after conducting interviews to retain details of the physical environment, record immediate responses to the interaction, and to capture participants' non-verbal behaviour which will not be revealed by audiotaped recordings. Field notes were made during the FGIs by the note-taker and included the observation of participants' verbal as well as non-verbal behaviours as they occurred.

- **Note-taker's role**

The note-taker recorded the key issues that emerged during each FGI and also observed and recorded non-verbal responses. The notes taken by the note-taker assisted the researcher to understand how participants felt about clinical accompaniment. Non-verbal responses that were recorded by the note-taker included participants using their hands (and sometimes arms) when expressing how they actually felt during their second year of clinical accompaniment. At the end of each of the group discussions, the note-taker summarised what she believed to be the main issues that emerged from the focus group discussions for confirmation or clarification by the group members (Gerrish & Lacey 2010:364). These authors confirm the confirmation and clarification of the field notes represents the first stage of the data analysis where tentative themes can be identified and tested within the detailed analysis of the group transcripts (Gerrish & Lacey 2010:364).

### 3.3.4 Data analysis

According to Polit and Beck (2008:747), data analysis is a process of organising and synthesising data so as to answer research questions. The data were analysed by means of qualitative content analysis. The aim of qualitative analysis is to organise data obtained so that it can be interpreted and provide meaning. Moule and Goodman (2009:387) define content analysis as an analysis of textual data content often produced as part of qualitative research to identify the key themes. The process of data analysis starts during data collection whereby rich data will be obtained.

In this study audio-recorded FGI were transcribed and the field notes were written in detail. The data obtained from these two sources were analysed separately by the co-coder, the researcher and the supervisors. The co-coder was a registered professional nurse with a PhD qualification; she is a psychiatric nurse specialist and a lecturer in the psychiatric module. She is experienced in facilitating FGIs and possesses both listening and observation skills.

Themes were identified to reveal nursing students' views of the challenges experienced in the CLE related to clinical accompaniment. The quotes denoting similar meanings were grouped together and named according to their contents to create themes. Categories containing similar contexts were also combined to form main categories which were linked to the themes and, lastly, sub-categories emerging from the categorising process were identified.

### **3.3.4.1 Coding**

Coding is the process by which “data extracts are labelled as indicators of a concept” (Green & Browne 2011:165). Saldana (2013:262) defines coding as a researcher-generated word or “short phrase that symbolically assigns a summative, salient essence-capturing and evocative attribute for a portion of language-based or visual data”. According to Saldana (2013:262), the coding process can “range from a single word to a full paragraph to an entire page of text to a stream of moving images”. Coding leads the researcher from the data to the idea and from the idea to all the data pertaining to that idea. Major and Savin-Baden (2010:63) state a good code is the one that has a sufficient number of characters to make it distinguishable from others, it clearly delineates a description of a theme, and can be augmented as sub-themes emerge.

### **3.3.4.2 Theme**

A theme is a recurring regularity emerging from an analysis of qualitative data (Polit & Beck 2010:570). Saldana (2013:175) defines a theme as “an outcome of a coding, categorisation and analytic reflection not something that is in itself coded”. The author adds the function of a theme is to categorise a set of data into an implicit topic that organises a group of repeating ideas. Themes can consist of ideas and descriptions of behaviour within the culture; themes provide an explanation for why other things are happening and are usually iconic statements and/or morals derived from the participants’ stories (Saldana 2013:267).

In the view of Siu and Comerasamy (2013:123), the purpose of developing themes is to provide a pathway for reaching an explanation about the research topic under study. Thematic data analysis was appropriate for this study because it enabled the researcher to identify, describe and analyse what the nursing students perceived as the challenges related to clinical accompaniment.

### **3.3.4.3 Categories**

Costley, Elliott and Gibbs (2010:123) define categories as “creative constructs or ‘bins’ into which discrete events, action and behaviour are placed for later analysis”. They further state “categories can help and inform the reflective process in thinking about relationships between events, actions and behaviour and are broader and more general than codes”. The characteristics of categories described by Gerrish and Lacey (2010:159) include it should occur frequently in the data and has to explain variations in the data. In addition, categories emerge naturally without being forced out by the researcher. Categories are discovered towards the end of the data analysis.

The steps of content analysis described by Baheiraei, Mirghafourvand, Mohammadi Nedjat, Charandabi, Rajabi and Majdzadeh (2011:4), Polit and Beck (2008:517) and Creswell (2006:191) were followed by the researcher and co-coder for the data analysis.

- **Step 1:** The transcribed data and field notes were read through to obtain a “general sense of the information” and to “reflect on its overall meaning”. (Baheiraei et al. 2011:4; Creswell 2006:191).
- **Step 2:** The challenges were identified and grouped into themes, categories and sub-categories.
- **Step 3:** The grouped “prominent themes and patterns among the themes” were refined from the ideas indicated in the transcribed data and field notes. The ideas were broken down into “smaller units” and coding as well as naming of the ideas according to the data they represented was done.(Polit & Beck 2008:547)
- **Step 4:** Consensus was reached among the researcher, co-coder and supervisors on the themes, categories and sub-categories identified.

Three main themes, six categories and five sub-categories emerged from the data gathered during the three FGIs. An in-depth discussion of the identified themes, categories and sub-categories are presented in Chapter 4 (view Table 4.1).

### 3.4 ESTABLISHING TRUSTWORTHINESS

Polit and Beck (2008:768) define trustworthiness as the “degree of confidence” qualitative researchers have in their data. The strategies of trustworthiness designed by Lincoln and Guba (1985:289-331) were applied in the current study. These strategies are: credibility, dependability, confirmability and transferability as well as authenticity. The strategies and application thereof in this study are explained and discussed next.

#### 3.4.1 Credibility

Credibility as a criterion for evaluating integrity and quality in qualitative studies refers to having confidence in the truth of the data (Polit & Beck 2008:751). With credibility the focus is on the trust

which can be placed in the accuracy of the data and the process by which it was acquired (Major & Savin-Baden 2010:179). The following are ways of establishing credibility:

#### **3.4.1.1 Prolonged engagement**

Prolonged engagement is the researcher's substantial level of immersion in the research process. It can be such that the researcher becomes truly engaged with the research study, establishes valid and meaningful relationships with the study participants, and is open to the deeper meanings that unfold during the process of research (Stommel & Wills 2004:289). The researcher achieved prolonged engagement as she spent a long period of time at the NEI where this study was conducted. At the time of the study, she had already spent four years doing clinical accompaniment of the nursing students in the CLE.

#### **3.4.1.2 Member checking**

Member checking is observed by Yin (2011:310) as a procedure whereby the researcher shares the study findings (also known as the draft material) with the study participants. Member checking is used to determine the accuracy of the qualitative findings through taking a final report or specific description or themes back to the participants for them to determine whether these findings are accurate (Streubert & Carpenter 2011:48). According to Yin (2011:310), member checking permits the participants to correct or improve the accuracy of the study while at the same time reinforcing the collaborative and ethical relationship. In this study, the co-coder was utilised to confirm the themes, categories and sub-categories identified.

#### **3.4.1.3 Comprehensive recording of data**

This is the step whereby the researcher needs to carefully and thoughtfully prepare field notes that are rich with description of what transpired in the field as suggested by Polit and Beck (2008:543). Comprehensive field notes were documented in a specific notepad during the FGIs by the note-taker. It also included the participants' non-verbal behaviour and facial expressions during the FGIs. A summary of the data collected was also written on the same notepad at the end of the FGI. Audiotaped recordings were used to aid in gathering and recording of the data.

#### **3.4.1.4 Data saturation**

Data saturation is the collection of qualitative data to the point where a sense of closure is attained because new data yield redundant information (Polit & Beck 2010:567). Data saturation occurs when

no new relevant concepts can be found that are important for the development of the emerging theory (Gerrish & Lacey 2010:159). Major and Savin-Baden (2010:182) suggest once the themes are continually repeated, it is no longer necessary to continue sampling for the sake of finding additional justification for the existence of the theme. The researcher in this study analysed the verbatim transcribed FGI data and assessed it for data saturation. There was no need for additional FGI scheduling as data saturation was obtained from the three focus groups.

### **3.4.2 Dependability**

Dependability is defined as the criterion for evaluating integrity in qualitative studies and refers to the stability of data over time and over conditions (Polit & Beck 2008:751). According to de Vos (20:306), dependability is the alternative to reliability. With dependability the researcher attempts to account or any change in the condition of the phenomenon chosen for the study as well as for changes in the design created by an increasingly refined understanding of the setting. Comprehensive field notes were kept during the FGI and audiotaping was used to aid in gathering and recording of the data. The FGIs were transcribed verbatim.

### **3.4.3 Confirmability**

Confirmability is defined by Polit and Beck (2008:750) as a criterion for integrity in qualitative inquiry; it refers to the objectivity or neutrality of the data and the interpretations thereof. The researcher, according to Major and Savin-Baden (2010:179), must remain neutral during the data analysis and interpretation and needs to demonstrate that the results could be, and at times should be, confirmed or corroborated by others. An independent facilitator was used to conduct the FGIs as the researcher was (and currently is still) a nurse educator and clinical facilitator involved with the second-year nursing programme; hence, the need for another person to confirm the findings of the study.

Petty, Thomson and Stew (2012:383) mention qualitative researchers recognise their own experiences and their interpretations are influenced by subjectivity; therefore, this is made known to the reader through the process of reflexivity. The way in which the current researcher arrived at the themes and their interpretations, the implications and conclusions in this study are made explicit through recommendations.

### 3.4.4 Transferability

Transferability is defined as the extent to which qualitative findings can be transferred to other settings or groups (Polit & Beck 2008:768) According to Major and Savin-Baden (2010:183) and Petty et al. (2012:383), transferability is considered the responsibility of those who wish to apply the results into a new context. A researcher is therefore expected to provide detailed and thick descriptive data about the study context and assumptions as this will enable others to determine the degree to which the findings may be applied to their own setting (Holloway & Wheeler 2010:303).

The knowledge acquired in one context will be relevant in another and those who carry out the same research in another context will be able to apply certain concepts originally developed by the first researcher. Rich, thorough, vivid descriptions were provided in this study which related to the study context, the participants, the experiences, and processes observed during the FGI inquiry. The researcher strived to ensure that sufficient information was provided to allow the readers to make judgements related to contextual similarities. Comprehensive field notes were kept containing rich descriptions of what had transpired in the study field.

### 3.4.5 Authenticity

Polit and Beck (2008:748) define authenticity as the extent to which qualitative researchers fairly and faithfully show a range of different realities in the analysis and interpretation of their data. As a nurse educator, the current researcher had at the time of study been involved in nurse education of students for approximately four years. Comprehensive field notes were kept containing detailed descriptions of what had transpired in the field. Audio-recording was used to aid in gathering and recording of the data.

Authenticity as described by Holloway and Wheeler (2010:304) consists of fairness, ontological authenticity, educative authenticity, and tactical authenticity.

The researcher must be fair to participants to gain their acceptance throughout the whole of the study process. In this study, the researcher maintained an informed consent and also took into account the social context in which the participants worked and lived. Ontological authenticity means the readers as well as the study participants have been made more aware of how to better understand their social world and their human condition through the study. With educative authenticity the participants improve

the way in which they understand other people and with educative authenticity participants' decision making skill is enhanced (Holloway and Wheeler 2010:304). With Authenticity the researcher was able to understand the lives being portrayed by the nursing students in a CLE with some sense of mood, feeling experience, language and content of those lives, as suggested by Polit and Beck (2008:748).

### **3.5 SUMMARY**

In this chapter qualitative data using an exploratory and descriptive design was used to explore and describe the challenges of clinical accompaniment as experienced by the second-year nursing students at the NEI in North West. Three FGIs were conducted to collect data from the third-year and repeating second-year nursing students who rotated in different wards such as the medical, surgical, gynaecological, casualty and outpatient department over a period of one year.

Chapter 4 provides an overview of the study findings and discussion of related literature.



## 4 RESEARCH FINDINGS AND DISCUSSION

### 4.1 INTRODUCTION

Chapter 3 focused on the research design and methods used to address the research question. In Chapter 4 an overview of the research findings and discussion on related literature is presented.

### 4.2 OVERVIEW OF THE RESEARCH FINDINGS

The third-year nursing students provided input based on their clinical accompaniment as second-year nursing student regarding their experienced challenges as well as wishes related to clinical accompaniment offered by the clinical facilitators. Information was gathered by means of three focus group interviews. The researcher read the field notes and transcripts and listened to the audiotapes to acquaint her with the data. The researcher also had a meeting with the co-coder and supervisors to discuss and agree on the themes, categories and sub-categories. Content analysis method was used to identify themes to reveal nursing students' views of the challenges experienced in the clinical learning environment (CLE) related to clinical accompaniment.

The research findings were based on the following open-ended question asked to the nursing students during the focus group interviews (FGIs).

*“What are the challenges second-year nursing students experience pertaining to clinical accompaniment at a nursing education institution in the North West?”*

**Table 4.1: Summary of themes, categories and sub-categories of Objective 1**

Theme	Categories	Sub-categories
4.2.1 Clinical facilitators' approach	4.2.1.1 Negative feedback	<ul style="list-style-type: none"> <li>• Intimidation of students</li> </ul>
	4.2.1.2 Negative attitude of the clinical facilitators	
4.2.2 Clinical accompaniment structure	4.2.2.1 Inadequate planning	
	4.2.2.2 Ineffective communication	
	4.2.2.3 Theory-practice gap	
4.2.3 Clinical learning environment	4.2.3.1 Insufficient resources	<ul style="list-style-type: none"> <li>• Shortage of staff</li> <li>• Shortage of equipment</li> </ul>
	4.2.3.2 Negative attitude from ward staff	<ul style="list-style-type: none"> <li>• Favouritism</li> <li>• Inconsistent support</li> </ul>

As reflected in Table 4.1 three main themes emerged from the question that was asked to the third-year nursing students relating to Objective 1 concerning the challenges they experienced during their second year of clinical accompaniment. These themes were the clinical facilitators' approach; the clinical accompaniment programme; and the clinical learning environment. The themes, categories and sub-categories are discussed with relevant quotations from the participants as well as supportive literature.

#### 4.2.1 Theme 1: Clinical facilitators' approach

The first theme to emerge was that the nursing students experienced the clinical facilitators' approach as concentrating on negative feedback and the latter seemingly also displayed a negative attitude towards the nursing students. In Table 4.2 the findings related to Theme 1 with categories and one sub-category are displayed.

**Table: 4.2 Clinical facilitators' approach**

Theme 1	Category	Sub-category
4.2.1 Clinical facilitators' approach	4.2.1.1 Negative feedback from the clinical facilitators	<ul style="list-style-type: none"> <li>• Intimidation of students</li> </ul>
	4.2.1.2 Negative attitude of the clinical facilitators	

Most of the participants indicated an inappropriate approach was shown by the clinical facilitators when talking to them or dealing with issues that affected the nursing students.

The following are some of the participants' quotes that linked to the clinical facilitators' approach:

*"... they [clinical facilitators] will also shout at you in front of the patient and then the patient loses confidence in you. They don't take you to a more private area to tell you what you did wrong and they disrespect us."*

*"... they [clinical facilitators] always take the sisters' side of the story. In the hospital, we have lunch at ... when the clinical facilitators come, they say, 'Go back to the ward' even if you [nursing student] just came to have lunch..."*

**Discussion:** In the Nursing Education Association (NEA) guidelines (NEA 2013:7) the approach measures that should be used by the clinical facilitator when managing conflict are stipulated. According to the NEA guidelines (NEA 2013:7), such measures include gathering information from all parties, addressing the issue with people involved when there is time, using an appropriate venue and communicating openly in a non-threatening way avoiding emotional response. Shouting at the nursing students in front of the patients reduces the students' self-confidence; therefore, the clinical facilitator should act professionally by building a non-threatening relationship with the student during clinical accompaniment. Two categories emerged from this theme namely *negative feedback* and *negative attitude*.

#### **4.2.1.1 Category 1: Negative feedback**

The findings show the nursing students experienced that the clinical facilitators only focused on the mistakes made by the nursing students rather than on both the mistake and the good performance of the nursing students.

The following are some of the quotes linked to negative feedback:

*"... they [clinical facilitators] are only focusing on that we [students] do wrong..."*

*"... it is like they [clinical facilitators] are investigating us [students]..."*

*"When they [clinical facilitators] find you [nursing students] doing the procedure they tell you that you are wrong and in front of the patient..."*

*"... they [clinical facilitators] focus on students' absenteeism..."*

*"... they [clinical facilitators] focus on your [nursing students] mistakes..."*

**Discussion:** Clinical facilitators should not only focus on the mistakes made by the nursing students but need to also focus on the roles of the clinical facilitator which includes giving guidance, teaching, supervising and others as described in Chapter 2 (section 2.4.1.1-2.4.1.10). Gravett and Geysler (2013:109) are of the opinion that negative feedback and feedback that focuses on a nursing student as a person has the potential to damage a learner's motivation to learn. Clinical facilitators should ensure honest and motivating feedback to the students and provide positive comments before addressing any negative ones as suggested by Gravett and Geysler (2013:109).

Seibel (2013:273) state some of the nursing students may see negative feedback as a threat and resort to maladaptive coping strategies where students may present with denial and deflection to preserve their sense of the self. Nursing students, according to Seibel (2013:273), may as well respond to negative feedback by withdrawing to protect themselves from a sense of failure. This author therefore proposes that since nursing students are highly vulnerable to negative feedback, all feedback should respect students' dignity and self-esteem and belittling and demeaning words have to be avoided.

The importance of giving positive feedback to the nursing students includes increased confidence, motivation and self-esteem as well as improved clinical practice (Clynes & Raftery 2008:405). One other importance of giving positive feedback to the nursing students is that it can help them improve their ability to reflect themselves more accurately to better their performance of skills and contribute to clinical instructions in the CLE (Plakht, Shiyovich, Nusbaum & Raizer 2013:1264). Emerson (2009:162) is of the opinion that the quality of feedback provided by a clinical facilitator should be a balance of positive and negative and should be presented in a caring and respectful manner. This opinion is supported by Billings and Halstead (2013:289) that one method of giving feedback regarding clinical performance is to point out positive aspects of performance as well as areas that require improvement.

#### **4.2.1.2 Category 2: Negative attitude of the clinical facilitators**

The nursing students in this study viewed the attitude of the clinical facilitators as negative. There was a unanimous feeling that the clinical facilitators were always too serious, disrespectful, unapproachable, unsupportive, shouting at them and not listening to their concerns. About 70% of the participants indicated the clinical facilitators shouted at them in front of the patients; the nursing students experienced embarrassment in front of the patients. In their study "Guidelines for value-sensitive clinical accompaniment in community health nursing" Beukes and Nolte (2013:306) also found students felt embarrassed if shouted at in front of the patients that, according to the nursing students, demonstrated a lack of professionalism and respect on the side of the clinical facilitators. Nursing

students seek respect, support and acknowledgement from their clinical facilitators during clinical accompaniment.

Supportive quotes that link to negative attitude are as follows:

*"...The challenge that I have is that we have a workbook with things that we do and they don't help us they just come there and they don't do what they are suppose[d] to do..."*

*"... they [clinical facilitators] don't assist us [nursing students], when you ask questions like when you don't know about a particular process, 'Can you please assist us and then sign the workbooks?' Then they say no, they are not supposed to do that, they are there to guide us..."*

*"... they [clinical facilitators] are also too serious all the time..."*

*"... they [clinical facilitators] don't want to accompany us [nursing students] through the wards..."*

*"... when they [clinical facilitators] come, your side of the story is always wrong and when you try to explain then they say you are disrespectful..."*

*"... they [clinical facilitators] don't assist us [nursing students] then [the] patient think[s] you are not competent enough and tell you to leave then and that become[s] a problem..."*

**Discussion:** Attitude is determined by how easy the nursing students are able to approach the clinical facilitators during their accompaniment. In the view of De Guzman, Pablo, Prieto, Purificacion, Que and Quia (2008:48), an ineffective clinical facilitator impedes students' development in the CLE by causing conflict through their personal attitude. Melincavage (2011:786) argues that the nursing students who experience any negative attitude from the clinical facilitators have the potential to display the same kind of attitude when becoming professional nurses or nurse educators. Some of the nursing students experienced emotional stress because of the negative attitude of the clinical facilitators.

It is therefore important for a clinical facilitator to acknowledge that nursing students indeed learn more than only clinical skills and patient care during their clinical experience; they must understand the way they treat the students may have a huge impact on how the students react to learning and training (Melincavage 2011:786). In the process of learning, nursing students also learn the behaviour of the clinical facilitators and the language used as well. Therefore, the clinical facilitator should be mindful of non-verbal aspects of communication such as their attitude. The clinical facilitator has to display a positive attitude towards the nursing students to create an environment conducive for clinical learning. According to Kinnell and Hughes (2011:38), attitude is one of the intrapersonal variables that significantly influences nursing student-clinical facilitator relationships since it reflects the way one

thinks (cognitive component), the way one feels (affective component), and the way one behaves. Additionally, the clinical facilitators must show the nursing students they have the time and are available to willingly assist and handle situations in a manner that they do not embarrass the nursing students (Kotze 2008:210). In the study conducted by Mattila, Pitkälä and Erikson (2010:155) positive attitude was seen to be beneficial to the nursing students in that they felt comfortable and at ease in the CLE. This sense of belonging allowed them to self-actualise and develop a feeling of profound satisfaction. A positive attitude also enhances professional growth that includes a sense of awareness, own potential and empowerment as stated by Mattila et al. (2010:156).

Beukes and Nolte (2013:305) indicate in their study for the clinical facilitator and the nursing students to engage effectively during clinical accompaniment, they need to understand and demonstrate respect to one another. A disrespectful treatment by the clinical facilitator has the potential to disturb the potential of the nursing student to learn during clinical accompaniment as noted by Beukes and Nolte (2010:4).

○ **Sub-category: Intimidation of students**

There is clear evidence that the presence of clinical facilitators impact negatively on the performance of the nursing student. Some of the nursing students felt that keeping quiet during the presence of the clinical facilitators or absenting themselves from the CLE was a better option than encountering intimidation.

The nursing students had the following comments on how they experienced intimidation clinical accompaniment:

*“... that makes us [nursing students] incompetent when we try to answer...”*

*“... and we [nursing students] feel intimidated by them [clinical facilitators]...”*

*“I [nursing student] feel stressed because it feels like I didn’t do the work...”*

*“... and putting you [nursing student] on a very low self-esteem and it’s not right...”*

*“... we [nursing students] start to be afraid of them [clinical facilitators] and when they come, none of us want to ask questions...”*

*“... they [clinical facilitators] are scaring us [nursing students]...”*

*“... when our preceptors come, we [nursing students] are not comfortable...”*

**Discussion:** Kinnell and Hughes (2011:28) show concern about some of the nursing students who fail to show interest, enthusiasm and motivation and appear to lack initiative. These authors suggest that all

these stated behaviours may be due to the nursing students' insecurity, reduced self-esteem and threatened self-efficacy. Data collected in this study also confirmed that the participants portrayed such behaviour and blamed the clinical facilitators for it. A clinical facilitator is described by De Guzman et al. (2008:51) as someone who makes students' learning experience enjoyable, listens to the students, demonstrates consideration and kindness towards the students and is pleasant, approachable, and open-minded. Chandan and Watts (2012:4) state clinical facilitators should support the nursing students through difficulties associated with the CLE to increase their self-esteem and help socialising them into the nursing role. This refers encouraging nursing students to participate in the discussions during ward rounds or case presentation or patient care in a CLE to enhance a spirit of solidarity among clinical facilitator and nursing students (Papastavrou et al 2010:177).

Chan and Ip (2007:768) state nursing students' value recognition from the clinical facilitator for their contribution to patient care. According to Henderson, Briggs, Schoonbeek and Paterson (2011:197), a successful clinical learning environment is created through inspirational leadership and good leadership practice that involves a relationship of trust between the clinical facilitator and the nursing students. Henderson, Cooke, Creedy and Walker (2012:299) emphasise nursing students placed in a CLE need to be motivated; they have to feel included as part of the team and encouraged to develop good relationships with the team members. They should be able to feel free to ask questions in order to explore the clinical practice.

#### 4.2.2 Theme 2: Clinical accompaniment structure

The findings concerning the structure of the clinical accompaniment of nursing students are shown in Table 4.3. No sub-categories emerged.

**Table 4.3 Clinical accompaniment structure**

Theme	Category
4.2.2 Clinical accompaniment structure	4.2.2.1 Inadequate planning (Infrequent short visits) 4.2.2.2 Ineffective communication within clinical environment 4.2.2.3 Theory-practice gap

Another situation mentioned by some of the participants was that they did not receive accompaniment at all; instead, the clinical facilitator were there for assistance to the third-year students and not for

them. It is thus evident that the clinical facilitators did not have a structure for conducting clinical accompaniment.

The next supportive quotes relate to the clinical accompaniment structure:

*"...They [clinical facilitators] come for 30 minutes..."*

*"...The challenges that I [nursing student] have experienced is that our clinical accompaniment didn't come for us. They [clinical facilitators] came for other students in other levels but they didn't come for us..."*

*"...Sometimes we [nursing student] don't see them [clinical facilitators] in other wards, they only come once a month ..."*

**Discussion:** Clinical accompaniment is defined by the NEA (2013:3) as the "formal clinical teaching, practice and support of nursing students by designated and appropriately trained staff at the clinical facility where the student is placed". Meyer and Van Niekerk (2008:176) identify two ways of conducting clinical accompaniment; it can either be situational or structured. In intentional situation-based accompaniment the clinical facilitator arranges with learners to accompany them when they are unsure of the specific procedure or when their learning needs must be assessed. Non-intentional situation-based accompaniment involves active accompaniment of the nursing student where the clinical facilitator discusses clinical issues with the student and plans a nursing intervention while acting as a role model.

Structured clinical accompaniment refers to having a formal plan for conducting an accompaniment. The accompaniment involves holding formal discussions about a patient, conducting academic ward rounds with the nursing students as well as case study presentations. As outlined by Meyer and Van Niekerk (2008:82) structured clinical accompaniment should accommodate nursing students' learning needs and should be aimed at developing the nursing student as a professional, responsible nurse practitioner.

#### **4.2.2.1 Category 1: Inadequate planning (Infrequent short visits)**

The study revealed there was no specific structuring of clinical accompaniment for the nursing students. There was also clear evidence that the nursing students were receiving insufficient clinical accompaniment by the clinical facilitators in the CLE. Furthermore, nursing students placed on night duty were not accompanied by clinical facilitators. Some of the participants were concerned about the



short times the clinical facilitators spent with them for accompaniment as well as how fast the clinical accompaniment was done. Other nursing students felt that even though the accompaniment was done, it was not a fair as it was done for nursing students on other levels and not for them (second year of training) which made them feel neglected.

Supportive quotes linked to inadequate planning are:

*“...they [clinical facilitators] don’t tell us when they are coming to check on us...”*

*“...they [clinical facilitators] are not there for us [nursing students]...”*

*“...when they [clinical facilitators] come here they are always quick...”*

*“...we [nursing students] are also expected to work night shift without accompaniment...”*

*“...the other thing that I [nursing student] have in mind is that we have old people [clinical facilitators] there and if we can have a mix of old people and young people it would be better...”*

**Discussion:** Planning is defined by Zerwekh and Claborn (2009:308) as a “process of setting goals and objectives and determining actions necessary for them”. According to Meyer and van Niekerk (2008:182), planning is an intellectual operation that involves decision making, critical thinking and value choice making. The plan must be time-specific and steps to the plan should include frequency of the action and the duration (Zerwekh & Claborn 2009:308). As outlined by Jooste (2013:105) planning should be future-oriented as well as specific, realistic and achievable. Mattila et al. (2010:156) discovered in their study the constant ‘hurrying’ of the clinical facilitators resulted in nursing students developed feelings of not being welcome to their clinical placement. This feeling resulted in the nursing students using their energy to anticipate difficulties instead of focusing it on learning. The clinical facilitators therefore need to have knowledge and insight into the methods of clinical accompaniment as it will allow them to properly plan for clinical accompaniment which will benefit the learning needs of all the nursing students.

A clinical accompaniment plan, according to the NEA guidelines (2013:7), should be compiled annually. The year plan as per NEA guidelines need to include the following: the induction of nursing students at the beginning of clinical allocation; remedial days for students needing additional support in a CLE; all clinical formative assessments; demonstration and planned clinical activities; and practical days and summative assessment dates (NEA guidelines 2013:7). The clinical facilitators should also involve the educators when compiling the year plan to prevent any clashing of time and availability. These guidelines further advice all changes or updates which thereafter should be communicated to all

concerned including the nursing students. According to Chan and Ip (2007:680), the clinical facilitator should be innovative in planning new, interesting and productive ward experiences, teaching techniques, learning activities and patient allocations. Such plans will allow the nursing students to meet their clinical learning needs.

Kinnell and Hughes (2011:93) state an effective plan can turn a negative encounter into a positive and viable experience for the nursing students. These authors propose a Strength, Weaknesses, Opportunities and Threats analysis can also be considered for effective planning to make the clinical learning experience more positive for students (Kinnell & Hughes 2011:93).

#### **4.2.2.2 Category 2: Ineffective communication within clinical environment**

There is clear evidence from the data that communication between the clinical facilitators, clinical staff and the nursing students was ineffective. Communication is a core strategy that the clinical facilitator should use in creating a CLE that is conducive to training. The clinical facilitator has to also develop a collaborative relationship with the clinical staff to make nursing students' clinical learning more effective.

Supportive quotes that signified ineffective communication included:

*"... when they [clinical facilitators] come they just come in and they take us [nursing students] out to an office and they won't tell the sisters that they are taking us and then the sister shouts at us because the work is not done..."*

*"...to add on about communication, when our preceptors come, they will tell us that we have a meeting at, for example, ten-thirty [10:30]. They don't inform the sisters and when we tell them they ask us where is our preceptors. It causes conflict between us and the nursing staff..."*

*"...I would also like to add that there seems to be a communication problem between our preceptors and the nursing staff. Sometimes we are given a project and we will have our own strategies in place and then the nurses will know nothing about it..."*

*"...clarity needs to be given to the professional nurses about the allocations of the students..."*

**Discussion:** Jooste (2013:106) defines communication as "a process by which information is exchanged and understood by two or more people usually with the intent to motivate or influence behaviour". Creating an environment for learning in this context includes listening to the nursing students' concerns. To be an effective communicator, clinical facilitators need to be aware of their communication abilities to develop the required skill (Sharples & Elcock 2011:84). Furthermore, clinical

facilitators and ward staff need to work as a team towards meeting the learning needs of the nursing students. Clear and open communication among team members is perceived by Nisbet, Hendry, Rolls and Field (2008:66) as an important component of effective teamwork. Goran (2012:7) adds communication among all teams must not be offensive but professional and non-judgmental to avoid spoiling the clinical accompaniment. Zerwekh and Claborn (2009:236) advocate for communication to always be clear and directed to the appropriate, responsible individuals. These authors state within a workplace a dominant communication style is direct, confident and assertive. By using a dominant communication style conflicts between the ward staff, clinical facilitators and the nursing students can be avoided for example, in the mentioned case where the nursing students were taken randomly *“out to an office and they won’t tell the sisters that they are taking us and then the sister shouts at us because the work is not done...”*.

Andrews et al. (2006:869) advocate for the CLE to be effective; there is a need for stronger a communication link between the clinical staff, the clinical facilitators and the nursing students. Effective communication is intrinsic in a fostering and caring attitude and allows for mutual understanding of the roles of both the clinical facilitator and the clinical staff regarding nursing student learning in a CLE (Andrews et al. 2006:869). Effective communication between the clinical facilitator, the ward staff and the nursing students in a CLE should involve critical reasoning and possibilities about clinical practice as suggested by Henderson et al. (2012:300). Effective communication can thus be achieved through meetings, discussions and questioning around the learning issues of the nursing students. In Jooste’s (2013:205) opinion, communication is a core component of a sound relationship, collaboration and cooperation which are essential aspects of professional practice. Clinical facilitators should work collaboratively and cooperatively with the ward staff during clinical accompaniment through effective communication to facilitate nursing students’ learning. As outlined by the NEA (2013:12), the clinical facilitator is a role model in a CLE and should set a good example by notifying the nurse unit manager when she or he arrives and leaves the ward. She or he also needs to liaise with the relevant clinical staff about student performance and assessment. According to Zerwekh and Claborn (2009:240), professional credibility enhances effective communication between the clinical facilitator, the ward staff and the nursing students. Sharples and Elcock (2011:84) emphasise that good, effective communication will allow nursing students to feel they are listened to; their concerns are validated and not trivialised and, importantly, they also feel understood and supported.

Bach and Grant (2012:77) identify some guides to effective communication, namely, sharing and transmitting information; creating a platform for renewed understanding; understanding perceptions and

exchanging ideas; establishing a trusting and respectful relationship; and enhancing understanding of the various attitudes, ideas and beliefs of the different people involved in the communication activity.

#### 4.2.2.3 Category 3: Theory-practice gap

Evidence from the data collected suggested there was a gap in correlating theory and practice. This was a significant concern for some of the nursing students. As nursing education consists of a theoretical and a practical component, theory forms the foundation of the learning that the nursing students have to apply in a clinical setting. Some of the participants indicated the clinical facilitators focused more on theory than the practical in a CLE and did not maintain a balance between the two components thus a theory-practice gap was created. Kaphagawani and Useh (2013:182) explain the theory-practice gap as the disparity between what has been learned in the classroom setting and what is practiced in the CLE.

Quotes related to the theory-practice gap are as follows:

*“...when the clinical facilitators come they focus more on the theory than on the practical...”*

*“...they [clinical facilitators] give us a lot of theory work than practical work...”*

*“...they [clinical facilitators] need to balance theory and practice...”*

*“... when they [clinical facilitators] come it is only theory and never practical...”*

**Discussion:** Nursing education is characterised by a close relationship between theory and practice. According to Papastavrou et al. (2010:117), this characteristic means nursing cannot be learned through either theory or practice only but, as Henderson et al. (2006:8) also agree, the integration of theory and practice is an important component of nursing education that is maximised through effective clinical placement. As indicated in the NEA guidelines for facilitators of learning in a CLE, one goal of the clinical accompaniment is to promote the ability of the nursing student to integrate theory and practice (NEA 2013:8).

In a CLE nursing students are allocated to the relevant real-life setting in which they can apply the theory they have obtained. During clinical accompaniment the clinical facilitator will reinforce the theoretical aspect of all clinical activities with the student (NEA 2013:8). Lambert and Glacken (2005:669) states clinical facilitators were introduced to support the nursing students in the clinical setting with the aim of bridging the theory-practice gap. This statement is supported by Kinnell and Hughes (2011:124) who emphasise clinical facilitators are responsible for helping the nursing students translate theory into practice and make what has been learned in the classroom a reality. According to

Lindahl, Dagborn and Nilsson (2009:9), the clinical facilitator forms a bridge between the classroom and the clinical area and is responsible to promote the exchange of experiences between theory and practice. An effective and efficient clinical accompaniment is regarded by Beukes and Nolte (2013:304) as the means by which theory-practice integration is achieved. Reaffirming this view, Midgley (2006:338) confirms the clinical facilitator is responsible for linking the '*knowing what*' and the '*knowing how*'. In order to enhance the personal and professional development of a nursing student, Meyer and Van Niekerk (2008:81) suggest clinical facilitators need to consider the method of theory-practice integration in order to enhance the personal and professional growth of the nursing student.

Meyer and Van Niekerk (2008:81) add that failure in theory-practice integration affect the development of nursing students. They do not have the ability to solve problems; they demonstrate an apathetic attitude in a CLE as well as dependency in the execution of patient care and the fragmentation of patient care. Beukes and Nolte (2010:1) are of the opinion that theory-practice integration encapsulates the facilitation and development of professionalism in nursing students as future health care professionals.

#### 4.2.3 Theme 3: Clinical learning environment

As far as the CLE was concerned two categories with two sub-categories each were identified during the data analysis as indicated in Table 4.4.

**Table 4.4 Clinical learning environment**

Theme 3	Category	Sub-category
4.2.3 Clinical learning environment	4.2.3.1 Insufficient resources	<ul style="list-style-type: none"> <li>• Shortage of staff</li> <li>• Shortage of equipment</li> </ul>
	4.2.3.2 Negative attitude from ward staff	<ul style="list-style-type: none"> <li>• Favouritism</li> <li>• Inconsistent support</li> </ul>

Most of the nursing students did not value the quality of CLE they were exposed to. According to the data collected, the CLE did not meet some of their learning needs as they had expected the training hospital to be equipped with both human and material resources.

Quotes related to clinical learning environment are:

*"...when the clinical facilitators come they focus more on the theory than on the practical..."*

*"...some of the wards where we students are allocated do not give us time to learn and we just work like we are not students..."*

*"...we [nursing students] end up not going to the sessions because we think what is the point of going when you are demotivated..."*

*"...we [nursing students] go to the wards and work the whole day without learning anything..."*

**Discussion:** D'Souza et al. (2013:25) state in a CLE there is a variety of influences that can significantly hinder the clinical learning of the nursing students during their clinical placement. Nursing students, according to D'Souza et al. (2013:26) feel vulnerable in the CLE which obviously makes learning become a bigger threat in a clinical area than learning in a classroom. It is therefore vital that the hospital management ensures the availability of both human and material resources so that the needs of the patients as well as the nursing students' learning needs are met.

Henderson et al. (2012:300) outline the importance of CLE to enable the nursing students to develop their clinical skills and to learn about the process in care delivery. These authors mention several characteristics of the CLE, namely, nursing students should be motivated in the CLE; they need to feel free and safe to ask questions; they should feel included and be able to explore practice. Quality CLE occurs if all stated characteristics are met. Ali and Panther (2008:38) states a conducive CLE is one in which nursing students are treated as respected adult learners who can take responsibility for their learning. A clinical facilitator is the key figure in creating a CLE that is conducive for a nursing student's learning. Therefore, the clinical facilitator during accompaniment should create a climate that promotes learning and where the nursing students are continuously encouraged to analyse, evaluate and act when confronted with problematic situations. Two categories emerged from the CLE theme: insufficient resources and ward staff.

#### **4.2.3.1 Category 1: Insufficient resources**

The insufficient resources mentioned by the participants included the shortage of staff and equipment in the wards where they were placed. This was a challenge to the participants as it denied them the opportunity for learning.

Quotes that linked to insufficient resources are:

*“...another problem is that we are too many students and when a sister gets a chance to demonstrate a procedure, we cannot come and see as we are too many students so that is a challenge. The tools and equipment are not sufficient enough as we are too many students...”*

*“...when you go to the wards we [nursing students] don't find the equipment that we [nursing students] used when we practice in the clinical laboratory and the sister will say they only have old ones and some of them are not working ...*

*“...in second year we do sterile procedures like suturing but we find that when we give feedback there are not towels that make the sterile pack and no enough instruments then we struggle to do how we were taught...”*

**Discussion:** According to Stuart (2013:112), resources required for learning includes both material and human. As ascertained by the author such resources need to be identified and their use should be well planned. Ulrich (2012:205) notes organisational accountability relates to the provision of sufficient resources including enough staff members with an appropriate staff mix and the availability of equipment. Two sub-categories emerged from the category of insufficient resources namely, human resources (shortage of staff) and material resources (shortage of equipment).

- **Sub-category 1: Shortage of staff**

There was overwhelming evidence in the findings that no effective accompaniment of the nursing students took place in the CLE during their placement. The nursing students blamed this on the shortage of staff and that too many nursing students were allocated to the CLE.

The following quotes relate to the shortage of staff that consequently meant there were too many nursing students with few staff members to assist them:

*“...there is always a shortage of staff and then we [nursing students] have to work independently without supervision...”*

*“...we are so many students in one ward and we work with one or two sisters...”*

*“...there is no [not] enough sisters in the wards to help us when the preceptors are not there...”*

*“...sometimes when there is a complication, you will be calling them and they will just be sitting and after that they will say no the student saw that patient, they hold you accountable...”*



*“...the thing is, if you treat a patient, the sister will hold you accountable even if you asked her for help.*

*“...she will only come when the doctor comes...”*

**Discussion:** Human resources in a CLE play a critical role in the education of the nursing students. Hence, if there is a shortage of staff it has an extremely negative impact on the nursing students' learning. Buchan and Aiken (2008:3262) discovered that the world has entered a critical period for human resources in the healthcare domain due to the scarcity of qualified health professionals – especially the staff shortages of professional nurses currently experienced is one of the biggest obstacles in achieving health system effectiveness. The shortage of nurses has an enormously negative impact on the learning of nursing students.

Buchan and Aiken (2008:3262) conclude that the shortage of nurses is not necessarily a shortage of individuals with nursing qualifications, but more a case of nurses who are only willing to work under certain conditions such as “poor incentive structures, and poor recruitment, inadequate workforce planning and allocation mechanism as well as retention and return policies”. As verified by the participants in this study, the nursing students complained they had to work alone while the clinical staff would be seated and only be present when the doctor comes for ward rounds. In a situation like this where there is no active accompaniment by an experienced and committed professional nurse may discourage the nursing students; they may feel disheartened and demotivated because they are not given the opportunity to make the best possible use of the available learning opportunities (Meyer & Van Niekerk 2008:107).

- **Sub-category 2: Shortage of equipment**

The data collected indicated a shortage of material resources. For the purpose of this study material resources referred to the general supplies and equipment used in the CLE to facilitate clinical accompaniment of the nursing students and to ensure quality patient care. Some of the participants were not satisfied about their practical evaluations as they were evaluated with limited resources; they felt that it affected their performance negatively. The participants voiced they were placed in the wards in large numbers which also limited their practical opportunities as they were always expected to improvise.



Quotes that verified the finding that there was a shortage of equipment are as follows:

*“... you [nursing student] cannot practice procedure in the correct way because you don't have equipment...”*

*“... it makes it difficult because during practical, when they show you the procedure you do it with different equipment and because there is no [not] enough supplies it looks like you are incompetent and they [clinical facilitators] give you low marks...”*

*“...in the clinical area you sometimes cannot perform a procedure because of the instruments and at the same time the procedure needs to be performed so we need them [clinical facilitators] to help us and guide us...”*

**Discussion:** Clinical accompaniment requires that an effective, well-organised learning environment is created by the clinical facilitator. One of the characteristics of a learning environment that promotes learning is the availability of adequate resources (Chandan & Watts 2012:4). Material resources need to be organised and controlled in such a manner that economical utilisation is ensured. Monitoring systems are required, for example, the daily checking and regular servicing of equipment as well as a strict control of supplies. Ranse and Grealish (2007:173) assert the CLE must allow nursing students to become immersed in practice and needs to provide them with the opportunity to repeat experiences. Repeated practice, according to Stuart (2013:156), will assist the nursing students to acquire confidence, dexterity and consistent performance. When there is a shortage of equipment it becomes extremely difficult for the nursing students to repeat their experience to gain competence in clinical skills.

#### **4.2.3.2 Category 2: Negative attitude from ward staff**

The participants indicated that the ward sisters also shouted at them when they did something wrong without even listening to what the students had to say or explain about it. It seemed to the participants as if the ward sisters resented their presence and made no effort to participate in their learning experience.

Quotes related to the negative attitude from the ward staff includes:

*“...when we as students have maybe done something wrong, the sister shouts at me [us] without hearing both sides of the story...”*

*"...the sisters are saying they are not coming for us they are coming only for the patients..."*

*"...some sisters when you talk to them they make as if they don't hear even if you are sure that you are loud enough..."*

*"...some nurses will also help us and guide us but other nurses are short-tempered towards us..."*

**Discussion:** Jackson, Hutchinson, Everett, Mannix, Weaver and Salamonson (2011:108) conducted a study on the experiences of nursing students regarding organisational aggression, resilience and resistance. They found the nursing students were at risk of being exposed to aggression and bullying in the CLE.

Two sub-categories emerged from ward staff category, namely, the unfair treatment of the nursing students and inconsistent support. According to Dadgaran, Parvizi and Peyrovi (2013:6), having a positive and supportive attitude towards the nursing students is profoundly effective where the clinical learning of the students is concerned. Conversely, if a negative, unsupportive attitude prevails it can result in the deterioration of the educational quality in the clinical environment. If this scenario is encountered by the nursing students, it can lead to disappointment and discouragement among the nursing students.

○ **Sub-Category 1: Favoritism**

Currently, nursing students from both the college and from the university who are enrolled for the four-year comprehensive nursing programme are placed in the same CLE. Some of the nursing student participants shared they felt they were not treated fairly by the ward staff. They voiced that they noticed that some students seemed to be receiving more attention in terms of teaching. Apparently, according to the transcribed data, nursing students from the college received more attention than those from the university.

Quotes which verified the nursing students' reference to favouritism are:

*"...they [ward staff] also go with favour; they are very favouritism [they favour some students]..."*

*"...they [ward staff] only call their favourites to help. If we get a job to do we can't complain because the sisters will tell the preceptors that we are refusing to do the work..."*

*"...one thing about the staff is that we are the university students and college students so they [ward staff] give more attention to the college students, they don't favour us..."*

*"...some sisters favour the other students, especially the college students. They will explain the procedures to them, when we come from class they say that we should know the procedure..."*

**Discussion:** The findings of Altmiller (2012:17) and Del Prato (2013:288) concur that favouritism is a major challenge for nursing students in a CLE, especially during the practical evaluations. Altmiller (2012:17) considers favouritism as an unprofessional behaviour that can trigger a feeling of anger in a nursing student. Behaviour identified by nursing students as favouritism in this study included explaining the procedures to some of the nursing students and excluding others.

- **Sub-category 2: Inconsistent supervision/support**

Although the participating nursing students said they did receive support from the ward staff, they still experienced the support as inconsistent because the reaction of the ward staff to the learning of some was experienced as positive while for others it was very negative.

Supportive quotes that link to inconsistent support are as follows:

*"...some of the staff is supportive because for us university students there are procedures that we haven't done yet and they help us, but some of them are very 'cheeky'..."*

*"...ninety per cent [90%] of us go through emotional trauma. The sisters are shouting at us..."*

*"...my experience is not positive at all. When you need clarity on something the nurses will be too relaxed and they don't want to help you..."*

*"...they don't put any effort in teaching us the correct things; they are more focused on knocking off at four so time is money..."*

*"...some sisters are very approachable; whenever you ask a question they will clarify and explain to you, other sisters are not approachable at all. When you do a procedure they become impatient with you and push you away to do it themselves. It is also a very difficult situation to get them to sign your workbook..."*

**Discussion:** Croxon and Maginnis (2009:236) state for the CLE to be constructive the ward staff has to be friendly, approachable, available and willing to teach. Such staff members do their utmost to give the nursing students opportunities to develop confidence and competence in clinical skills. These authors assert the clinical nursing staff needs to really focus on the nursing students' learning needs rather than only on the service needs of the facilities. According to Delany and Molloy (2009:58), nursing students

in a CLE expect to be accepted as students and to get on well with clinical staff; they expect to be assisted to perform well and to be able to put in practice what they feel they already know. However, this was contrary to what the nursing students were experiencing as they were left to attend to patients unsupervised and being held accountable for patients' change in condition which led to a lot of frustration on the part of the nursing students.

The ward sister has the responsibility to supervise the nursing students allocated to his or her wards. They have to ensure that tasks performed by the nursing students are relevant, they must provide details and discuss aspects of the task as well as ensuring whether students do qualify to perform such tasks as asserted by Jooste (2013:226). A further suggestion made by this author is that the ward sister should facilitate the personal and professional development of the nursing students and provide the opportunity for evaluation of their learning. As nursing is a practice-based discipline nursing students are entitled to well supervised clinical learning opportunities that will assist them to translate theory into practice (Barnett, Cross, Jacob, Shahwan-Akl, Welch, Caldwell & Berry 2008:56). Inadequate supervision from the clinical staff leaves the students frustrated and anxious throughout their placement. On the other hand, support and encouraging supervision from the nursing staff enhance the nursing students' clinical reasoning, problem solving, time management and interpersonal communication skills (Barnett et al 2008:56).

### **4.3 SUMMARY**

Chapter 4 presented the findings of the obtained data in terms of identified themes, categories and sub-categories. The researcher supported the findings with quotes from the participants and related literature sources.

In Chapter 5 conclusions and the limitations and recommendations based on the findings are presented.

## 5 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

### 5.1 INTRODUCTION

In Chapter 4 the study findings were discussed in detail. Verbatim quotes from the participants and literature reviewed supported the findings. In Chapter 5 the conclusions of the study are summarised, an overview of the limitations and recommendations based on the study findings are also given.

### 5.2 AIM OF THE STUDY

The overall aim of the study was to explore the clinical accompaniment challenges second-year nursing students experience at a nursing education institution (NEI) in North West.

### 5.3 CONCLUSIONS

A consistency emerged in the challenges perceived by the nursing students during clinical accompaniment. All the participants from the three focus groups experienced similar challenges. This implies a negative perception of clinical accompaniment that may impact negatively on the learning experience of the nursing students.

The purpose of this study was to gain an in-depth understanding of the challenges regarding clinical accompaniment experienced by the nursing students. The following three main themes derived from the study guided the recommendations made.

- Theme 1: Clinical facilitator's approach
- Theme 2: Clinical accompaniment programme
- Theme 3: Clinical learning environment

The conclusions for each of the three themes are delineated in sections 5.3.1.1 to 5.3.1.4.

### **5.3.1 Theme 1: Clinical facilitators' approach**

Most of the nursing students experienced some emotional stress because of the attitude displayed by the clinical facilitators. They perceived that the clinical facilitators only focused on what the students did wrong; their feedback was only negative; they made no effort to encourage the students in the CLE. There was a strong united feeling among the participants that effective communication between the clinical facilitators and the ward staff has to be addressed and promoted to prevent conflicts that mostly ended up affecting the nursing students in a negative way. The nursing students indicated they felt incompetent, intimidated, demotivated, stressed, afraid and uncomfortable around the clinical facilitators who were unfriendly, unapproachable and always shouting at them in front of the patients. The researcher concluded that the inimical attitude of the clinical facilitators impacted negatively on the learning of the students.

### **5.3.2 Theme 2: Clinical accompaniment structure**

Inadequate planning on the side of the clinical facilitators was perceived by the nursing students as a significant challenge. Most of the time, the clinical facilitators did not accompany the students; they were simply not there, not present but left the nursing students to their own devices. On the occasions that they did show up for clinical accompaniment, they did not stay long in the CLE. Most of the participants felt the approach the clinical facilitators had towards them was inappropriate. When they spoke to the nursing students or talked to the latter about issues the students had to deal with, their manner was authoritative, unapproachable and devoid of any understanding, assistance and support. The participants again indicated that the clinical facilitators only focused on their mistakes rather than on what they did wrong as well as on what they did right. To the participants it seemed as if the clinical facilitators were ignorant of their needs; they ignored the nursing students' good performances and treated them with disrespect. Some of the participants were very worried about the clinical facilitators' tendency to emphasise the theory rather than the practical in a CLE. It discouraged the students from asking questions, made them feel incompetent because even if they had learned the theory in the classroom, they were not able to put it into practice in the CLE without guidance and support. According to the participants, no balance between the two components (theory and practice) was maintained in the CLE thus contributing extensively to the theory-practice gap.

### 5.3.3 Theme 3: Clinical learning environment

The participants mentioned the shortage of resources as a challenge that negated their clinical learning. These resources included the shortage of ward sisters as well as the shortage of equipment. Some of the nursing students indicated the nursing students from the college and university were not treated equally by the ward staff. They noticed that students from a different NEI received more attention in terms of teaching. They experienced such favouritism as unprofessional and discriminatory. The nursing student participants appreciated the support they received from a few of the ward sisters although the majority of the ward sisters were unsupportive. The participants were encouraged by the guidance and assistance of those ward sisters who apparently understood the critical importance of helping nursing students to apply what they have learned (theory) in a real life environment to close the theory-practice gap.

## 5.4 RECOMMENDATIONS

The following recommendations emanated from the study findings.

### 5.4.1 Clinical facilitator as an accompanist

- The clinical facilitators in collaboration with the educators should develop clinical accompaniment guidelines that are in line with the SANC regulation R425 (2005 or 1985:19) .
- As authorized by the SANC regulation (R425) these guidelines should specify the annual period of clinical accompaniment the nursing student should receive as well as the objectives for the particular level.
- Macro clinical placement of the nursing students should be jointly planned with other NEIs that use the same CLE to avoid overcrowding of students in some of the wards.
- Clinical facilitators should act professionally and use both critical thinking and problem solving skills in managing conflicts that arise during clinical accompaniment.
- The clinical facilitator should be assessed on personal, professional and educational levels to determine if the individual possesses the characteristics needed to perform the expected role.
- The clinical facilitators should create some debriefing sessions and give a balanced feedback to the nursing students after each evaluation session.

- Monthly feedback sessions should be conducted after every clinical placement to discuss the students' issues including their learning need and challenges and successes and to make suggestions that will benefit the students in their learning.
- All clinical facilitators should undergo clinical facilitation orientation as well as clinical facilitation courses and also attend seminars and workshops related to their work on a regular basis to keep up-to-date with new practices.
- Clinical facilitators should ensure that all skills practiced in the nursing simulation laboratory be re-demonstrated at the hospital on real life patients.
- As accompanists of nursing students, all clinical facilitators should engage in research related to clinical facilitation/accompaniment.
- Clinical facilitators should provide sufficient time for clinical accompaniment so as to assist the nursing students in meeting their clinical learning needs.

#### ***5.4.1.1 The role of the Nursing Education Institution in developing clinical facilitators as accompanists***

- The NEI should employ more clinical facilitators and should prepare them for their role in clinical accompaniment.
- An introductory, more effective course should be conducted to the newly appointed clinical facilitators so that they can be clinically competent and confident.
- Clinical facilitators should be developed academically through continuous education and training.
- Clinical facilitators should be provided with the necessary support and training to allow them to function according to the expectation of the NEI.

#### ***5.4.1.2 The role of the clinical learning environment in developing clinical facilitators as accompanists***

- Accredited hospitals for clinical learning should have all the necessary and functional equipment. It will not only benefit the nursing students but also improve the quality of patient care.
- The hospital management should take the responsibility to ensure that all nursing students who are receiving clinical accompaniment in an accredited hospital are able to perform clinical practice that is appropriate to the level of their training and with the availability of the necessary equipment.



- A CLE that is conducive to nursing students' learning should be ensured by providing ward staff who understand why the nursing students are there; who are skilled at dealing with the students and who can communicate in a professional manner.
- The hospital management should address the challenge of the shortage of ward staff by motivating for the provision of additional clinical staff which will not only benefit the nursing students' learning but also promote the quality of patient care.

#### **5.4.2 Communication system**

- There is an urgent need to improve the quality of the relationships among the clinical facilitators, nursing students and the ward staff. Paying attention and promoting the communication among these three groups will subsequently render positive results in that better clinical accompaniment will lead to an improved quality of clinical learning which will ultimately result in providing better quality patient care.
- Learning opportunities for nursing students should be planned collaboratively by the clinical facilitator, the ward sister and the nursing student. There should be a shared commitment between the clinical facilitator and the ward sisters towards clinical learning of the nursing students.
- The system of communication in a CLE should be formalized to prevent conflicts and misunderstandings and to improve clinical facilitators' communication skills.
- Clinical facilitators should advocate for the nursing students where necessary and teach them the correct channels of communication. Quality relationships should be built between the clinical facilitators and the ward sisters for delivery of quality education for nursing students.
- There should be monthly meeting between the clinical facilitator and the educators in order to manage the theory-practice gap.

#### **5.4.3 Future research**

The researcher recommends that future research be conducted on the following areas:

- Evaluation of the clinical facilitators' competencies in clinical accompaniment.
- Investigating the clinical facilitators' views regarding clinical accompaniment
- Investigating factors to enhance the effective clinical accompaniment of nursing students.

## 5.5 LIMITATIONS OF THE STUDY

The study was conducted using three focus groups from both the repeating second-year students and the third-year students. Other levels such as level one, two and four were not involved. The study focused specifically on the challenges regarding clinical accompaniment and not on the nursing students' perceptions of clinical accompaniment in whole (although some positive aspects pertaining to clinical accompaniment entirely were also detected in the findings). Some of the participants' voices were soft and the recording was not clearly audible and was therefore not used during the reflective quotes as evidence for the study findings. However, the data was rich and data saturation was achieved as supported by the extensive field notes taken during the data collection process.

Following ethical considerations, the researcher, as active clinical facilitator for the second-year nursing students, opted not to participate during the data collection process (see section 3.3.3.2). The study findings were therefore not the first-hand experience of the researcher, but were derived from listening to the audiotapes and reading the transcribed data and field notes.

## 5.6 PERSONAL REFLECTION

I view it as a privilege to share my feelings and experiences of one of the most difficult journeys I have ever undertaken in my life. This personal reflection is an attempt to express my sincerest gratitude to all whom I have met and worked with; it is also my wish that this meditation will serve to encourage many others to pursue and follow their dream. I am a self-motivated person with a strong belief that I am able to face any challenge and overcome all obstacles. It was this self-concept that I started out on this journey. My enthusiasm spurred me on and I encouraged my colleague join me and we both started off together. I managed to pass the theory at my first attempt, but deciding on the study topic was a daunting experience. Nothing came out the way I thought it would; I changed the topic more than four times and all the while both my supervisor and co-supervisor stood firm and supported me through the storms I had to weather.

Finally, after settling for the topic, I had to change my job. By changing my job I was obliged to again change the very topic that I had already spent many months of research and effort on. Because the topics kept on changing, the research methods also continuously changed – it was nerve-racking. But the positive aspect was that I learned many research approaches and methods. Starting off with

Appreciative Inquiry I moved on to the nominal group technique and finally settled on focus group interviews. After having made the final decision on the topic and the research method, I broke my ankle. My research endeavour had become just as wobbly and challenging as me walking with sticks and wearing a moon boot. Through all these ordeals I was blessed with the unwavering support and love of my husband. Just when my ankle had almost completely healed, I lost my husband. He died after a very short illness. People had to come from very far to pack all my articles, books as well as my laptop and remove them from my study area. During this time, I also offered to support my son and his wife as they were struggling to come to terms with the loss of their 3 premature babies.

In spite of the hardships I went through, I have gained so much by persevering with this research study. My typing skills improved significantly; I became skilful at searching for research articles on the Internet; my mind was stimulated with new knowledge and I acquired an immense insight into the innate strength that helps one to endure even when endurance seems illusory. I am deeply thankful for this. As a coordinator for clinical learning I have gained on my supervisory skills in clinical accompaniment and preceptorship to the extent that feel fully prepared to supervise students in their research projects. Although I have yet to publish an article in a scientific journal, I managed to write a manuscript and presented it at a research retreat. The uplifting and positive comments inspired me to complete it more effectively.

*“God is good all the time, and all the time God is good”.*

## 5.7 CONCLUSION

The study objectives were met. This chapter concluded the study with a dissemination of the findings and a discussion of the limitations. Numerous recommendations were developed to address the challenges identified by the participants with regard to clinical accompaniment. Some ideas for future research were noted followed by the researcher’s personal reflection of the study project.

The findings reflected that clinical facilitators did not act as role models for the nursing students during their clinical learning. Several challenges related to clinical accompaniment were identified that included the shortage of both human and material resources, overcrowding of nursing students in the CLE, and inadequate planning as well ineffective communication among the clinical facilitators, the nursing students and the ward sisters.

It was important to conduct a study on how clinical accompaniment of second-year nursing students can best be conducted. The study was done in a specific nursing education domain and the findings revealed it was a useful, relevant and timely study. It elicited some specific ideas and recommendations on how clinical accompaniment can best be conducted, namely, by addressing and meeting all the learning needs of the nursing students.

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