Feedback in clinical settings: perceptions of nursing students at a small rural district hospital in the southern part of Namibia

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DECLARATION

By submitting this thesis electronically, I Vistolina Nenayishula Nuuyoma, declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third-party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

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ABSTRACT

Feedback is one of the basic elements that should be present in all clinical interventions used in clinical education. This is because it delivers the path by which assessment becomes a tool for teaching and learning. Learning in a clinical environment is critical to acquire the knowledge, skills and attitudes required of a health professional. Placement of students in clinical settings enables them to learn from clinical encounters with patients, families and communities. In addition, it affords students an opportunity to transfer theory into practice. Although feedback is widely acknowledged as an important element of clinical education, which is supposed to accompany all learning and teaching activities, it is a component in which educators continue to fall short. In Keetmanshoop District in Namibia, some nursing students are not confident and do not feel free to practise their nursing skills during their practical placements due to the nature of the feedback that they receive while in these placements. This study was conducted to explore nursing students' perceptions of the feedback that they received during placements in clinical settings, with the objective to ultimately improve clinical nursing education.

The study followed an explorative qualitative design with an interpretivist perspective. It was conducted at the Keetmanshoop district hospital. Twenty four nursing students from the University of Namibia and Keetmanshoop Regional Health Training Centre participated in the study. The two data gathering techniques used in this study were: one–on- one in-depth interviews with nursing students and the observation of feedback given to students in clinical settings. All interviews were audio recorded with a digital voice recorder followed by verbatim transcriptions, with the participants' permission. Thereafter, data were analysed manually by coding, and then related codes were grouped to form themes. Emerging themes are presented as the findings of this study.

The four themes that emerged from the results of this study are: *positive perceptions of feedback*, *negative perceptions of feedback*, *the perception of students on the feedback process* and *recommendations of nursing students on feedback*. The findings further revealed that no individual feedback was given to the students in clinical settings and that feedback was provided without having directly observed the skills performed by a student. The study exposed areas that need to be improved and this will ultimately benefit the students as their mentors' skills in providing feedback will improve.

Key words: Feedback; learning in clinical environment; clinical settings; nursing students; southern Namibia

OPSOMMING:

Terugvoer is een van die basiese elemente wat teenwoordig behoort te wees in all kliniese intervensies tydens kliniese opleiding. Die rede hiervoor is dat dit die weg baan vir evaluering om instrumenteel tot onderrig en leer te kan wees. Leer in ‘n kliniese omgewing is noodsaaklik vir die verkryging van die nodige kennis, vaardighede en houdings wat van ‘n gesondheidswerker vereis word. Die plasing van studente in kliniese omgewings bemagtig hulle om te kan leer uit die kliniese blootstelling aan pasiënte, gesinne en gemeenskappe. Dit bied verder ook die geleentheid om teorie in die praktyk toe te pas. Alhoewel terugvoer oor die algemeen herken word as ‘n belangrike element van kliniese onderrig – wat veronderstel is om deel te wees van alle onderrig- en leergeleenthede – is dit steeds ‘n komponent waarin vele opvoedkundiges kort skiet. In die Kettmanshoop Distrik in Namibië, is daar sekere verpleegstudente wat nie die self-vertroue het in, en nie vry voel om hul verpleegvaardighede toe te pas nie, as gevolg van die aard van terugvoer wat hulle ontvang gedurende hul kliniese plasings. Hierdie studie is onderneem om verpleegkunde studente se ervaringe van terugvoer ontvang tydens kliniese plasings te verken, met die uiteindelik doel om verpleegkunde opleiding te verbeter.

Die studie het ‘n verkennende, kwalitatiewe navorsingsontwerp met ‘n vertolkende perspektief gebruik en is uitgevoer in die Keetmanshoop Distrik. Vier en twintig verpleegkunde studente van die Universiteit van Namibië en die Keetmanshoop Distriksgesondheidsopleiding Sentrum het aan die studie deelgeneem. Die twee data-invorderings tegnieke wat gebruik is was: een-tot-een in-diepte onderhoude met verpleegkunde studente; en die waarneming van terugvoer aan studente verskaf in kliniese omgewings. Alle onderhoude is op band opgeneem deur ‘n digitale bandopnemer, gevolg deur die verbatim transkribering waarvoor elke deelnemer toegestem het. Data is gekodeer, waarna verwante kodes saam gegroepeer is om temas te vorm. Die temas wat op die manier verkry is, word as die bevindinge van hierdie studie aangebied.

Die vier temas wat deur hierdie studie gegenereer is, is die volgende: *positiewe ervaringe van terugvoer*, *negatiewe ervaringe van terugvoer*, *student se ervaring van die terugvoer-proses* en *verpleegkunde studente se aanbevelings omtrent terugvoer*. Die bevindinge het verder getoon dat geen individuele terugvoer aan studente in kliniese omgewings gegee was nie en soms gegee was sonder direkte waarneming van die vaardighede wat deur ‘n student uitgevoer is. Die studie het areas waarop verbeter moet word uitgelig en die verbetering van hierdie areas sal op die langduur tot voordeel van die student strek aangesien dit hul mentors se vermoë om terugvoer te gee, sal verbeter.

Sleutelwoorde: Terugvoer; leer in kliniese omgewings; verpleegkunde student; Suid-Namibië.

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LIST OF ACRONYMS AND ABBREVIATIONS

KRHTC	Keetmanshoop Regional Health Training Centre
UNAM	University of Namibia

CHAPTER 1
ORIENTATION AND BACKGROUND

1.1 BACKGROUND

Nursing education is classified under the umbrella concept of post compulsory education and training, which means that it is education and training that take place after finishing compulsory schooling (Hughes & Quinn, 2013). In addition, it is also classified under the umbrella term of health professions education. A large portion of learning in the health professions may be skills-based, which means that it leads to a person becoming competent at performing specific clinical interventions that are carried out to improve patients' or service users' health (Gopee, 2008). This is normally achieved via clinical education. Feedback is one of the basic elements that should be present in all clinical strategies employed in clinical education (Branch & Paranjape, 2002). It is contended that feedback delivers the path by which assessment becomes a tool for teaching and learning (Van der Vleuten & Schuwirth, 2005). Although feedback is widely acknowledged as an important element of clinical education, it is a component in which educators continue to fall short (Weinstein, 2015).

According to Hughes and Quinn (2013), nursing education can take place in settings such as university departments of nursing, private and public hospitals, clinics, general practitioners' surgeries, prisons, nursing homes and patients'/clients' own homes. In health professions training programmes, students generally are required to complete theoretical and practical components within a specific time frame. In practical courses, students may learn how to perform clinical skills in clinical skills centres at training institutions and also in real clinical settings. A clinical skills centre is one of the facilities established to allow students to acquire and practise the skills that are required from them as health care practitioners, in simulation (Bradley & Postlethwaite, 2004). A clinical environment or setting refers to the environment where students learn to become real practitioners, learn while engaging with real patients, and it usually consists of community settings and hospital inpatient and outpatient setups (Ramani & Leinster, 2008).

Clinical settings constitute an important learning environment in nursing education because they provide experiential learning. This means that learning takes place through experience, which is considered to be more meaningful than classroom learning (Hughes & Quinn, 2013). Feedback is one of the components that makes experiential learning meaningful (Hughes & Quinn, 2013).

Clinical settings as a learning environment

Learning in a clinical environment is therefore critical to acquire the knowledge, skills and attitudes required of a health professional (Bradley & Postlethwaite, 2004). Placement of students in clinical settings enables them to learn from clinical encounters with patients, families and communities. In addition, it affords them an opportunity to transfer theory into practice (Bruce, Klopper & Mellish, 2011).

In Namibia, the process of sending students to clinical settings is often referred to as *practical attachment*, or *clinical attachment*. Here, the learning of nursing students in clinical settings is facilitated by clinical instructors, lecturers and tutors via clinical accompaniment and follow-up visits. During clinical accompaniment, clinical instructors, lecturers and tutors work side by side with learners or they nurse patients nearby (Meyer & Van Niekerk, 2008). During clinical follow-up visits, the educators arrange to visit the learners in clinical settings when they are unsure of specific duties, to teach them procedural skills or to conduct assessment. However, in Namibia, registered and enrolled nurses based in clinical units also play a major role in facilitating student nurses' learning in clinical settings. Supervision and mentoring in clinical settings are conducted by unit registered nurses who have the duty to ensure that nursing care is carried out by those capable of doing so. These unit nurses therefore also have a duty to teach, mentor and supervise students in their units (Bruce *et al*., 2011). Registered nurses are considered as nurse mentors in the training and education of nurses although their primary responsibility is patient care and service provision. Further key players in the teaching of students in clinical settings are clinical instructors. A clinical instructor is a registered nurse employed by the nursing school or by a clinical setting for the purpose of clinical teaching (Bruce *et al*., 2011). Various names are used to refer to registered nurses who assist nursing students in clinical settings. These names are 'facilitator', 'mentor', 'instructor' and 'preceptor' (Broadbent, Moxham, Sander, Walker & Dwyer, 2014).

In order to learn clinical skills, key individuals within each clinical unit support students to enable them to identify learning opportunities. Students must then make sense of their practice through the application of theory, reflection on their clinical practice experience and feedback (Hughes & Quinn, 2013). Feedback is one of the most dominant influences on learning and achievement (Hattie & Timperley, 2007); however, its impact on learning can be either positive or negative (Hughes & Quinn, 2013). Furthermore, feedback is fundamental to the support of cognitive, technical and professional development (Archer, 2010). Lack of feedback is detrimental to effective clinical teaching and learning in health professions education (Hughes & Quinn, 2013). Therefore, clinical educators are encouraged to provide

continuous feedback to students about their performance and how they can improve on it (Gaberson & Oermann, 2007).

1.2 PROBLEM STATEMENT

There is evidence that learners may view feedback as a negative experience when their performance is criticised. (Ramani & Krackov, 2012). Similarly, in the Keetmanshoop District hospital in Namibia, some nursing students are not confident and do not feel free to practise their nursing skills during their practical placements due to the nature of the feedback that they receive while in these placements. This was reported to the researcher during a student nurse-lecturer forum for the School of Nursing at the University of Namibia (UNAM) Southern campus - which was held in October 2015. The student nurse-lecturer forums are platforms where nursing students and lecturers regularly meet to discuss general academic and non-academic issues that affect their training. Furthermore, informal conversations with nursing students in the Keetmanshoop District hospital indicated that the feedback that they received was experienced as a barrier to completing their practical workbooks. In all nursing programmes offered in Namibia, learners have practical workbooks for each course with a practical component. These workbooks list the clinical learning experiences that learners have to undergo, and a space is provided for the registered nurse to sign after a learner has demonstrated competency in a specific skill. In addition, there are also a minimum number of procedures that learners have to complete for each study level. These also serve as requirements for registration by the Health Professional Council of Namibia upon completion of the programme. Therefore, it is compulsory for all learners to complete their workbooks before they proceed to the next level of study.

In Namibia, rural health facilities experience problems such as shortages of nursing staff and clinical supplies. This may negatively affect teaching and learning in clinical settings, which could possibly result in providing poor feedback to students on their performance. This study was therefore conducted to explore the perceptions of nursing students in the Keetmanshoop District hospital in Namibia about the feedback that they received from nurse mentors in clinical settings. This may help to provide a foundation for understanding feedback given to students in order to enhance the provision of feedback in clinical settings.

1.3 MOTIVATION FOR THE STUDY

Harden and Laidlaw (2013) propose that feedback should be regarded as a crucial teaching activity; however, there are a number of reasons why providing feedback to students in clinical settings can be challenging. In the mentioned clinical education forum that took place at the Keetmanshoop District hospital in October 2015, registered nurses from clinical settings, lecturers, tutors and clinical instructors from UNAM and the Keetmanshoop Regional Health Training Centre (KRHTC) discussed issues that were challenging in clinical settings. These challenges included a lack of registered nurses with post basic qualifications or training in nursing education or related fields. This was said to hinder the teaching and learning of students in the clinical environment, including the provision of feedback. The researcher therefore identified the need to conduct a study to explore students' perceptions of the feedback that they received.

Furthermore, previous research on feedback has demonstrated its importance and effectiveness in health professions education, as well as the influence that feedback has on the recipients and the perceptions of medical students of the quality of the feedback received during clinical rotations (Al-Mously, Nabil, Al-Babtain & Abbas, 2014; Archer, 2010). However, none of those researches focused on training in rural settings. In addition, most research in this regard was conducted in developed countries, without evidence of similar studies conducted in a small rural district and underserved settings such as in Namibia. Furthermore, the researcher has a vision of improving clinical nursing education in Namibia, and this study can serve as a starting point in order to fulfil this goal.

1.4 RESEARCH QUESTIONS

In exploring nursing students' perceptions of the feedback that they received in clinical settings in a small rural district, the following questions were formulated:

1.4.1 Primary question

How do nursing students in a small rural district experience the feedback that they receive in clinical settings?

1.4.2 Secondary questions

1. What is the nature of feedback that nursing students receive in clinical settings in a small rural district?
2. How is feedback given to nursing students in clinical settings in a small rural district?
3. How does the feedback received by nursing students in a small rural district influence their performance during a clinical attachment?

1.5 AIM OF THE STUDY

The aim of the study was to explore nursing students' perceptions of the feedback that they received in clinical settings, with the objective to ultimately improve clinical nursing education.

1.6 METHODOLOGY

An explorative, qualitative research with an interpretivist perspective was used in this study.

1.6.1 Study design

The explorative research is conducted to explore the full nature of a phenomenon not well understood (Polit & Beck, 2008). In addition, it is often conducted towards building a new understanding (Maree, 2016). Therefore, an explorative and qualitative approach was appropriate for this research because little was known about the feedback given to nursing students in the Keetmanshoop District. Moreover, it allowed for inductive reasoning, meaning the researcher can work from specific observations to broader generalisations and theories (Maree, 2016).

1.6.2 Research context

This study was conducted at the Keetmanshoop District Hospital located in the Keetmanshoop district, Kharas Region of Namibia. There are two higher education institutions that offer nursing programmes in the Kharas Region and allocate students at the

Keetmanshoop district hospital for clinical practice. The institutions are the University of Namibia (UNAM) and the Keetmanshoop Regional Health Training Centre (KRHTC), therefore students who participated in this study are both from UNAM and KRHTC.

1.6.3 Data collection

The two data gathering techniques used in this study were individual in-depth interviews with nursing students and the observation of feedback given to students practising in clinical settings. All interviews were audio recorded with a digital voice recorder followed by verbatim transcriptions, with the participants' permission.

1.6.4 Data analysis

Data were analysed manually by coding, and then related codes were collapsed into themes. To differentiate the two concepts, coding and themes, Maree (2016:116) defines coding as the "process of reading carefully through your data, line by line, dividing it into meaningful analytical units" while themes refer to similar codes aggregated to make up a main idea that can be used in data analysis (Creswell, 2014). Furthermore, themes were given names that were inclusive of all the codes under them. Emerging themes were considered as representative of the results of this study. Themes were used in data analysis because this was a qualitative study and themes formed a core element in the data analysis process (Creswell, 2014).

1.7 ETHICAL CONSIDERATIONS

Ethical clearance (S16/04/072) was obtained in May 2016 from the Health Research Ethics Committee of Stellenbosch University (Addendum 3). Permission to interview UNAM students was granted by the Office of the Assistant Vice-Chancellor at the Southern campus (Addendum 6). Permission to interview KRHTC students was granted by the Office of the chief tutor at the centre (Addendum 5). The Keetmanshoop District Hospital falls under the jurisdiction of the Ministry of Health and Social Services; therefore, the study was granted ethical approval by the Office of the Permanent Secretary via the Research Unit in June 2016 (protocol reference number 17/3/3) (Addendum 4). Thereafter, permission to conduct research on the hospital premises was granted by the Office of the Senior Medical Officer of the Keetmanshoop District Hospital via the Office of the Kharas Health Directorate. Both approval and permission were granted prior to observations and interviews with participants.

Protecting the welfare of research participants is the chief purpose of research ethics and should be a concern for all researchers in the planning, designing, implementing and reporting of research conducted with human participants (Terre Blanche, Durrheim & Painter, 2006). In this study the researcher prepared participant information sheets that provided an explanation regarding the purpose of the study and what was expected from participants and their rights, for example the right to withdraw from the study at any stage. In addition, the researcher also included a consent form that was read and signed by all participants prior to each interview and before each observation. Protection from harm is also considered to be the most fundamental and important ethical issue in research (Gay, Mills & Airasian, 2009). This principle protects participants from any kind of harm, be it physical, mental or social. There were no direct or indirect risks involved in participating in this study. Moreover, the researcher applied the ethical principle of confidentiality. According to Gay *et al*. (2009), researchers maintain confidentiality by not disclosing information obtained from the study although they may know the participants.

1.8 DELINEATION AND LIMITATIONS

This study focused only on the perceptions of nursing students of the feedback that they received in clinical settings in the Keetmanshoop District hospital. Students who were registered at the training institutions in the Keetmanshoop District but did not practise in this district were not included in the study because they went to other settings for their practical attachments. Their perceptions might thus be different due to differences in clinical context. In addition, the study did not explore the perceptions of feedback providers such as lecturers, tutors, registered nurses and clinical instructors in clinical settings because there is a need to conduct a larger study in order to capture both feedback providers' and receivers' perceptions of feedback in clinical settings. This was not within the scope of this study. Lastly, the study focused on a smaller setting because it was the clinical area available for practical attachment for students from the three programmes; therefore, the researcher did not focus on larger clinical settings.

As a study limitation, the researcher is a lecturer in one of the nursing programmes in the Keetmanshoop District and was therefore considered as an insider. Some students were perhaps not comfortable with expressing themselves freely, and the researcher's presence might have influenced responses from the participants. As a quality assurance measure, the researcher explained the aim of the study and all procedures to be followed at the beginning of the study, as explained in the participant information sheet.

1.9 REPORT OUTLINE

The preceding section provided the context of this study. The next chapter will present the literature review, which includes the definition of feedback, the advantages thereof, the barriers to feedback and students' perceptions of feedback. Chapter 3 presents the research design and ethical considerations of this study. It is followed by the results and discussion chapters. The last chapter concludes the report and also includes the implications of this study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Feedback is considered as one of the key elements in clinical education. Moreover, different definitions are used to define feedback and there are different classifications of feedback. This section will provide an overview of feedback in health professions education, which includes its classification. It will also include the benefits of feedback, the barriers to feedback provision and students' perceptions of feedback. In addition, the theoretical framework used to guide this study will be discussed.

2.2 CONTEXTUALISING FEEDBACK

Feedback is defined as an interactive process that aims to provide insight to learners regarding their performance (Clynes & Raftrey, 2008). Furthermore, Harden and Laidlaw (2013) define feedback as information communicated to the learner that is envisioned to amend his or her thinking or behaviour in order to expand learning. Terms used to define feedback may be classified into two broad main groups, which are constructive/corrective/negative feedback and reinforcing/positive feedback (Clynes & Raftrey, 2008). Negative feedback relates to how far a student deviates from the goal and is aimed at helping students to achieve the goal while positive feedback relates to what is good and, once the original objectives have been met, looks at what lies beyond the current requirements (Gibbs, Brigden & Hellenberg, 2006). Moreover, Archer (2010) mentions two feedback concepts, which are directive and facilitative. They are used to categorise feedback according to its purpose. Directive feedback is meant to inform the learner of what needs to be rectified while facilitative feedback involves the provision of comments and ideas to aid recipients in their own revision. If correctly done, a feedback provider observes the trainee performing certain tasks in order to compare this performance with the expected standards. Feedback based on this comparison is given for the purpose of improving skills or behaviour (Van de Ridder, Stokking, McGraphie & Ten Cate, 2008).

For the purpose of this study, the definition of feedback provided by Harden and Laidlaw (2013) was adopted as a working definition. This specific definition was chosen because learning in clinical settings involves nurturing learners' thinking and behaviour to enable them to master the expected competencies.

Moreover, for feedback to contribute to learning, it has to be effective feedback. Effective feedback is consistent, constructive, student focused and actionable (Hughes & Quinn, 2013). In addition, Archer (2010) defines effective feedback as feedback in which information about previous performance is used to stimulate a positive and desirable development. Effective feedback requires collaboration between teachers and learners rather than feedback just for the purpose of teaching (Wood, 2010). Feedback must also be constructive in order to be effective (Gibbs et al., 2006). According to Gibbs and Simpson (2004:16), feedback is effective if students act on it to advance in their future work and learning. In addition, the authors also mention the following characteristics of effective feedback: feedback can be linked to the purpose of the assessment task and criteria, it must be frequent, timely, sufficient and detailed enough, it must be understandable and it must focus on learning rather than marks.

Effective feedback is primarily given for the purpose of improving learning. According to Watling (2014a), feedback is an intricate tool with a powerful effect on learning and is one of the key components in the support needed by students while learning in clinical settings. Harden and Laidlaw (2013) indicate provision of feedback to learners as one of the principles that leads to more effective learning. Providing students with feedback gives them direction for learning, motivation and guidance (Watling, 2014a). Students may learn from various teaching activities, but value, meaning and retention are added to these activities through feedback (Gibbs *et al*., 2006). Therefore, nursing instructors and supervisors should seriously consider and make time for frequently providing high-quality feedback to their students since it is critical in clinical learning situations (Plakht, Shiyovich, Nusbaum & Raizer, 2013).

Feedback is typically provided by a clinical educator or a staff member from a clinical setting who is responsible for teaching students while a feedback recipient is the trainee (Van de Ridder et al., 2008). In the Keetmanshoop District, which is the context for this study, trainees are nursing students at different levels of their studies and feedback providers are registered and enrolled nurses and midwives from clinical settings. In addition to the clinical instructors, there are also tutors and lecturers from the training institutions. The staff from training institutions are also considered as feedback providers in the context of this study.

2.3 BENEFITS OF FEEDBACK

Studies exploring the provision of feedback to medical students have revealed that they receive formal and informal feedback from a variety of sources during their clerkship (Van de

Ridder, Berk, Stokking & Ten Cate, 2015), and this is the same in the training of nurses. Feedback helps students to derive meaning from experiences gained in clinical settings, offering them a route forward (Watling, 2014a). There is evidence that constructive feedback provided to students during clinical practice is associated with the accuracy of their self-evaluation as students tend to be more accurate and realistic in the process of evaluating their own performance (Plakht *et al*., 2013). Students are more accurate and realistic because through feedback, they are made aware of their strengths and weakness, which means they know more about themselves. Feedback points out deficiencies and areas for improvement. In addition, it helps to identify students' strengths and provide guidance for future practice (Cleary & Walter, 2010).

Feedback assists in the learning process through formative assessment (Stuart, 2013). Formative assessment is one of the reasons why learners are assessed (Biggs, 1999). It refers to assessment that is used to provide feedback to learners about their progress (Luckett & Sutherland, 2000). This is for the purpose of encouraging learners, to help learners progress in their learning, to consolidate work done to date and to provide a profile of what a learner has learnt (Luckett & Sutherland, 2000). Therefore, it does not encompass the grading of clinical performance (Clynes & Raftrey, 2008). Biggs (1999) states that both teachers and learners need to know how learning is progressing. Feedback is considered as a central concept in formative assessment (Wood, 2010). In addition, it offers a route by which assessment becomes a tool for teaching and learning (Wood, 2010). Therefore, feedback operates as a vehicle to improve the learning of individual learners and to improve teaching (Biggs, 1999). It is therefore evident that there is a strong link between feedback, assessment and learning because in formative feedback, students receive feedback on their performance.

Effective feedback in nursing education is seen as an opportunity to improve learning because it allows for dialogue between a student and a teacher in which clarification and discussion can take place (Hughes & Quinn, 2013). Clarification and discussion help teachers to realign their teaching contents and methods in order to maintain the balance between the teaching content, methods and learning activities in clinical settings, and to respond to students' needs. In addition, effective feedback allows students to think deeper and creates an opportunity for teachers to provide guidance on how to improve (Hughes & Quinn, 2013).

2.4 BARRIERS TO FEEDBACK PROVISION

Hughes and Quinn (2013) outline the factors that hinder effective feedback. At times, feedback providers rush to give feedback and allow no time for discussion and clarification on performance or tasks observed. Furthermore, some students may be more concerned about marks obtained in assessments in which marks are allocated than about qualitative feedback from the teacher (Hughes & Quinn, 2013). Feedback providers may also offer comments that can be difficult to act upon as they lack clarity, are demotivating and are negative (Clynes & Raftrey, 2008). Interestingly, Clynes and Raftrey (2008) indicate feedback providers' sick leave, vacation leave and night duty as factors that can hinder provision of feedback as students are left with no supervision and thus no feedback given in clinical settings. Moreover, lack of time between patient encounters and demanding schedules of supervisors are also indicated in the literature as barriers to feedback provision (Al-Mously *et al*., 2014).

Another barrier to feedback provision identified by Clynes and Raftrey (2008) is the conflicting demands of patient care and supervision of students. The primary role of the registered nurses in clinical settings is care of the patient, but at the same time, they are expected to teach and supervise the nursing students placed in their settings. This may lead to poor quality supervision of students which in return lead to poor provision of feedback. In busy clinical settings, it's difficult to ensure that students are observed at all times and that they receive information regarding their performances (Boud, 2015). Similar findings were reported by Allen and Molloy (2017) who indicated that registered nurses identified trying to cope with a patient load and to give students opportunities to practice and engage in discussions as a barrier to provision of feedback.

Some supervisors in clinical settings avoid giving negative feedback because they try to maintain positive relationships with students (Clynes & Raftrey, 2008). In contrast, some students reported receiving primarily negative feedback in clinical settings (Allen & Malloy, 2017). Supervisors' avoidance to give negative feedback could also relate to the fact that feedback influences the emotional reactions of students. In a study conducted on medical students who train in music or sport to understand why feedback is challenging, the receipt of feedback was widely perceived as an emotionally laden experience (Watling, Driessen, van der Vleuten & Lingard, 2014). Moreover, Pekrun (2006) identified feedback as one of the many environmental factors that can have a great influence on students' emotions. For example, it was confirmed that people who received negative feedback experienced strong and disturbing unpleasant emotions such as anger, worry and being annoyed, with them still recalling these emotions two years after the event (Sargeant, Mann, Sinclair, Van der

Vleuten, & Metsemakers, 2008). Although Sargeant, et al. (2008) focused on negative feedback, it is also documented that both negative and positive feedback may trigger the students' emotions. In return, these emotions have a positive or a negative influence on learning, by either supporting or interfering with learning (Hattie & Timperley, 2007). In a study that measured nine academic emotions reported by students when receiving feedback (shame, relief, pride, hopelessness, hope, enjoyment, boredom, anxiety and anger), hope was reported to be more prevalent in students who received constructive feedback, whilst anger, boredom and discouragement were reported to be experienced when receiving negative feedback. The academic emotions of embarrassment and pleasant emotions (such as pride and happiness) were more prevalent in students who received positive feedback (Fong, Warner, Williams, Schallert, Shen, Williamson & Lin,2016).

The duration of the relationship between the teacher and students is also known to have an effect on feedback. It may be a hindrance or a facilitative factor to feedback provision. For instance a long-term close working relationship between students and teachers was found to facilitate acceptance of critical feedback by a receiver and it also enabled an atmosphere of trust (Waitling et al, 2014). Kogan (2012) and her fellow researchers conducted a study to explore faculty staff perceptions of feedback to residents after direct observation of clinical skills. The relationship between faculty staff and students was found to impact the provision of feedback. In general, faculty staff found it easier to give feedback to residents they knew because the existence of a prior relationship fostered understanding and trust (Kogan, Conforti, Bernabeo, Durning, Hauer & Holmboe, 2012).

On the preparations of individuals to take up their teaching roles, most clinical teachers have received little or no instruction in giving feedback (Cantillon & Sargeant, 2008). Likewise, nurses are assigned the role of 'supervisor of students' and their abilities to provide feedback may not have been taught or assessed. This means that they are selected to teach because they are clinically competent practitioners but no requirement regarding their ability to provide feedback to students is set (Clynes & Raftrey, 2008). However, the same may not be true for nurses with a nursing education qualification because they are appointed based on their ability to teach and also considering their clinical competency. Although nurses are required to attend Continuing Professional Development (CPD) activities, these tend to focus on clinical procedural skills and less attention is focussed on teaching itself. This is also the case with the CPD activities conducted in the Keetmanshoop district hospital (MoHSS, 2016). The ongoing training of registered nurses who supervise and teach students in clinical nursing, is needed in order to expand their awareness of the academic programme followed by students. Furthermore, training facilitates the nurses' ability to supervise, providing the necessary encouragement and support to students, and also the provision of

constructive feedback (Frazer, Connolly, Naughton & Kow, 2014). Ramani and Leinster (2008) stated that clinicians do not become teachers by being experts in their fields but have to take a reflective approach to teaching and professional development in order to adapt to and perform better as clinical teachers.

Additionally, personal characteristics of supervisors such as lack of assertiveness are also identified as a hindrance to feedback provision. Supervisors may feel uneasy and anxious and fear criticism from the students and therefore avoid giving feedback (Clynes & Raftrey, 2008).

2.5 STUDENTS' PERCEPTIONS OF FEEDBACK

The literature on medical education includes findings on students' perceptions of feedback. According to Watling (2014a), the perceptions of students and their judgment on the credibility of feedback appear to guide their choices about it. Generally, students ignored feedback that seemed to lack credibility or quality (Harrison, Könings, Dannefer, Schuwirth, Wass & van der Vleuten, 2016). For feedback to be influential to a student and recognised as such, it must pass the student's judgement on credibility of feedback (Watling, *et al*. 2012). Credible feedback is based on direct observation and must be available within the learning culture in order for it to have impact on the students' learning (Watling, 2014b).

Murdoch-Eaton and Sargeant (2012) have demonstrated that medical students frequently perceive the feedback that they receive as insufficient. Although feedback is known to make learning encounters engaging and meaningful (Ferris & O' Flynn, 2015), feedback given in clinical settings is said to lack focus on skills development and enhancement of clinical performance (Clynes & Raftrey, 2008). However, supervisors in clinical settings tend to perceive feedback provided as adequate (Murdoch-Eaton & Sargeant, 2012). Students may also perceive and use feedback in different ways. This can depend on their seniority in the programme, where students in the early years of their studies simply expect to hear whether they are meeting standards and performing adequately while students nearer to graduation are guided by feedback to adjust their learning styles (Murdoch-Eaton & Sargeant, 2012).

In an article that revisited students' perceptions of clinical teaching, Kelly (2007) indicated that students prefer timely and private feedback, which is given in an honest manner. That means that students expected feedback to be conveyed soon after the performance of a task and it should be given only to a person it is directed to. Bekkink, Donders, van Muijen, de Waal and Ruiter (2012.) however revealed that there was no additional effect of immediate feedback on the results of a formal course examination following an interim assessment in which immediate feedback was given as an intervention during the study.

Kelly (2007) indicated that students prefer feedback that helps cultivate a culture of trust between a student and a clinical educator. In addition, Beitz and Weiland (2005) revealed that one of the students' expectations of clinical teaching behaviours is the ability to give them positive feedback that would make a student feel confident in future performances.

Al-Mously and his colleagues conducted a cross-sectional study in Saudi-Arabia to explore the perceptions of medical students of the quality of feedback received during clinical rotations. The study revealed that students received corrective feedback on their actions during patient encounters, however the overall quality of the feedback was perceived to be poor (Al-Mously *et al.*, 2014). Poor and inadequate feedback from clinical teachers during clinical rotations was also revealed by Ahmad, Roslan, Mohammad & Yusoff (2015). Students however believed that receiving feedback could improve their clinical skills in all domains (Al-Mously *et al.*, 2014).

In a study conducted by Glover and Brown (2006) to investigate the perceptions of students of the quality and relative effectiveness of feedback, the results revealed that most feedback was mark-loss oriented, not learning oriented. Feedback seemed to primarily serve as justification of why a certain grade was awarded instead of what could be improved and learnt from an assessment task. Students however consider receiving feedback important because it is given with the purpose to improve academic performance (Murdoch-Eaton & Sargeant, 2012). Students may however not recognise verbal feedback that is given immediately after performance. Students generally perceive written comments as feedback, but they do not necessarily react when verbal feedback is provided (Bevan, Badge, Cann, Willmott & Scott, 2008). This could be because students tend to acknowledge the role of feedback as a rationalisation for marks obtained (Price, Handley, Millar & O'Donovan, 2010). In some instances, students are only concerned about their marks and take little or no notice of the feedback given (Glover & Brown, 2006), especially verbal feedback. Despite the fact that students do not recognise verbal feedback, which is normally given soon after an event, Iskander (2015) proposes that early feedback is intrinsically more valuable.

2.6. THE INFLUENCE OF FEEDBACK ON STUDENTS' PERFORMANCE IN THE CLINICAL AREA

Feedback is recognized as a key feature of the curriculum and it helps students to respond to the learning process, which means it drives learning (Boud, 2015). In clinical settings, it helps students to develop an understanding of what they know and what they do not know. In addition, it helps them understand what they can and what they cannot do. According to Boud (2015), in a feedback session, a feedback provider should ideally ask students for their

opinion on their performances, which is followed by comments from the feedback providers. In clinical settings, feedback also helps students to evaluate whether their clinical judgement skills are sound, which will help improve their performance (Boud, 2015).

Calleja, Harvey, Fox and Carmichael (2016) indicated that feedback on performance is necessary to help students to learn effectively and to meet professional standards during clinical placements. However, the same authors stressed that it is important to assist students to engage with and utilise feedback to improve clinical performance. That means giving feedback alone will not have an effect on performance but a student has to put feedback into action or should implement all suggested changes in order to improve from the current performance to the expected or desired standards. For students to be able to utilize feedback they need specific skills such as the ability to reflect (Hattie & Timperley, 2007), which enables them to internalize the content of feedback. Without proper understanding and internalization of feedback, students will not understand its purpose and what needs to be changed. According to Sweet and Broadbent (2017), students appreciate feedback that enables learning. This was revealed in a study that explored undergraduate nursing students' perceptions of qualities of clinical facilitators that enhanced their learning. Moreover, these authors also revealed that the ability to give appropriate feedback was ranked the number three quality of an effective clinical facilitator. In contrast, facilitators who have not provided feedback or do not make any comments on the students' performances were labelled as inhibitors of learning in clinical settings. Therefore, findings from Sweet and Broadbent (2017) strengthen the importance of feedback on the improvement of student performances in clinical settings.

Although feedback is known to have an effect on learning, the learning process itself is also known to have an influence on feedback. According to Watling et al (2014a) the learning culture influences feedback in three ways; by defining the expectations of teacher and teacher-student relationship, by establishing norms for and expectations of feedback and by directing teachers' and learners' attention towards certain dimensions of performances. The constructiveness of feedback is also a criterion used by students to determine its influence on his/her learning (Watling, 2014b). Therefore, if the feedback is perceived to be constructive by a student, he/she is likely to act on it and this will affect their learning.

The researcher used key concepts such as teaching and learning in clinical settings/environment/attachment, feedback and nursing students'/medical students'/health professional students' perceptions of feedback to search for literature for this study. With this search strategy, there was no evidence of a study that explored nursing students' perceptions of feedback in Namibia.

2.7 THEORETICAL FRAMEWORK

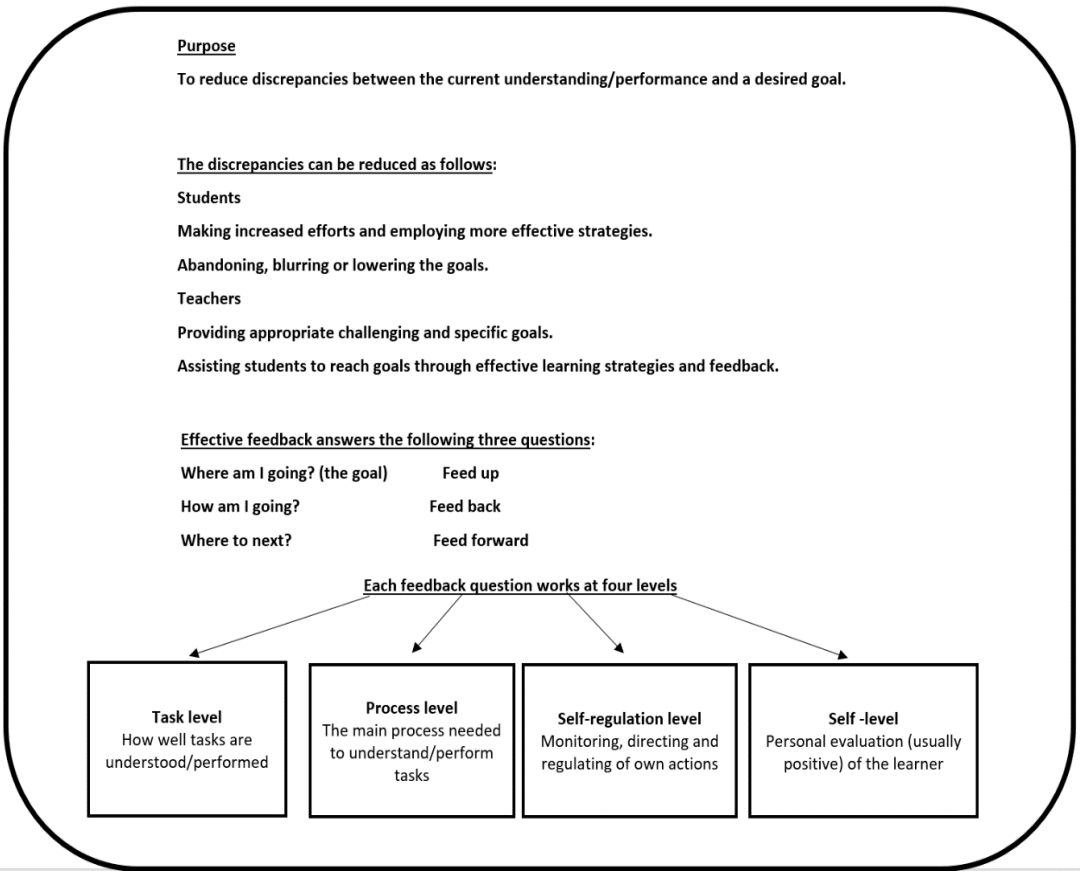
Constructivism is a learning paradigm that can underpin the training of health professions students. A constructivist learning paradigm has to do with how learners create their own understanding of the world (Dennick, 2012). In addition, constructivists believe that knowledge is created by learners through incorporating learning activities and experiences into their beliefs and knowledge (Dennick, 2012). After that, new meanings are created. The process of creating knowledge in the constructivist paradigm involves critical reflection on the learners' assumptions (Torre, Daley, Sebastian & Elnicki, 2006). Although constructivists are criticised and viewed as seeing learning as a separate entity from the learner's environment, it predominantly utilises learner-centred approaches for learning to take place (Fenwick, 2001). A learner-centred approach focuses on the learners and what they learn (Spencer & Jordon, 1999). According to Kaufman (2003), one of the implications of a constructivist approach to learning is that the teacher is viewed as the facilitator of learning,/ not as the information provider. Therefore, the process of feedback should also actively involve learners. This is because feedback should be provided in a way that involves the learner as part of a learner-centred approach. In addition, it should inspire learners to take charge of their own learning and become self-regulated (Nicol & Macfarlane-Dick, 2006). Within the constructivist paradigm, feedback is viewed as facilitative because the comments and suggestions offered during feedback help learners to gain new understanding without teachers dictating what that understanding will be (Archer, 2010).

The learners' involvement in the learning process is vital (Rushton, 2005), however, that does not mean that the teachers are not recognised. This is because the teachers' role is to encourage the learners to reflect critically and to uncover their assumptions in order to help them to construct meanings. Because of the involvement of learners in the learning process, this study adopted a feedback model proposed by Hattie and Timperley (2007) called 'a model of feedback to enhance learning' as a theoretical framework. This model is shown in Figure 2.1 on page 28. According to this model, the main purpose of feedback is to reduce discrepancies between the current performance or understanding and a desired goal (Hattie & Timperley, 2007). This purpose fits with the definition of Harden and Laidlaw (2013), which is the working definition for this study. The reason the two seem to fit together is because information that is communicated to the learner help them to identify the gap in performance or understanding and the way forward is to help reduce it. Furthermore, the model involves both learners and teachers in the feedback process. Each partner has a role to play in order to reach the expected goal. This is in accordance with Boud (2015), who indicates that feedback should be a two-way process. Teachers assist learners by providing appropriate challenges to help them to reach their goals. To reduce discrepancies, learners may then

increase their efforts or abandon actions that impede their efforts in reducing the identified discrepancies (Hattie & Timperley, 2007).

Figure 2.1: A model of feedback to enhance learning

[Adapted from Hattie and Timperley (2007)]



The model further indicates the three questions that should be answered by effective feedback, namely 'Where am I going?', 'How am I going?' and 'What is next?' (Hattie & Timperley, 2007). This means that the feedback provided should help a learner to address these questions regarding the learning task for which feedback is provided. Additionally, the model also links the three questions to the notion of 'feed up', 'feed-back' and 'feed forward'. The first question is directly linked to the goal of the task and is considered as the critical aspect in feedback provision (Hattie & Timperley, 2007). According to Ramani and Leinster (2008), it would be more common in the clinical setting for the student to be told that their performance was inadequate. This normally forms part of answering the 'where am I going' question or the 'feed up' notion.

The second question, ‘How am I going?’ relates to the progress made toward the goal. Answering this question and addressing the ‘feed-back’ involves a teacher or a feedback provider who conveys information related to current performance (Hattie & Timperley, 2007). The third question, ‘what is next?’ links to the ‘feed forward’ and it relates to the activities that have to be undertaken in order to make better progress in achieving the goal, usually by providing information that leads to greater possibilities for learning (Hattie & Timperley, 2007). Feedback is known to increase students’ awareness about their performance and it leads their future actions (Ramani & Krackov, 2012). In addition, feedback puts forward suggestions for making improvements (Ramani & Leinster, 2008), which answers the ’what is next’ question of the model and speaks to the notion of feed forward.

According to Hattie and Timperley (2007), the three questions in their model of feedback to enhance learning operate or can be applied at four levels in the feedback session. These levels are task, process, self-regulation and self. Although the levels are all about one feedback session, they are different from each other. Taking into consideration that feedback is given with the purpose of narrowing the gap between actual and desired performances (Archer, 2010) there is a need to focus on the task level. The ‘task level’ shows how well the task was executed or understood by a learner; therefore, at this level, the feedback provider indicates whether something is correct or incorrect (Hattie & Timperley, 2007). It is important that students are aware of their levels of performance , hence appropriate feedback should provide detailed information on the student’s performance level (Glover, 2000), which is the focus of the task level. At the simplest level of feedback, which is the ‘task level’, feedback informs the student that they have either succeeded or failed at the task (Ramani & Leinster, 2008).

The ‘process level’ of the feedback session points out the steps or items needed to understand or perform the task as expected (Hattie & Timperley, 2007). Since this level involves pointing out step by step how a task should be performed, this level of feedback could also entail a demonstration of how it should have been done (Ramani & Leinster, 2008), in case the student fails to follow the correct steps.

It is known that feedback may be appropriate and accurately delivered to the student but they do not recognise the message within the feedback or understand the content of the message. The student who failed to recognise and understand the feedback message is known to be unreceptive to feedback (Murdoch-Eaton, 2012). Therefore, the level of self-regulation determines how feedback is received, interpreted and utilized by an individual student (Murdoch-Eaton, 2012). The ‘self-regulation’ level involves the learner him-/herself. This entails the process of students monitoring their own performance, directing the way

forward and regulating their own action, based on their performance. This also entails the learners' ability to develop their own error detection skills, which will help them in future learning (Hattie & Timperley, 2007). In self-regulation, a student seeks to accomplish learning goals through self-generated initiatives and actions (Sandars & Cleary, 2011).

The last level is the 'self'. Hattie and Timperley (2007) indicate that this level does not relate to the task but is directed at the learner him-/herself. This is a personal evaluation of the learner, which usually consists of short positive comments given by the feedback provider, such as 'well done' and 'good'. Because feedback at self-level does not relate to the task, its impact on learning depends on whether it leads to changes in students' effort, engagement, or feelings of efficacy in relation to the learning strategies employed in understanding or performing the task.

This model was found to be an appropriate theoretical framework for the study because it is comprehensive. It does not only approach feedback from the teachers' perspective but also encompasses the active involvement of the learners. Involvement of learners in the feedback process is greatly encouraged (Boud, 2015) and is one of the elements that makes feedback effective (Gibbs & Simpson, 2004). This model was also adopted because of the inclusion of self-regulation in the feedback process.

Evans (2013:72) defines self-regulated feedback as feedback that "focuses on metacognitive elements, including how a student can monitor and evaluate the strategies he/she can use". Self-regulation is one of the processes that promote the mastering of clinical skills in nursing (Hughes & Quinn, 2013).

2.8 CONCLUSION

The aim of the chapter was to give a description of the relevant theoretical perspectives related to feedback as they were found in the literature. A description of feedback and an overview of feedback in the health professions education field were given. The benefits of feedback, barriers to feedback and students' perceptions of feedback were also included. The model of feedback to enhance learning by Hattie and Timperley (2007) was described and was identified as an appropriate framework for this study. The following chapter will give a description of the methodology used for this study

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This study was conducted with the aim to explore nursing students' perceptions of the feedback that they received in clinical settings, with the objective to ultimately improve clinical nurse training. In order to reach that aim, the following primary research question was formulated:

How do nursing students in a small rural district experience the feedback that they receive in clinical settings?

Based on the research aim and question, a qualitative research design and methodology were determined to be the most appropriate. This chapter will discuss the design and methodology employed in this study in order to explore the perceptions of nursing students of the feedback that they received in clinical settings at a small rural district hospital in the southern part of Namibia.

3.2 RESEARCH SETTING

A detailed description of the study context in qualitative research is necessary to ensure transferability (Frambach, Van der Vleuten & Durning, 2013); therefore, this section on the study setting is incorporated in the final report. The Keetmanshoop District is situated in the Kharas Region in the southern part of Namibia. It had a population of 36 400 people, served by a 154-bed state district hospital, two state health centres, five state clinics and two private clinics (MoHSS,2015). The hospital is situated in the Kronlein suburb and houses departments such as maternity, casualty/outpatient, including physiotherapy, dental and eye clinics, and X-ray department. In addition, there is a female ward, male ward, paediatric ward and tuberculosis ward. This study was conducted at the Keetmanshoop District Hospital.

UNAM and the KRHTC are two higher education institutions that offer nursing programmes in the Kharas Region. UNAM offers a four-year undergraduate programme leading to a Bachelor of Nursing Science (Clinical) Honours degree while the KRHTC offers two programmes: a two-year Certificate in Nursing and Midwifery Science and a three-year Diploma in Nursing and Midwifery Science. For clinical learning, some students from the

three programmes are placed at the Keetmanshoop District Hospital and some state clinics and health centres in the district. Due to limited space, a large number of students from the diploma programme are placed in other regions for clinical attachments. Only a few who come from Keetmanshoop practise in the district.

Teaching and supervision are conducted by registered nurses in the clinical settings where students are allocated, and they are considered as nurse mentors. In addition, clinical instructors, lecturers and nurse tutors from training institutions also supervise students through clinical accompaniment and follow-up appointments. At the Keetmanshoop District Hospital, nursing students rotate in the clinical departments during their placements. The students spend two weeks to one month in each department. In addition to the nursing students, UNAM also sends medical, pharmacy and final-year nursing students from the main campus in Windhoek for a six week rural clinical block to the Keetmanshoop District Hospital and primary health care facilities in the district.

3.3 RESEARCH DESIGN

A qualitative research method was employed to explore the perceptions of nursing students of the feedback that they received in clinical settings. Creswell (2014:10) defines qualitative research as “an inquiry approach useful for exploring and understanding a central phenomenon”. The study entailed exploration and understanding nursing students’ perceptions of feedback, and therefore qualitative research was an appropriate method to conduct the study. In addition, qualitative methods are chosen if research problems require researchers to learn about the opinions of individuals (Creswell, 2014), which was the case in this study.

According to Maree (2016), the qualitative research method is divided into three types of research approaches or designs, which are exploratory, descriptive and physiologically or theoretically grounded research. An explorative qualitative research with an interpretivist perspective was used in this study. Interpretivists derive their view from the concept of interpretivism, which is one of the research paradigms. Interpretivists believe that reality should be understood through the meaning that research participants assign to their world (De Vos, Strydom, Fouche & Delport, 2011). This meaning can only be interpreted through language. Explorative research is conducted to increase the knowledge of the field of study and to address an issue or problem in need of a solution and/or understanding (Grove, Burns & Gray, 2013). In addition, explorative research explores the full nature of a phenomenon not well understood (Polit & Beck, 2008). Explorative qualitative research is

often conducted towards building a new understanding (Maree, 2016). It was therefore an appropriate method for this research because little was known about the feedback given to nursing students in the Keetmanshoop District. Moreover, an explorative qualitative design was appropriate for this study because it allows for inductive reasoning. That means the researcher can work from specific observations to broader generalisations and theories (Maree, 2016). Nonetheless, explorative designs have been critiqued by those who view qualitative research as an inadequate or inappropriate strategy of inquiry because it does not enable the researcher to study a large number of participants (De Vos et al., 2011). In addition, qualitative research is critiqued for its inability to facilitate the generalisation of the findings to other situations (Leedy & Ormrod, 2010). This did not affect this study because the results were specifically for the Keetmanshoop District and did not aim to be generalised to other settings. Keetmanshoop hospital presents a unique setting because the district is affected by a severe shortage of registered nurses and there are many students allocated to small capacity units. Often, students' practice is inadequately supervised especially if their lecturers and tutors are busy with the theoretical teaching of other students at the university or training centre.

3.4 DATA COLLECTION

To ensure credibility, two data sources were used to collect data in this study (Frambach et al., 2013). The two data gathering techniques used in this study were one-on-one in-depth interviews with nursing students and the observation of nursing students practising in clinical settings in which feedback provision opportunities were included. In addition, field notes and reflective notes made by the researcher were used.

A one-on-one in-depth interview is defined as a data collection process in which the researcher asks questions to one participant in the study at a certain point in time and records the answers (Creswell, 2014). This technique has advantages such as allowing participants to share their ideas comfortably, and it is ideal for people who are not hesitant to speak (Creswell, 2014). De Vos et al. (2011) indicate that a minimum of 12 interviews are needed to create stability among the views in the sample. However, in this study, data saturation was reached with 11 participants. Data saturation refers to a state in which the researcher makes a personal judgment that new data will not provide any new information or insights for the emerging categories (Creswell, 2014).

The researcher contacted the clinical coordinators from the two training institutions in order to familiarise herself with the academic calendars of their programmes which assisted in

arranging the interviews. The prospective participants were contacted personally during clinical attachments and also on campus. The researcher explained the purpose of the study and gave the students a copy of the participant information sheet together with a consent form (Addendum 1). A follow-up was done the next day to enquire whether the students agreed to participate in the study. An interview schedule was then drawn up according to the availability of the students and the interviewer. Interviews took place at the UNAM campus, the KRHTC diploma programme offices and the hospital administration building.

The researcher used an interview guide, attached to this report as Addendum 2, that consisted of open-ended questions. This was done to ensure that all the information required to answer the research questions could be obtained. The interview guide consisted of questions on students' understanding of feedback, the importance of feedback, their experiences of feedback and how feedback could be improved. In addition, prompts were used to clarify statements and to trigger the thoughts of the participants.

The interviews took place during July 2016. The interviews ranged from 28 to 37 minutes. This ensured prolonged engagement with participants, which is one of the techniques to ensure credibility (Frambach *et al*., 2013). The interviews were concluded when all the issues in the interview guide had been addressed and the participants and researcher had nothing to add. All interviews were audio recorded with a digital voice recorder followed by verbatim transcriptions, with the participants' permission. In this study, transcriptions were done by the researcher. To ensure anonymity, each interviewee was assigned a code. The transcription took place soon after the data had been collected to ensure that all questions had been answered and to arrange for further clarification by participants should the need arise.

The second data collection method used in this study was observation. Observation is defined as an everyday activity whereby people use their senses such as smelling, tasting, touching, hearing and seeing to gather data (Maree, 2016). The focus of observation is on the natural experiences of respondents (De Vos *et al*., 2011). In this study, the researcher did not interfere or communicate with those observed but was a complete observer. This means that she was a nonparticipant observer looking at the situation from a distance, which is in accordance with the views of Maree (2016). This can however influence those observed, because they were aware of the observer's presence. The other limitation of being a complete observer is that the researcher is not immersed in the situation. This means that it could happen that at times she/he does not really understand what is observed (Maree, 2016).The researcher observed students in practical attachments at three different clinical settings in order to identify feedback sessions in clinical settings. Three observations were

conducted, each lasting for up to ten hours. Thereafter the researcher recorded in writing a description of what she had observed, followed by a reflection on what had been observed. This is also in accordance with a template of recording observations proposed by Maree (2016) (a template is attached as Addendum 7). The researcher thus created field notes and a reflective journal from the observed sessions and interviews. Field notes refer to the texts noted by the researcher during an observation in qualitative research (Creswell, 2014) while reflective notes record the personal feelings and views that the researcher has to relate to his/her understanding and the broad ideas or themes that emerge from the data (Creswell, 2014). In order for the researcher to know that what she had observed represented what had actually happened, she employed a technique called 'member checking'. This means that she verified her understanding of what had been observed with those observed (Maree, 2016). Verifications were done by confirming what was written in the field notes with the students who were observed, this was conducted by the researcher a day after all three units were observed.

Prior to the observation of the feedback sessions, the researcher wrote a letter to the medical officer in charge of the hospital in order to request permission for observation. Attached to the letter was information regarding the aim of the study and a form that mentors were to sign if they agreed to be observed. This means that only mentors who had agreed to be observed were included. Students were also requested to give written consent to the study; furthermore, only students who met the inclusion criteria of the study were part of the observations.

The researcher observed the practice in the three settings mentioned in order to spot feedback sessions, and recording was only done for feedback activities. Her presence might have influenced the behaviour and communication between students and mentors; however, the results from these observations were analysed together with the findings from the individual interviews. Observations of students' practice in clinical settings were conducted in departments where the researcher noticed that most students were placed. This was confirmed from clinical allocation schedules for the two institutions. However, the researcher did not made appointments for observation sessions because feedback was supposed to occur if and when tasks were being performed. The researcher therefore went to the clinical settings at the time the students and their mentors were expected to be conducting the wards' routine activities and she identified feedback sessions in these wards.

3.5 PARTICIPANTS

The research population was nursing students from the KRHTC and UNAM Southern campus. Creswell (2014) defines a population as a group of individuals with similar characteristics. A total of 380 students were registered for the three nursing training programmes in the district for the 2016 academic year. According to the clinical placement records from the two training institutions, only 82 students practiced in the Keetmanshoop district hospital. The rest were sent for practical placements in other districts. In accordance with qualitative research, this study employed nonprobability and purposive sampling (Maree, 2016). In purposive sampling, participants are selected because of some defining characteristics that make them appropriate respondents to provide information for the study or the data needed for the study (Maree, 2016). Nonprobability sampling refers to any type of sampling whereby the statistical principles of randomness do not determine selection of participants in the study (Terre Blanche, et al. 2006). The criteria used to select participants were that they had to be registered nursing students at KRHTC or UNAM Southern campus, should not be in their first year of study (first-year clinical placements commenced only in May 2016) and had to be doing clinical practise in the Keetmanshoop District. UNAM did not have a third year cohort as the programme was only introduced in 2015, therefore only second year students from this institution participated.

A total of 12 out of 82 nursing students who practise in Keetmanshoop district hospital were approached and invited to participate in the in-depth interviews. However, only 11 students participated in the individual in-depth interviews as one student did not consent to take part. In this study, data saturation was attained with 11 students who were interviewed, therefore data quality was not affected by one student who did not consent to take part. Moreover, a total of 15 students were approached to be observed in clinical settings, only 13 participated in the study as two students did not consent to be observed. This did not influence the study sample as the number of students who consented was adequate for observations. The total number of participants in this study was 24 nursing students.

Table 3.1: Characteristics of study participants

Characteristics	UNAM	KRHTC (certificate programme)	KRHTC (diploma programme)	Total
Female	7	2	7	16
Male	1	4	3	8
Total	**8**	**6**	**10**	**24**

Second-year level	8	6	5	19
Third-year level	0	0	5	5

3.6 DATA ANALYSIS

The data analysis process commenced immediately after the data collection in order to identify gaps and inform further data collection. This technique enhanced validity (Frambach *et al*., 2013). The researcher listened to the audio recordings and read through the transcriptions several times. This was done to familiarise herself with the data and to write down any impressions: the process that Maree (2016:115) refers to as "memoing". Data were analysed manually by coding, and then related codes were grouped to form categories and then similar categories formed themes. To differentiate the two concepts, coding and themes, Maree (2016:116) defines coding as the "process of reading carefully through your data, line by line, dividing it into meaningful analytical units" while themes refer to similar codes aggregated to make up a main idea that can be used in data analysis (Creswell, 2014:13). Furthermore, themes were given names that were inclusive of all the codes under them. Emerging themes were considered as the findings of this study. Themes were used in data analysis because this was a qualitative study and themes formed a core element in the data analysis process (Creswell, 2014). In addition, the researcher debated the various naming of the themes with research supervisors in order to reach consensus. The raw data are kept by the researcher should it be needed for an audit trail (Frambach *et al*., 2013).

3.7 LIMITATIONS

The researcher is an insider because she is a lecturer in one of the theoretical courses and a coordinator of the clinical education unit for the nursing programme at UNAM Southern campus. However, she is not directly involved in the teaching or follow-up of students in clinical settings as her role is limited to coordination. For an insider researcher, there is a need to maintain reflexivity by means of using reflective notes. Reflexivity means that the researcher reflects on his/her own biases, values and assumptions and writes about them openly in his/her research (Creswell, 2014). According to Maree (2016), reflective notes are useful as they later prompt the researcher to critically ponder the ideas and insights gained during the study alongside the patterns emerging from the data; thus, the researcher kept a research journal for this purpose as she found it necessary to use in this study. As discussed

in the study limitations, some students perhaps did not feel free to express themselves openly in the presence of the researcher who was also their lecturer. As a quality assurance measure, the researcher explained the aim of the study and all procedures to be followed at the beginning of the study, as explained in the participant information sheet.

3.8 ETHICAL CONSIDERATIONS

Ethical clearance (S16/04/072) was obtained in May 2016 from the Health Research Ethics Committee of Stellenbosch University (letter attached as Addendum 3). Permission to interview UNAM students was granted by the Office of the Assistant Vice-Chancellor at the Southern campus (letter attached as addendum 6). Permission to interview KRHTC students was granted by the Office of the chief tutor at the centre (communication attached as Addendum 5). The Keetmanshoop District Hospital falls under the jurisdiction of the Ministry of Health and Social Services; therefore, the study was granted ethical approval by the Office of the Permanent Secretary via the Research Unit in June 2016 (protocol reference number 17/3/3, attached as Addendum 4). Thereafter, permission to conduct research on the hospital premises was granted by the Office of the Senior Medical Officer of the Keetmanshoop District Hospital via the Office of the Kharas Health Directorate. Both approval and permission were granted prior to observations and interviews with participants.

Protecting the welfare of research participants is the chief purpose of research ethics and should be a concern for all researchers in planning, designing, implementing and reporting research with human participants (Terre Blanche *et al.*, 2006). Furthermore, informed consent has historically been seen as the only determinant of the ethicality of research (Terre Blanche *et al.*, 2006). It comprises the provision of appropriate information to participants, participants' competence and understanding, voluntariness in participating and freedom to decline to participate or to withdraw after the study has started, and formalisation of consent, which is normally done in writing (Terre Blanche *et al.*, 2006). According to Terre Blanche *et al*. (2006), the researcher must provide participants with clear, detailed and honest information about the study, its methods, its risks and its benefits. Therefore, in this study the researcher prepared participant information sheets that provided an explanation regarding the purpose of the study and what was expected from participants and their rights, for example the right to withdraw from the study at any stage. In addition, the researcher also included a consent form that was read and signed by all participants prior to each interview and before each observation. Participants were also afforded an opportunity to ask questions and to request more clarification with regard to their participation in the study. Furthermore, they were also informed that their participation or refusal to participate in the

study would not affect their clinical attachments or practices and would not have any influence on their academic performance.

Protection from harm is also considered to be the most fundamental and important ethical issue in research (Gay, et al. 2009). This principle protects participants from any kind of harm, be it physical, mental or social. There were no direct or indirect risks involved in participating in this study. Moreover, the researcher applied the ethical principle of confidentiality. According to Gay *et al*. (2009), researchers maintain confidentiality by not disclosing information obtained from the study although they may know the participants. In this study, confidentiality was maintained by ensuring that data were not linked to any participant's name. In addition, voice recordings and hard-copy data were stored in a locked cupboard while data in a soft-copy version were stored on a laptop protected by a password. Transcribed data were given code numbers, and no names were identified with the interview scripts. All voice recordings were deleted at the end of the study to prevent identification of participants' voices.

3.9 CONCLUSION

This chapter discussed the design and methodology of this study. Details were given on the research setting, the researcher, the data collection procedure, the participants, the data analysis and the ethical considerations. In addition, different sections of this chapter also incorporated the data quality measures employed in this study. The following chapter will report the results from the conducted data gathering processes as described.

CHAPTER 4

RESULTS

4.1 INTRODUCTION

This section describes the results as collected using the two data collecting methods, namely observation of feedback opportunities in three departments and in-depth interviews with students. The three departments were the maternity ward, the male ward and the out-patient department. This helped the researcher to understand the type of feedback that students received in clinical settings. Data from the two data collecting methods were separately coded, but later the categories were merged from which the different themes emerged.

4.2 OBSERVATION OF FEEDBACK SESSIONS

In all the departments, the students arrived for duty at exactly 06h45 every day, together with the permanent nursing staffs who are allocated to these departments. They also attended the handing over between the nursing staff on night and day duty at the beginning and end of shift. Thereafter, the nurse in charge delegated students to different rooms in order to know who was responsible for nursing which patients and carrying out the various tasks in the patients' rooms. Observations were conducted from 06h45 to 20h45 because that is the time most students go for clinical practice. The researcher stayed in the units the entire day observations were conducted, she only left during lunch and two tea breaks which lasted one hour each. That means students who were allocated on night shift were not observed due to less nursing activities taking place during night shift. In addition, only a few students are allocated to night shift in Maternity ward for them to get more practical exposure to Midwifery cases. In contrast, day shifts, especially morning time is where most ward routine activities occur. Later during the day, students may be delegated other activities outside the ward, for example accompanying patients to the X-ray department, taking medicine boxes to the pharmacy and collecting stock from the general stores.

The Maternity, Out-Patient and Male wards were chosen for observations as generally, these are the wards where the majority of students are placed for clinical practice. This is because these units provide a better learning environment due to the availability of both equipment and experienced nurses who are more suitable to guide the students in clinical settings. In addition, some departments are unique, for example the Maternity ward is the

only in-patient unit where students are placed to get exposure to Midwifery cases, thus it was also included in the departments observed.

In most cases, registered nurses and enrolled nurses gave instructions on the specific procedures the student nurses should execute and gave feedback to students in the wards. However, no one-on-one feedback sessions were observed in the three departments; although feedback was directed at a particular student, it was given in the presence of either all the other students or the patients. Some feedback was conveyed at the nurses' station, in procedure rooms, in patients' rooms and even in the corridors. Additionally, students did not really participate in the feedback conversation. Students seemed too shy and uncomfortable to discuss their performance in front of the patients and other students and in most cases, they did not comment on the feedback they received, despite the feedback provider asking them to do so. The nurses also seemed to give a great deal of positive feedback; for example, the registered nurse at Out Patient Department informed the students that they competently conducted a full physical examination on a sick child.

The section below gives a summary of field notes from the observations in three hospital departments.

Male ward

The researcher visited the ward on 01/07/2016 and observed the students and their mentors from 06h45 – 20h30. The registered nurse called all six nursing students allocated in male ward and instructed them to go make beds, take vital signs and feed breakfast to patients in the rooms where they are allocated for the day.

From there, students checked the delegation book to confirm which room they were allocated to. They started to prepare for bed making and some started packing the trolley for taking vital signs. Students made beds, washed patients who were bed-ridden and fed them. They took vital signs and recorded these in the patients' files. There was no direct observation from the registered nurse as she was at the nurses' station busy with administrative duties. There was also no supervision from enrolled nurses as they were busy carrying out tasks in other rooms. The registered nurse later enquired if students were done with all tasks she delegated to them for the morning, students replied by saying they were done and she then requested two files to see how they recorded vital signs and other procedures carried out. The registered nurse checked the files together with all students and she explained how they were supposed to record. She also informed the students not to delete what they already recorded as it will make the files untidy.

The other observation was that practical workbooks were mostly signed at the end of the shift and that was also mostly the time used to give general group feedback. In all departments, the nursing students gathered at the nurses' station when the end of their shift was approaching and the registered nurses gave them feedback as a group. They were told what the nurses did not like and were reminded not to repeat it the following day. In addition, it was observed that students were told to read more about certain topics. Feedback given at the end of the shifts did not only relate to the students' performance and skills but also included their professional conduct and appearance. No use of sheets or any form of written feedback was observed apart from signing of the workbooks. Students themselves did not give feedback to their peers.

Researcher reflection on observations of feedback opportunities in male ward

From the observation in the male ward, the students got instructions from the mentors, but there were no direct observations by their mentors while students performed the tasks allocated to them. Furthermore, students only received feedback on some tasks. In this case, students were delegated to make beds, take vital signs and feed patients but the registered nurse only focused on the recording of nursing procedures.

Out-Patient Department (OPD)

The researcher visited OPD on 02 July 2016 and observed the student from 06h45 to 20h45. Three students were busy screening a sick baby who was brought in by her grandmother at OPD. The registered nurse was there directly observing the students. When they finished taking the history, the registered nurse checked the health passport and explained questions they were supposed to ask and how to obtain a full history. Students asked questions again and recorded in the passport, which was followed by the registered nurse checking the passport and instructing the students to continue with the physical examination. Students conducted the physical examination under direct observation of the registered nurse who also examined the baby with them. He requested students to share their findings with him before he explained to them what he had observed. Students explained their findings and they were asked to formulate a nursing diagnosis. After that, the registered nurse instructed students to take the baby to the doctor's consulting room. No other feedback occurred in the entire day, students were busy recording patients' in the OPD registers and some assisted in taking vital signs and translating for patients who do not speak English.

Researcher reflection on observations of feedback in OPD

From the observations of feedback opportunities in OPD, the researcher came to the conclusion that students were directly observed by the registered nurse, who gave feedback to the group, but it was in the presence of patients. Feedback included corrections and suggestions on the spot. During this observation, students were involved in the feedback process.

Maternity ward

The researcher conducted observations in the maternity ward on 03 July 2016 from 06h45 to 20h45. All 5 students who arrived on duty were directed into the post-natal ward. They found night and day nurses handing over patients. Students took babies to the baby room for their daily bath. Students bathed the babies without supervision of registered or enrolled nurses and no feedback was given on their performances. After bathing the babies, all students went to the puerperium room were they conducted assessment of women in puerperium. There was no direct observation by the registered nurses. Furthermore, during the day, students gave health education to the mothers on importance of immunization and breastfeeding. Towards the end of the shift, students took all patients vital signs and also observed registered nurses handing reports to their colleagues on night shift.

Researcher reflection on observations of feedback in maternity ward

From the observation in maternity ward, the researcher concluded that during the time she visited the ward, students were not observed by their mentors while performing routine tasks. Moreover, no feedback was given to students in the maternity ward while the observation was conducted.

Conclusion

From observation of students in clinical practice, it became clear that in many cases, students perform procedures without being observed. Feedback or information on their performance was often given based on how students recorded procedures in the patients' records. Moreover, even when files where checked to see how students had recorded their observations, the nurse mentors requested students to select files for them to check. There was no individual feedback observed in all departments visited. The section below presents findings from the interviews with nursing students.

4.3 INDIVIDUAL INTERVIEWS

A total of 11 individual in-depth interviews were conducted with students who practice in the Keetmanshoop district. The results obtained from the individual interviews and observations were grouped into four themes: *positive perceptions of feedback*, *negative perceptions of feedback*, the *perception of students on the feedback process* and *recommendations of nursing students on feedback*. These themes were obtained after reading through the transcriptions many times and developing codes manually. Related codes were grouped together to form categories, that were merged to form themes (list of codes, categories and themes attached as addendum 8). Emerging themes were considered as the findings of this study. The table below indicates themes and categories that emerged as results of this study.

Table 4.1: Summary of study results

Categories	Themes
Positive feedback Corrective feedback Feedback as part of the learning process Feedback as a monitoring process Feedback enhances students' self-development Feedback enhances interpersonal skills between students and nurse mentors Feedback evokes students' involvement.	Positive perceptions of feedback
Negative feedback Feedback relates to providers' emotions No individualized feedback to students Lack of students' involvement in the feedback process.	Negative perceptions of feedback
Non-verbal feedback Departmental differences Students evaluation form as part of feedback received in clinical settings Feedback providers' approach.	The perceptions of students on feedback process
Scheduling a feedback time in each department Development of feedback guidelines	Recommendations of nursing students on feedback process

Synchronizing of clinical activities Follow-up of students on feedback they received Appointment of a focal departmental training person.	

4.3.1 Positive perceptions of feedback

This theme is made up of several categories that emerged as positive perceptions of feedback that nursing students received in clinical settings. Table 4.1. gave a summary of categories under positive perceptions of feedback.

4.3.1.1 Positive feedback

Some of the nursing students mentioned that they received positive feedback after performing procedures in clinical settings. They further mentioned that sometimes positive comments, which they considered as positive feedback, were made by the registered nurses at the end of their shifts in the clinical units. This was expressed as follows:

"*They give us positive feedbacks for example they can tell you … I like your eagerness, I like the way you relate theory with practice." P6*[1]

4.3.1.2 Corrective feedback

Some of the nursing students mentioned that they were corrected if their performance was not according to the expected standards and guidelines. In addition, they also indicated that the nurse mentors demonstrated procedures to them and explained again how the procedures should be performed. Students said the following about it:

"For example if took long to cut the umbilical cord or if I cut it at the wrong site, the sister told me, you are supposed to cut like this … (demonstrating with hands)." P7

"One gets corrections, critiques and valuable information on what might have been done wrong or left out so that one does not repeat the same mistakes." P10

[1] P refers to participants and their unique number allocated to during data analysis

4.3.1.3 Feedback as part of the learning process

Another positive perception expressed by some nursing students was that they acknowledged and considered feedback as part of their learning process. This was because it helped them to improve their knowledge and skills in clinical settings and also helped them to learn from their mistakes. This was expressed as follows:

"It [feedback] helps you fix your mistakes." P5

"Feedback helps me improve my skills and knowledge." P8

4.3.1.4 Feedback as a monitoring process

One nursing student mentioned that feedback helped them to monitor their progress because they could obtain comments on their performance and how they could maintain their good performance. The following quote will explain it:

"It's good to know how far you have come and how you are supposed to maintain good performance." P4

4.3.1.5 Feedback enhances students' self-development

Another positive perception expressed by nursing students was that they associated feedback with self-development. They appreciated that feedback helped them to engage in self-reflection and self-evaluation and further boosted qualities such as self-confidence, self-motivation, self-esteem and sense of personal satisfaction. These are all part of self-development. This was indicated by the following quotes:

"You can rate yourself after receiving feedback." P6

"Feedback aids in reflection on the part of the student." P10

"Feedback is very important because it helps increase students' confidence, self-motivation, self-esteem and sense of personal satisfaction." P6

4.3.1.6 Feedback enhances interpersonal skills between students and nurse mentors

The majority of the nursing students indicated that feedback helped to build strong relationships between them and their nurse mentors. They further mentioned that feedback

encouraged students to ask questions and to request more guidance from their nurse mentors. This is what students mentioned:

"Students have good relation with nurses who give them feedback, we are free to communicate to them and ask for advice…." P6

"Feedback builds a good work relationship between nurses and students." P4

4.3.1.7 Feedback evokes students' involvement

Nursing students mentioned that nurse mentors involved them actively in the feedback process by requesting them to comment on their performance. In addition, the participants also indicated that they were sometimes involved in problem solving. This was expressed as follows:

"Sometimes they ask you to give your views and then you come up with a solution together." P8

"Some allow you to give input on what you have learned." P1

4.3.2 Negative perceptions of feedback

This theme is made up of several categories related to the deficiencies in the feedback provided to nursing students in clinical settings. Table 4.1 gives a summary of categories under negative perceptions of feedback.

4.3.2.1 Negative feedback

The majority of the students interviewed indicated that they mostly received feedback when something was not right, when they did not perform according to the expected standards and guidelines. They indicated that feedback providers did not point out what was done well and did not recognise good work but focused more on shortcomings and what was not done correctly. This is what students mentioned:

"We don't really get feedback, unless something goes wrong." P4

"We mostly get negative feedback (laughing), you know how people are, they only speak out when something bad happens." P9

4.3.2.2 Feedback relates to providers' emotions

Another negative perception mentioned by the students was that some feedback providers used the time to give feedback as their chance to express their negative emotions, and feedback was provided in a harsh manner. However, although students were approached in a harsh manner, feedback providers were also apologetic. This was expressed as follows:

"Some approach you in a harsh manner but can come back to apologise." P7

Furthermore, students mentioned how they controlled their own emotions and behaved when feedback was provided accompanied with strong emotional reactions. This was expressed as follows:

"Some nurses are very rude, but we can't fight with them. Maybe the nurse is angry at that moment; sometimes students have to remain calm." P8

4.3.2.3 No individualized feedback to students

Nursing students mentioned group feedback as a negative experience of feedback that they received in clinical settings. They indicated that most nurses liked to give them general feedback as a group and that it was difficult for the students as they did not really learn more about their individual shortcomings in clinical settings. This was indicated by the following quote:

"Sometimes they can tell the whole group that most of you still do not know how to record vital signs … such statements are too vague because you don't know if you need to improve or if you are doing it right." P6

"There is no one- on- one feedback, feedback seems to address the group rather than the individual, it's not really important to me because it doesn't address me personally." P9

Giving feedback to the whole group was also observed during the researcher's observation in clinical settings.

4.3.2.4 Lack of students' involvement in feedback process

Nursing students identified lack of involvement of students in the process of feedback as a common practice in clinical settings. Students mentioned that they were not invited to participate and was afraid of questioning or giving their personal opinion as the sister (Registered Nurse) might not help them again. This was expressed as follows:

"After observing how you perform a procedure, the sister tells you how you performed and gives your book back, sometimes you want to ask but you can't since you're not invited to comment." P8

This was also observed during the researcher's visit to clinical settings where she observed that the students were passive during the feedback process and in most cases it was the feedback providers who communicated information without involving the students.

4.3.3 Perceptions of students on the feedback process

This theme is made up of a group of subthemes that students expressed as related to the process of giving feedback in clinical settings. Subthemes under perceptions of students on the feedback process are summarized in table 4.1.

4.3.3.1 Non-verbal feedback

Nursing students strongly indicated that feedback in clinical settings was conveyed to them not only via verbal communication but also via other modes. Feedback was also conveyed in the form of non-verbal communication that students recognised as cues that indicated that their performance was up to the expected standards. This was indicated by the following quote:

"They don't really use words to tell how you're performing, sometimes it manifests in trust, if they notice that you can perform a certain procedure without any assistance, they will always delegate that task to you." P4

Furthermore, nursing students indicated that signing of practical logbooks and workbooks was a form of feedback that indicated that they had mastered a skill since these books were supposed to be signed only after a student had demonstrated mastery of the skill. Students therefore recognised signing as a way of conveying to them that their supervisors were impressed with their work. This was expressed as follows:

"I think the signing of our practical workbooks is a way of giving feedback because they only sign when satisfied with performance." P5

4.3.3.2 Departmental differences

Nursing students indicated that they rotated among different clinical units and departments and were also exposed to many differences in the way in which teaching was conducted, including feedback. There were also some departments where nurses gave more feedback in comparison to other departments. Students specifically pointed out the maternity ward and casualty department as clinical settings where students received a great deal of feedback. This was expressed as follows:

"What I noticed is that nurses at maternity ward are more strict, they give more detailed feedback, maybe because the maternity department is more critical." P2

"I received a lot of feedback from the casualty department, maybe because there were a lot of emergency cases." P7

In addition, nursing students also indicated that departmental workloads negatively influenced the process of giving feedback to the students in clinical settings. In addition, they also indicated that the provision of feedback depended on the registered nurses whom they were working with. This was indicated as follows:

"When they are busy, they don't give feedback at all." P2

"Feedback depends on who you're working with, some registered nurses don't really care but maybe if you ask for it …." P3

4.3.3.3 Students evaluation forms as part of feedback received in clinical settings

Nursing students strongly recognised the evaluation forms that they received from their training institutions as part of the feedback that they received in clinical settings although the forms were not directed at them. This was indicated as follows:

"When we go out for practical, we get two evaluation forms, the registered nurses give feedback on our performance and give it back to you to take to the training centre." P1

"The registered nurses write comments in our evaluation forms, although it's not meant for us, I get time to read it before handing it to the lecturers." P3

The study also revealed that feedback through evaluation forms was meant for the training institutions and was not discussed with the students. It was only communicated if there was a serious problem that required urgent attention. This was indicated as follows:

"Feedback from evaluation forms is not benefiting students, they (lecturers) only call in students with serious problems; others get their forms and send it to school and that is it …." P7

4.3.3.4 Feedback providers' approach

Nursing students indicated that the impact of feedback on learning depended very much on how they were addressed and the feedback approach employed by the provider of the feedback. This was because the feedback providers gave feedback differently and no standards or guidelines were followed to provide feedback to the students in clinical settings. The following quote will explain this:

"There seems to be no procedures to follow when giving feedback because everyone does it differently." P3

"Use of feedback and how you perceive its importance basically depend on how you were addressed." P1

4.3.4 Recommendations of nursing students on feedback process

This theme includes suggestions made by the nursing students to help improve the process of giving and receiving feedback in clinical settings in the Keetmanshoop District. The categories under recommendations of nursing students on feedback process are summarized in table 4.1.

4.3.4.1 Scheduling a feedback time in each department

The majority of nursing students indicated the need for nurses in clinical settings to allocate time in their schedule in order to provide feedback to students in their departments. They thought that feedback was not given or that they received improper feedback because it seemed as if the departmental routine did not make provision for nurse mentors to spend time with the students. This of course excludes the time that mentors spent teaching and demonstrating clinical skills. An example from one of the students' quote is as follows:

"It seems feedback is not recognised as part of learning in clinical teaching and I am requesting nursing sisters to give us feedback, they must make time for feedback, it seems like we are pushing them." P1

Furthermore, one nursing student indicated that because of not receiving feedback from clinical nursing mentors, they reflected on their performance and communicated with their lecturers in order to obtain feedback on how they performed. However, it was noted that the lecturers struggled to understand the events that took place in the clinical settings as they were not present; therefore, the students requested that the departments allocate time for feedback. This was expressed as follows:

"Sometimes nobody comments on your clinical performance, you wait until the end of the practical allocation and to talk to your lecturers but they won't understand as they were not there, I am requesting unit supervisors to allocate time for feedback because sometimes we really need to talk to someone." P5

4.3.4.2 Development of feedback guidelines

The majority of nursing students indicated that they observed many discrepancies in the way in which feedback was conveyed to students in clinical settings. They assumed that the nurse mentors were not trained to give feedback or that there were no guidelines to follow when giving feedback. They therefore requested nurses in clinical settings to be guided on how to give feedback. This was expressed as follows:

"The way they give us feedback sometimes (shaking head) …. I cannot blame them because maybe they were not trained or guided to give feedback. They teach so well but seem to have no idea on how to give students feedback. I am requesting experts in the field to write standard guidelines to be followed when giving us feedback." P2

4.3.4.3 Synchronizing of clinical activities

The majority of nursing students indicated that they received conflicting feedback because there seemed to be a lack of teamwork between the training institutions and the clinical settings. They indicated that nurse mentors from clinical settings and lecturers or tutors planned their teaching activities separately and in the process confused the students. It was also aired that students did not receive proper orientation before they were sent for clinical attachment; in addition, nurses in one department also gave them different or conflicting messages. Students were left wondering who was right and therefore called for communication within departments and also between clinical settings and training institutions. This was expressed as follows:

"We are sent to the hospital without orientation and at the end get conflicting feedback. One nurse can tell you your performance is excellent and the next moment one can tell you that you don't know anything and that's not how the procedure is supposed to be performed. What is worse, your lecturer did not even teach you about it, now you don't know which one to follow, they should work together (shouting)!" P4

4.3.4.4 Follow-up of students on feedback they received

As a way of improving nursing students' performance and monitoring the impact of feedback, participants recommended that follow-up be done with students in clinical settings. This could be done by the nurse mentor who provided feedback or anyone who was aware that the performance of a student was not up to par and needed to improve. The following is an example of a quote from the students:

"I am suggesting that nurses/educators should follow up on students to see if they're improving based on their feedback or they can delegate another person to follow up." P2

4.3.4.5 Appointment of a focal departmental training person

The majority of nursing students expressed the need for the hospital management to recruit a nurse responsible for training of students in each department. This was recommended because participants observed that the current nurse mentors were occupied with nursing care duties and only did clinical teaching when there were no clinical-related activities to take care of. Additionally, students mostly learnt by watching nurses carry out their clinical duties but they were not really taken through these duties step by step. Study participants therefore assumed that the availability of a training nurse would improve feedback to nursing students. This was indicated as follows:

"It's important for the government to employ training nurses who are responsible for students in each department." P6

4.4 CONCLUSION

In this chapter, the major findings from the observation of feedback sessions and also individual interviews were presented. Major observations that are worth reporting are that students were not involved in the feedback process and that feedback was given in a group and in cases where it was directed at an individual student, it was given in the presence of

other students. The major themes that emerged were positive perceptions, negative perceptions, the perceptions of nursing students on the feedback process and recommendations of nursing students on the feedback process. In the following chapter, these will be discussed in relation to the literature reviewed.

CHAPTER 5

DISCUSSION

5.1 INTRODUCTION

The primary research question sought to explore how nursing students experienced the feedback that they received in clinical settings at a small rural district hospital in southern Namibia. In the literature review conducted, no articles were found reporting on this specific experience. From the primary research question formulated for this study came secondary questions that addressed the kinds of feedback received by nursing students in clinical settings, how feedback was given and how the feedback received by students influenced their performance in clinical settings. The previous chapter has provided detailed information of data collected from the observation of students in clinical settings, which was conducted for the purpose of identifying and observing feedback opportunities. In addition, data from individual interviews with nursing students were also presented. This chapter discusses the results of this study from the perspectives of nursing students, merged with the results of the observation of feedback sessions. In addition, results are discussed in relation to the literature on feedback in clinical settings, as well as Hattie & Timperleys' model of feedback to enhance learning, which served as a theoretical framework for this study.

From the observation of feedback sessions in clinical settings, it manifested that nurse mentors provided some information to the students after conducting a procedure or carried out an allocated task (see addendum 7). Students also reported that they sometimes received comments on their performances. In both cases (observation and interviews), feedback seemed to be closely related to signing of the students' practical workbooks, especially from the observations, it became evident that a nurse mentor can observe a student performing a task but feedback will only be given at the end of the shift or sometime later when the practical workbooks are signed. However, it was clearly observed in some instances that nursing students are not directly observed when performing clinical tasks such as taking vital signs (see addendum 7) but feedback was given based on how they recorded their findings. Despite that, this practice was not revealed in interviews with students. The study results are discussed below under the following headings: positive perceptions of feedback received in clinical settings, negative perceptions of feedback received in clinical settings, the feedback process and recommendations. The researcher discussed results under these topics because these are the main themes of the study, thus each is discussed separately, in relation to available literature

5.2 POSITIVE PERCEPTIONS OF FEEDBACK RECEIVED IN CLINICAL SETTINGS

5.2.1 Positive feedback

Traditionally, nurse mentors give comments like 'good' and 'well done' in order to acknowledge good performance by a student. Students from this study indicated that nurse mentors convey positive statements after observing their performances in clinical settings. In this study, it was evident that the self-level of the Hattie & Timperley model of feedback to enhance learning was one of the focuses of feedback in clinical settings. This was because students indicated that they received positive feedback such as "I like your eagerness" that seemed to relate to the self-level. During observations of feedback sessions in clinical settings, no comments given to the students that could relate to the self-level of the Hattie and Timperley model of feedback to enhance learning, were observed. The self-level usually comprises remarks that relate slightly to the task performed and are more directed at the self (Hattie & Timperley, 2007). According to Hattie & Timperley (2007), these remarks are normally not considered as an important part of the feedback session because they convey little that provides answers to the three questions answered by effective feedback, which are: Where am I going? How am I going? Where to next? However, positive remarks directed to the self can have an impact on learning if they lead to change in efforts and engagement with the task that had to be learned (Hattie & Timperley, 2007). In this study, students consider this as a positive feedback and it motivates them to learn.

This study revealed that nursing students perceived comments directed to the self after the performance of clinical skill as positive feedback. This does not conform to the definition of positive feedback found in the literature. Gibbs *et al*. (2006) define feedback as related to what is good and once the original objectives have been met it looks beyond the immediate. Positive feedback should relate to the performance not the student's personally or characteristics.

5.2.2 Corrective feedback

In a cross-sectional study conducted to evaluate the level of feedback provided to nursing students during clinical practice in Israel, Plakht *et al*. (2013) found that a good supervisor was someone who provided constructive criticism so that inaccurate practices were not continued. In the current study, it was revealed that nursing students in this study were also corrected in case of inaccurate practices that did not conform to the expected standards and

guidelines. This was done via the use of corrective feedback. Although some students indicated that they were given corrective feedback, it was also revealed that sometimes they were confused because they could not really figure out how a required task should be performed due to conflicting messages they received from feedback providers.

Providing opportunities to close the gap between current and desired performance is one of the seven principles of good feedback practice (Nicol & Macfarlane-Dick, 2006), and undesirable performance can be addressed via corrective feedback. Similar results were reported by Bevan *et al*. (2008) in their study conducted to explore the views and perceptions of students and staff regarding feedback. Their findings revealed that students were told what they had done wrong, which could be followed by correction of undesirable performance.

In the Hattie & Timperley (2007) model of feedback to enhance learning, the purpose of feedback is to reduce discrepancies between the current understanding/performances and a desired goal. This was also the case in this study because by giving corrective feedback to the students, it means the mentor is aiming to reduce the discrepancies observed in the current performance and the desired performance. Moreover, the model also indicates that teachers can assist students to reach the desired goals by giving feedback and through effective learning strategies. Although this current study did not focus on the learning strategies, it was evident that nurse mentors in clinical settings help the students to reach their goals via corrective feedback.

5.2.3 Feedback as part of the learning process

The components of learning are cognition (*what to learn*), affect (*why learn*), and metacognition (*how to learn*) (Ten Cate, Snell, Mann & Vermunt, 2004). Such components are equally important and require proper guidance. Feedback is vital to technical, cognitive and professional development (Archer, 2010). In addition, it is capable of making a difference to learning (Sadler, 2010). That means feedback can make a difference between the current performance and a desired performance. Results revealed that nursing students acknowledged feedback as part of the learning process. They indicated that feedback helped them to improve their skills and knowledge. Although in general literature revealed that feedback is not given for the purpose of pointing out mistakes and shortcomings, students in this study indicated that it helped them to fix their mistakes. These could be due to the provision of corrective feedback which students indicated that they regularly receive from nurse mentors. This is in accordance with the results of Abraham and Singaram (2016),

who found that students felt that feedback informed them of the expectations regarding their skills and that they were also told what they needed to do to improve. In a separate study, Bevan *et al*. (2008) found that feedback helped students to improve their future work, which is also in line with the findings of this study. The improvement of future work addresses the question "*where to next*" which is one of the three questions that should be answered by effective feedback (Hattie & Timperley, 2007). Feedback was also found to have a motivational effect on learning (Abraham & Singaram, 2016). It is an indication that previous studies also acknowledged feedback as part of the learning process.

5.2.4 Feedback as a monitoring process

Nursing students receive practical requirements for their registered level in the workbooks or registers at the beginning of the academic year. These requirements also serve as pre-requisite for registration with the Nursing Council upon completion of their studies. After introducing the requirements at the beginning of the academic year, no formal monitoring of progress is made as students are required to monitor their own progress and identify practical requirements that they still need to master and complete. This study revealed that feedback helped students to monitor their progress because they were made aware of their performance and how they could maintain good performance to establish good practice. Feedback helped them to measure how far they had come and how far they still needed to go in order to reach their goals. This was previously substantiated by Wright (2012) who reported that students viewed feedback as a way of measuring their progresses. In addition, it also helped them to gain an understanding of which areas they still needed to work on. This is a form of the meta-cognition process of learning as stated by Ten Cate et.al. (2004) where students realise their level of knowledge or competence in a specific skill. If feedback is acknowledged as a monitoring tool by the students, it means it can assist them to reduce the discrepancies between current understanding and desired goal, which is the purpose of feedback indicated in the Hattie & Timperley model of feedback to enhance learning. In addition, self-monitoring is also part of the self-regulation process level of the Hattie & Timperley (2007) model.

5.2.5 Feedback enhances self-development in students

The purpose of clinical practice in health professions education is the acquisition of clinical skills, and feedback is acknowledged as a crucial step in this process (Ramani & Leinster, 2008). This is because it promotes self-reflection and self-assessment, which are considered

important qualities for lifelong learning. The results of this study concur with those of a study by Ramani and Leinster (2008) because feedback was perceived to be associated with self-development. Self-development entails activities that are directed at gradually improving the personal characteristics and abilities of an individual (Bruce *et al*. 2011). Self-evaluation and self-awareness are some of the factors that promote self-development. The current study found that feedback encouraged self-evaluation and self-awareness of nursing students while in clinical settings. Similar findings were reported by Abraham and Singaram (2016) who found that a majority of students indicated that feedback on clinical skills performance helped them to evaluate their own strengths and weaknesses. Moreover, Vickery and Lake (2005) also found that feedback encouraged self-reflection and self-awareness and helped students to plan for future learning. No evidence of contradictory results was found in the literature.

5.2.6 Feedback enhances interpersonal skills between students and nurse mentors

Learning in clinical settings is facilitated by the good interpersonal skills that are required between a student and mentors, students and peers/fellow students, students and patients or clients they are serving and also between students and other members of the health care team (Bruce, et al. 2011). In nursing education, students are expected to approach mentors and instructors should they plan to be assessed on a procedure that forms part of the practical requirements in the workbook but are not part of continuous assessment marks. These demonstrate the necessity of a good interpersonal relationship in clinical settings in order to facilitate learning. In the Hattie & Timperley model to enhance learning, the discrepancies between current performance and a desired goal is tackled by both the student and teacher, which means there is a need for a good interpersonal relationship between the two in order to successfully reduce this gap.

The results of this study revealed that feedback helped students to build strong relations with their mentors in clinical settings. Students also saw feedback as encouragement for them to ask questions and to express their need for guidance. This finding is substantiated by Glover (2000) who reported that feedback promoted positive interaction between students and teachers. This in turn led students to revisit their performance and make changes to improve. However, in their review of providing feedback, Bienstock, Katz, Cox, Hueppchen, Erickson and Puscheck (2007) found that feedback, most specifically negative feedback, might damage students' relationship with their teachers. Therefore, feedback is not always good for interpersonal relationships but may also do harm. In the observation of feedback sessions in clinical settings, I observed that students were not directly observed and seem to

distance themselves from the mentors. This contradicts the results from the interviews with students.

Interestingly, nursing students' responses indicated some feedback-seeking behaviour. This was evident by them seeking feedback from their lecturers and tutors at the training institutions after reflection on their performance in the clinical settings. However, students were concerned about this practice because in most cases, lecturers and tutors struggled to understand the events happening in the clinical setting as described by the students. This is supported by Gibbs *et al*. (2006) who indicate that students may ask for feedback if they feel that they do not receive enough. Furthermore, the practice of students seeking feedback is encouraged because feedback works well when sought (Hesketh & Laidlaw, 2002). However, in this study, this practice was found to be worrisome because the feedback that students received from their lecturers and tutors did not depend on first-hand data, but on what they 'assumed' was the situation or case.

5.2.7 Feedback evokes students' involvement in the learning process.

Nursing education is mostly practical based training which requires the active involvement of students. According to Boud (2015), for learning to be effective, there is a need for dialogue. This means that students have to be involved in the process of learning, including feedback. In this study, students indicated that they were actively involved in the feedback process because a mentor might request a student to comment on his/her own performance. In addition, students were also involved in finding solutions to those problems experienced with their own performance. These findings concur with those of Cantillon and Sargeant (2008) who indicate that teachers should allow learners to give their perspectives on their own performance and share their ideas on how their performance can be improved. This is further stressed by Ramani and Leinster (2008) who indicate that feedback should afford an opportunity for students to reflect on their performance and its possible consequences. In this study, the students who indicated that they were involved in the feedback process clearly stated that they were allowed to comment on their performances but not on the feedback process itself. Opposite results are reported by Vickery and Lake (2005), who recommend that trainees be given a chance to comment on the fairness of feedback.

The model of feedback to enhance learning proposed by Hattie & Timperley (2007) also recognised the importance of student involvement in the feedback process. They contend that the discrepancies between the current performance and the desired goal cannot be reduced by the teacher alone but require a combined effort.

5.3 NEGATIVE PERCEPTIONS OF FEEDBACK RECEIVED IN CLINICAL SETTINGS

5.3.1 Negative feedback

Gibbs *et al*. (2006) warn that feedback should not simply point out what was bad and what was not done well – in other words, only negative. However, results revealed that students felt that feedback was given to them in order to inform them mostly of what was incorrect and sometimes it's not accompanied by a statement of how . Students specifically indicated that their mentors only speak when something bad or incorrect happens in the clinical settings. This may lead students to believe or perceive that feedback is given for the purpose of pointing out what was not done well, which is against the purpose of feedback indicated in the Hattie & Timperleys' (2007) feedback model to enhance learning. The purpose stipulated in the model is to 'reduce the gap', and the teacher may do this by providing appropriate challenges, which may assist students in reaching the desired goals and to not point out what was lacking. In other departments students complain that they do not get feedback at all. They further indicated that the feedback that they received did not tell them what was done well and therefore, it did not recognise good work but rather focused on shortcomings. Similar results were reported by Bevan *et al*. (2008) who found that feedback was good at pointing out what was wrong with students' performance and that no guidance was given on how it could be improved. Despite the fact that negative feedback can be disheartening to students (Bevan *et al*., 2008), it can be helpful in planning a way forward.

Furthermore, the results revealed that clinical mentors were more likely to comment on students' performance when a deviation from expected practice was observed and this was identified as a 'common practice'. It is perceived to be a common practice because students indicated that its always done. Some have learnt from clinical practice that feedback is only conveyed to students when deviations are observed. This could be concluded that mentors give feedback when something is wrong with the student's performance.

However, in their guide to teaching in the clinical environment, Ramani and Leinster (2008:348) indicate that 'clinical teachers are reluctant' to provide negative feedback to their trainees. This could be because trainees perceive it as a personal attack. It could be concluded that clinical mentors in the departments where observations took place where comfortably giving negative feedback, no reluctance was observed. In addition, students did not perceive the feedback they receive in clinical settings as a personal attack but some see it as constructive.

In this study, students indicated that they used negative feedback to 'improve their learning'. This is because if a student is told their performance is not according to expected standards,

then they try to explore more on how it's supposed to be done and try to practice more until they master the skills. In this way, negative feedback may improve learning.

It was observed that negative feedback was given throughout clinical practice, this means that in some departments, it was given from the beginning of the student shift. This is contrary to the findings of Clynes and Raftrey (2008) who reported that negative feedback was given at the end of the placement. Negative feedback given at the end of a placement does not seems to benefit the students as there are no opportunities to improve, unlike when feedback is given throughout clinical practice.

According to the Hattie & Timperley's (2007) model, feedback should address the four levels; 'the *task*, *process*, *self-regulation* and *the self*. If feedback only focuses on what is not done well, that means there was no attention given at the *task* level. The feedback provided on task level should focus on how well the student performed or understood it and it should form part of the feedback session, irrespective of whether or not the student performed poor or well according to expected standards.

5.3.2 Feedback relates to providers' emotions

According to Archer (2010), feedback can be both harmful and productive, which is mostly associated with the way in which feedback is given. Feedback which is conveyed poorly, can ruin a trainee's confidence (Hesketh & Laidlaw, 2002). In this study, students sometimes related feedback to their clinical mentors' emotions. This is because the type of feedback they receive is closely related to the mood or state of emotion of the feedback provider. They therefore perceived that feedback in clinical settings serves as a platform for their mentors to express their negative emotions, and this affected the feedback process. Students associated the way in which feedback was conveyed to them with the subsequent action they take on learning. They specifically pointed out that if feedback was conveyed in a harsh manner, they normally did not implement or learn from such feedback. Although negative emotions were involved, students indicated that they normally remained calm and did not respond in a negative way and tended to control their emotions. On the other hand, the relationship between emotions and the manner in which feedback is conveyed was not observed in this study during observations in clinical settings. This could be due to the presence of the observer and that nurse mentors were aware that they were being observed. In the same vein, it was interesting to note that students mostly highlighted the issue of emotions - specifically negative emotions - and its influence on the way feedback is given,

but no mention was made of the positive emotions and how they influence feedback. The students seemed to be affected more when negative emotions were expressed.

5.3.3 No individualized feedback to students in clinical settings

Giving feedback to students in the presence of others influences their response to that feedback. Some students may be defensive when feedback is given in the presence of others. When feedback is given to groups of students, some may think it's not directed to them but to their peers. Although mentors may give positive and constructive feedback to groups, it seems that students still desire to get individualized feedback. In this study, during the observation of feedback in clinical departments, it was seen that feedback was given to groups and sometimes directed at one student but given in the presence of others. In addition, group feedback was perceived in a negative way because it was directed at the group and students felt that they did not have an opportunity to be informed of their own performance. For feedback to be effective, it should be individualised and given in private (Ramani & Leinster, 2008). In addition, Glover (2000) indicates that confidentiality and privacy must be valued when giving feedback. It was also observed that students in the Keetmanshoop District received criticism in the presence of other students. This is contrary to the view of Gibbs *et al*. (2006), who state that criticism should be given in private while praise may be conveyed in public. Contradictory results were reported by Abraham and Singaram (2016) where a majority of participants preferred group feedback because it was perceived as an opportunity to see whether others experienced the same problem. In this study, it was observed that feedback was given to students at the patients' bedside, at the nurses' station and in the corridor. The same observation was made by Glover (2000). In addition, the current study revealed that feedback was given in the medication room and patients' television room.

The Hattie & Timperley (2007) model of feedback to enhance learning does not specify whether the feedback should be individualized or conveyed to a group of students.

5.3.4 Lack of student involvement in the feedback process

Feedback must not be seen as passive information delivered to persons without any responses from them (Archer 2010). Moreover, feedback sessions should allow trainees to give their input (Vickery & Lake, 2005). In this study, although some students indicated that they were actively involved in the feedback process, there were some who indicated that they were not involved in the process. It was also observed at the three departments in the

clinical settings that students were not involved in feedback. Moreover, students indicated that they opted to remain silent because of fear of being labelled. Students may be labelled that they question too much or that they are denying that their performance is not up to expected standard. If they are labelled, it negatively affects their learning in clinical settings because nurse mentors may not teach them and work directly with them, thus students may prefer to keep quiet. It was also observed that students were very passive and did not participate in their feedback. This indicates that feedback in clinical settings is not a two way interaction as suggested by literature. Students are encouraged and acknowledged as major role players in the feedback process, as supported by Boud (2015), who indicates that learners are not mere recipients of information in the feedback sessions but should be active agents and the process should be a two-way interaction. In addition, students should be positioned as proactive individuals who can initiate feedback-seeking behaviour.

5.4 FEEDBACK PROCESS

5.4.1 Non-verbal feedback

Students do not only acknowledge and recognise feedback when it's conveyed through words but also see other cues as a way of receiving feedback on their performances. From the findings of this study, it's evident that feedback in clinical settings in the Keetmanshoop District was not only conveyed verbally. There were other practices that students interpreted as a way of giving feedback on their performance. Practices that students recognised as feedback were signing off practical workbooks and delegating tasks; these were strongly perceived as a form of nonverbal feedback. Students felt that when their practical registers are signed by the nurse mentors, it indicates that their performance of the required skills and attitudes are on par with the expected standard. This is because the nurse mentor is supposed to sign practical books only when satisfied with the performances of a student. Therefore, students felt that even if they are not informed verbally that they are doing well, signing off indicates that they are doing well. In addition, students felt that nurse mentors regularly delegating them the tasks of performing certain skills as an indication that they performed according to expected standards and when they notice that a student requires minimum supervision. Therefore, they perceive this as a positive feedback, because they know the mentors are satisfied with their performances. There is no evidence of studies with similar findings. In a separate study, verbal communication was preferred over non-verbal feedback because students perceived this as easier to understand. In addition, verbal

feedback is preferred because it enhances communication between teachers and students. It also helps to clarify information for learners (Abraham & Singaram, 2016).

It seems that students in the Keetmanshoop District assume that they are given feedback through mentors' actions and cues. This is worrying as some of these may be misinterpreted by the students. Some of these practices are discouraged as they may do harm. Therefore, Hesketh and Laidlaw (2002) warn feedback providers to avoid facial expressions and body language that may be misinterpreted.

5.4.2 Departmental differences

Differences in clinical departments were noted by students in terms of the way in which teaching was conducted. It seems that every department conducted teaching and student learning activities differently due to the lack of teaching policies and guidelines. When giving feedback, the nurse mentors are therefore guided by their own interpretation of how clinical teaching and assessment should be conducted. These also include the provision of feedback to students allocated in their clinical units. This study also revealed that there were departments where students received more feedback while at other departments they received none. Students received a great deal of feedback from the maternity and casualty departments. This could be related to the emergencies and critical cases in these departments, causing mentors to be strict with the students and make sure that they master the crucial skills required at these departments. In addition, there was also inconsistency from the feedback providers and at times, students received conflicting feedback. These results are in accordance with those of Hesketh and Laidlaw (2002); who point out inconsistent feedback from multiple sources as one of the barriers to effective feedback in clinical settings. Another departmental difference observed in this study was that in the outpatient department, students were given feedback after they had been directly observed performing a task, while in the male ward, feedback was given without having directly observed the students' performance.

5.4.3 Student evaluation form as part of feedback received in clinical settings

In the Keetmanshoop District, nursing students receive evaluation forms from the training institutions and hand them over to the clinical mentors in order to evaluate them on their performance at the end of the clinical rotation. That means that students are evaluated on each clinical rotation. Evaluation forms focus on issues such as professional appearance, conduct and diligence. Students are rated as poor, good or excellent. Space is also provided

for mentors to make comments regarding aspects that are not covered by the forms. Evaluation forms serve as a tool for nurse mentors to give information to the training institutions and to raise issues that are of concern in the clinical settings. The Nursing Council, which is a regulatory body for the education and practice of the nursing profession in Namibia, strongly recommends the use of evaluation forms and it's also a criterion under the stakeholders' feedback in the accreditation of the nursing schools. This is because regular feedback helps to strengthen the relationship between training institutions and clinical facilities where students are placed for their practical learning. It was revealed that students acknowledged evaluation forms as part of the feedback process. Despite this, students indicated that feedback from the evaluation forms served to inform the training institutions about their conduct in clinical settings and was mostly not discussed with students unless a serious problem such as prolonged absenteeism was reported. It can be deduced that feedback from evaluation forms is not discussed with the students. Students who are doing extremely well, good and fair, are not informed about it, only those students with serious problems are called in. That implies that minor problems are not corrected when they first appear and therefore, could escalate into major problems. Findings from this study contradict the findings of Ramani and Leinster (2008) who assert that feedback is not evaluation. It is not given to analyse what the learners did wrong as this does not give them an opportunity to learn. Moreover, Hesketh and Laidlaw (2002) also indicate that feedback is supposed to be given by the observer, which means that it should be based on first-hand data. In this study, it was revealed that some students were called by their lecturers and tutors to be given feedback based on their evaluation forms and what their mentors in clinical practice reported to the training institutions. This practice, however, does not support learning because trainees are less likely to accept this criticism as it is not based on first-hand data (Hesketh & Laidlaw, 2002).

5.4.4 Feedback providers' approach

Different types of feedback can be used to support learners (Archer, 2010), and this can also inform the approach that the provider employs. There seems to be a link between the feedback approach and its impact on learning. In this study, nursing students indicated that the impact of feedback on their learning in clinical settings depended on how they were approached. This means that if they considered an approach to be harsh and feedback is conveyed in a rude manner, they tended to ignore and perceive the feedback given in a negative way. Archer (2010) also indicates that an understanding of the types of feedback affords an ability to actively seek an appropriate approach that may support the

effectiveness of feedback. The Hattie and Timperley (2007) model of feedback to enhance learning does not indicate how effective feedback should be delivered to recipients but as long as it answers the three questions indicated in the model.

5.5 RECOMMENDATIONS OF NURSING STUDENTS ON THE FEEDBACK PROCESS

5.5.1 Scheduling a feedback time in each department

Students' dissatisfaction with feedback received in clinical settings is associated with a lack of time (Clynes & Raftrey, 2008). That means students blame lack of time for clinical mentors to engage with them in issues related to learning as a cause of the lack of feedback or as contributing to inadequate feedback. In this study, students suggested that clinical mentors allocate time in their schedule for the provision of feedback to trainees in their departments. The daily routine of an inpatient unit starts with handing over of reports when nurses are changing shifts, followed by dusting, bed making and full wash of patients, patient feeding, assessment of vital signs and report writings, ward rounds, minor procedures such as dressing, conducting investigations such as blood samples, administering medications, and lunch for patients. After lunch, there is normally a long rest period for the patient, followed by visiting hour and then the taking of vital signs and administering medications. The nurse mentors should allocate a few minutes to give feedback to the student who had conducted a task before moving on to the next patient. The time to conduct clinical teaching, assessment and feedback may be scheduled in between routine activities so that it does not interfere with the daily ward routine. Although clinical mentors take time to demonstrate clinical skills and assess students on their mastery of skills, students are required to study. The current practice in the Keetmanshoop District seems not to provide adequate time to give feedback to trainees in clinical settings. Therefore, the study participants recommended that mentors allocate time for feedback. This is in accordance with the recommendations by Plakht *et al*. (2013) who emphasise the need for supervisors to make time for providing feedback. In addition, Gibbs *et al*. (2006) also encourage supervisors to set aside adequate time to offer appropriate support and encouragement. Although this study identified the need to set aside time for feedback, there was no indication of how much time should be set aside. Branch and Paranjape (2002) also stress the need to set a specific time for feedback that should be agreed on by students as well. In addition, they indicate that five to twenty minutes is an appropriate duration of time to schedule for a formal feedback session. For feedback to be effective, it should be incorporated into day-to-day activities and be given as

close to the event as possible (Hesketh & Laidlaw, 2002), which is not the case in the Keetmanshoop District.

5.5.2 Development of feedback guidelines

Boud and Molloy (2013: 700) indicate that historically, educators have rectified students' work without any theory of feedback involved. In addition, feedback was purely accepted as information provided by teachers to students about their work. As the field of health professions education advances, the experts have developed and documented models, tips, techniques and guidelines to adopt as frameworks to help educators convey feedback and learners to receive it. An example of such a framework is the Pendleton (1984) model for giving feedback in clinical education settings, as described by Cantillon and Sargeant (2008:1293). According to the Pendleton model, feedback is given following four steps; firstly, the learner states what was good about his or her performance; secondly, the teacher states areas of agreement and elaborates on good performance; thirdly, the learner states what was poor or could have been improved; lastly, the teacher states what he or she thinks could have been improved.

It seems as if none of these frameworks has been adopted in the clinical settings in the Keetmanshoop District. The results of this study indicated that there were discrepancies in the way in which feedback was conveyed, indicating a lack of a common feedback framework, which is why the findings recommended the development of a guideline. This recommendation is crucial, considering that registered nurses are not trained as clinical educators and that a large number of lecturers, tutors and clinical instructors are appointed in their positions because of qualifications in their discipline that are, however, not education related. It is simply assumed that they will be capable of teaching and facilitating learning. In the Hattie and Timperley (2007) model of feedback to enhance learning, it is illustrated that effective feedback should answer the three questions; where am I going? How am I going? Where to next? These three questions may be used to guide nurse mentors when providing feedback, in order to ensure it is effective.

5.5.3 Synchronizing of clinical activities

Results revealed that nursing students were concerned about a lack of teamwork between training institutions and the nurses in clinical settings. It seemed as if the two settings planned their teaching activities without collaboration, which was confusing to the students. The training institutions recruit new intake independently without consulting the hospitals,

which means that the number of students taken into the programme is also not negotiated with the hospital. Despite the limited clinical facilities in the Keetmanshoop District, departments, the allocation of students is also determined by the training institutions as guided by their programme curriculum and the requirements set by the Nursing Council. That means clinical settings are not involved in working out how many students should be allocated in a specific unit. The clinical facilities in most cases are only notified after all decisions have already been made at the training institution level. The information students receive from clinical settings is also not verified with the training institutions. This includes the feedback received from clinical settings because it could conflict with feedback received from educators at the training institutions. A concern about working relations between clinical settings and training institutions was also identified by Jamshidi (2012) in her cross-sectional survey conducted to evaluate the challenges of teaching clinical skills in clinical settings. She found a lack of communication between the faculty members and the nursing staff. Relationships between faculty and clinical staff members were also reported to be a significant source of challenges in clinical settings (O'Mara, McDonald, Gillespie, Brown & Miles, 2014). Due to the concern about a lack of good relationships between clinical settings and training institutions, participants in this study recommended that teamwork be improved with regard to the feedback provided in the clinical settings in the Keetmanshoop District.

5.5.4 Follow-up of students on feedback they received in clinical settings

Bienstock *et al*. (2007) contend that action plans and follow-up activities should be key elements for successful feedback encounters. This is because changes in behaviour normally do not take place if follow-up is not conducted. In this study, as a way of improving nursing students' performance and monitoring the impact of feedback, participants recommended that follow-up be done with students in clinical settings. During observation of feedback opportunities in clinical settings, it was observed that students really need follow up after feedback is given. As shown in table 4.1, students in male wards were given corrective feedback on how to record findings of vital signs, and recommended that nurse mentors follow-up on and monitor whether these corrections have been implemented. Despite this recommendation, no provision is made for follow-up sessions in the Hattie and Timperley (2007) model of feedback to enhance learning.

5.5.5 Appointment of a departmental training focal person

As explained before, the nursing students in the Keetmanshoop District are directly supervised and taught by registered nurses/midwives and sometimes by enrolled nurses in charge of the clinical departments. In addition, the training institutions' lecturers, tutors and clinical instructors are also involved in clinical supervision and teaching. Nurses and midwives are also the basic patient care providers in their clinical departments, and no one is specifically delegated to conduct clinical teaching. Guiding and teaching of nursing students in clinical settings in the Keetmanshoop District occur if and when the opportunity arises, it does not really take place via planned activities but is placed within the provision of care to the patients. The students recommended that the Ministry of Health and Social Services and specifically the management of the Keetmanshoop hospital appoints one nursing staff member from each unit to be responsible for clinical teaching in the department. Students saw this as an opportunity to improve the feedback process in clinical settings.

5.6 CONCLUSION

This chapter explained the results of the study that explored the perceptions of nursing students of the feedback that they received in clinical settings. There is evidence that students perceive feedback as both a positive and a negative experience. Furthermore, they also acknowledge it as a part of learning that has a strong effect on self-development. However, they think that the feedback that they receive needs much improvement and therefore made recommendations to improve the feedback process and hence their learning in clinical settings. The next chapter will describe the conclusions from the study and its implications for learning in clinical settings and further research.

CHAPTER 6

CONCLUSIONS AND IMPLICATIONS

6.1 INTRODUCTION

The learning of clinical skills is an important element in the education of health care professionals. Feedback is widely acknowledged as an important element in clinical education. This study adopted the definition of Harden and Laidlaw (2013) as a working definition of feedback. It defines feedback as information communicated to the learner that is envisioned to amend his or her thinking or behaviour in order to expand learning and improve performance. Feedback is one of the most dominant influences on learning and achievement, and it is fundamental to cognitive, technical and professional development. It is also necessary for the effectiveness of clinical teaching. There are tips, guidelines, models and principles that could serve as a framework for guiding the process of feedback in clinical settings; however, students mostly still expressed their dissatisfaction with feedback.

In the Keetmanshoop District Hospital in Namibia, some nursing students are not confident and free to practise their nursing skills during their practical placements because of the feedback that they receive in clinical settings. This was the reason for the investigation about the perceptions of nursing students of the feedback that they received in clinical settings.

6.2 CONCLUSIONS

Based on this study findings and literature reviewed, the following conclusions regarding the perceptions of nursing students of the feedback that they receive in clinical settings are made:

Firstly, it can be concluded that nursing students who practise in clinical settings in the Keetmanshoop District Hospital receive feedback. During the observations of students practising in clinical settings, it was observed that their mentors made comments regarding their performance and during the individual interviews students commented on previous experiences of receiving feedback in the clinical setting. The findings indicated that feedback consisted of positive, negative and corrective feedback.

Secondly, it can be concluded that students who practice in the Keetmanshoop District Hospital portray feedback-seeking behaviour. Regarding feedback-seeking behaviour, students indicated that they looked for feedback from their lecturers and tutors although it

was clearly indicated that mostly this was not helpful as they never directly observed the students' performance.

Thirdly, it can be concluded that students generate their own feedback, which means students use their own observations as feedback for their performances. This was evident by the recognition of practices and non-verbal cues during clinical settings (such as signing of workbooks and delegation of duties) as a sign that they had mastered the necessary skills.

Fourthly, it can be concluded that students who practice in the Keetmanshoop District Hospital perceive evaluation forms completed by the clinical mentors at the end of placement with feedback on performance in clinical settings. This perception of the evaluation forms as a form of feedback was strongly expressed although students clearly indicated that the evaluation forms were not completed in their presence. The literature reviewed clearly indicated that feedback and evaluation were two separate processes.

Fifthly, it can be concluded that there is no uniformity in the process of feedback provision in the Keetmanshoop District Hospital. The results indicated that some students were involved in the feedback while others indicated that they were not involved at all. The results also revealed that no guidelines or framework were followed, which could be the cause of the lack of uniformity. It was also indicated that feedback was different at each department and that in certain instances, students received conflicting messages.

Sixthly, it can be concluded that students acknowledge and see feedback as part of the learning process that enhances learning in clinical settings. Students indicated how feedback enhanced their personal development and self-reflection and also improved student-mentor interpersonal relationships. This is in line with what is reported in literature on feedback.

Lastly, it can be concluded that improvements should be made in order to enhance the process of feedback in clinical settings, which will bring about improvement of teaching and learning in clinical settings.

6.3 IMPLICATIONS

The findings of and conclusions from this study may have implications related to learning and teaching in clinical settings and further research. These will be explained in the section below.

6.3.1 Implications for teaching and learning in clinical settings

Literature strongly indicates the positive influence and role of feedback in learning in clinical settings. This study shows where the Keetmanshoop District Hospital stands in terms of feedback as far as students' perceptions are concerned.

Secondly, there is a need to guide students on the feedback process. This can be part of their clinical practice preparation, and they should be made aware on what feedback is, given tips on how to accept feedback and taught feedback-seeking behaviour.

Thirdly, the study exposed areas that needed improvement, such as the training of feedback providers on the process of giving feedback in clinical settings, to teach them how feedback can be conveyed effectively to the trainees and to provide them with tips on how to integrate feedback in their day-to-day activities as the limited time available to provide feedback was one of the concerns of students. This will benefit the students as their mentors' skills in providing feedback will improve.

6.3.2 Implications for further research

This study only explored the perceptions of nursing students of the feedback that they received in clinical settings, and it should be necessary to explore the providers' perspective of feedback. From the findings of this study and the review of the literature, guidelines or guiding principles may be developed to guide feedback providers in clinical settings. An appreciative inquiry may be an appropriate approach to come up with the guidelines. Alternatively, one of the frameworks in the literature may be adopted in the Keetmanshoop District.

6.4 CONCLUSION

Nursing students' perceptions of the feedback that they received in clinical settings were explored. Conclusions were drawn and implications were identified and explained based on the study findings and the literature reviewed.

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