EXPERIENCES OF CLINICAL EDUCATORS ON BARRIERS AND ENHANCERS IN THE FACILITATION OF NURSING STUDENTS' CLINICAL LEARNING

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DECLARATION

By submitting this thesis electronically, I 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

The aim of the study was to explore the barriers and enhancers experienced by clinical educators that influence the value of the learning opportunities of undergraduate nursing students working in selected health care facilities in the Western Cape.

The objectives included:

- To explore critical aspects of the clinical nurse educator's role in the facilitation of students.
- To determine barriers to a positive clinical learning experience in general and specifically as related to patient care, teaching and learning, administrative and research responsibilities.
- To explore enhancers to a positive learning experience in general and specifically as related to patient care, teaching and learning, administrative and research responsibilities.
- To explore possible recommendations to facilitate students' clinical experiences in the specific context.

These objectives were met by means of a descriptive research design with a qualitative approach. The target population consisted of nine clinical educators from public hospitals in the Cape Winelands, Central karoo and West Coast.

Ethical approval for the study was obtained from the Health Research Ethics Committee at the Faculty of Health Science, Stellenbosch University. Informed consent was obtained from each participant.

An interview guide was used to pose questions relating to barriers and enhancers experienced by the clinical educator that influence learning opportunities of students from their first- to their fourth year. Specific prompt questions were further asked to explore information.

The data obtained was coded and categorised into themes and sub themes. The seven themes that emerged were: the role of the clinical educator, the clinical learning

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experience, patient care, teaching and learning, administrative responsibilities, research responsibilities, and the successful facilitation of student experience in the clinical environment.

The results show that clinical educators play an important role in the teaching and educating of the student in the clinical environment, where they have to ensure that a competent, skilled professional nurse is developed, who can function indepently.

Recommendations/suggestions were made by the researcher to further explore the barriers and enhancers experienced by the clinical educator in the private sector.

It was concluded that the clinical environment plays a vital role in the lives of nursing students, as it forms and develops students and prepares them for their role as successful nursing professionals.

Key words: clinical educator; learning opportunities; students.

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OPSOMMING

Die doel van die studie was om die hindernisse en versterkers van kliniese opvoeders te verken, wat die waarde van die leergeleenthede van voorgraadse verplegingstudente in geselekteerde gesondheidsorg fasiliteite in die Wes-Kaap beïnvloed.

Die doelwitte sluit in:

- Om die kritiese aspekte van die kliniese verpleegopvoeder se rol te ondersoekmet betrekking tot die fasilitering van studente.
- Om die hindernisse tot ’n positiewe kliniese leerervaring te bepaal in die geheel, en spesifiek tot pasiëntsorg, onderrig en leer, administratiewe- en navorsingsverantwoordelikhede.
- Om die versterkers tot ’n positiewe kliniese leerervaring te bepaal in die geheel, en spesifiek tot pasiëntsorg, onderrig en leer, administratiewe- en navorsingsverantwoordelikhede.
- Om die aanbevelings aangaande die fasilitering van studente se kliniese ondervinding in die spesifieke konteks te ondersoek.

Hierdie doelwitte is bereik deur middel van ’n beskrywende navorsingsontwerp met ’n kwalitatiewe benadering. Die teikenpopulasie bestaan uit nege kliniese opvoeders van die publieke hospitale in die Kaap Wynland, Sentrale Karoo en Weskus.

Etiese goedkeuring vir die studie is verkry deur die Etiekkomitee van die Fakulteit Gesondheidswetenskappe, Universiteit Stellenbosch. Ingeligte toestemming is van elke deelnemer verkry.

Die data is ontleed met behulp van kodering wat tot die gevolg gelei het dat temas en subtemas geskep is. Die sewe temas sluit in: die rol van die kliniese opvoeder, die kliniese leerervaring, pasiëntsorg, leer en onderrig, administratiewe verantwoordelikhede, navorsing, en die suksesvolle fasilitering van studente-ondervinding in die kliniese omgewing.

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Die resultate toon dat die kliniese opvoeder ’n merkwaardige rol speel in die lewens van die studente om ’n suksesvolle student te kweek vir die werk wat hulle as professionele verpleegkundiges sal verrig.

Die aanbevelings sluit in dat daar ’n meer breedvoerige ondersoek ingestel word op die kliniese fasiliteerder in die privaat sektor.

Die gevolgtrekking word gemaak dat die kliniese omgewing ’n beduidende invloed op die lewe van die verpleegstudent het, aangesien dit die student vorm en onwikkel tot ’n verpleeegkundige wat onafhanklik kan optree in die kliniese veld.

Sleutelwoorde: kliniese opvoeder, leergeleenthede en studente.

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DEDICATION

I dedicate this work to:

All the clinical educators out there who work hard to contribute to the success of the students to become competent skilled nursing professionals.

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TABLE OF CONTENTS

Declaration	2
Abstract	3
Opsomming	5
Dedication	7
Acknowledgements	8
CHAPTER 1: FOUNDATION OF THE STUDY	**16**
1.1 Introduction	**16**
1.2 Research problem	**18**
1.3 Rationale	**18**
1.4 Research question	**19**
1.5 Research aim	**19**
1.6 Research objectives	**19**
1.7 Research methodology	**19**
1.7.1 Research design	20
1.7.2 Study setting	20
1.7.3 Population and sampling	20
1.7.4 Data collection tool/instrumentation	20
1.7.5 Pilot interview	20
1.7.6 Trustworthiness	21
1.7.7 Data collection	21
1.7.8 Data analysis	21
1.8 Ethical consideration	**21**
1.8.1 Right to self-determination	22
1.8.2 Right to confidentiality and anonymity	22
1.8.3 Right to protection from discomfort and harm	22

Stellenbosch University https://scholar.sun.ac.za

1.9 Operational definitions **22**

1.9.1 Clinical education 22

1.9.2 Clinical supervision 22

1.9.3 Clinical accompaniment 23

1.9.4 Clinical learning opportunities 23

1.9.5 Undergraduate nursing students 23

1.10 Duration of the study **23**

1.11 Chapter outline **23**

1.12 Significance of the study **24**

1.13 Summary **24**

1.14 Conclusion **24**

CHAPTER 2: LITERATURE REVIEW **26**

2.1 Introduction **26**

2.2 Selecting and reviewing the literature **26**

2.3 Background **26**

2.4 Critical aspects of the clinical nurse educator's role in the facilitation of students' learning **27**

2.4.1 The clinical educator's role and responsibilities 27

2.4.2 What do the students expect from the role of the clinical educator? 29

2.4.3 Key educational expectations of the clinical educator 31

2.4.4 Reflection on the work environment 31

2.4.5 The clinical educator as a role model 32

2.4.6 Realities of clinical education in context 33

2.5 Barriers to a positive clinical learning experience **33**

2.5.1 The patient care context 33

2.5.2 Teaching and learning realities 34

2.5.3 Administrative responsibilities and human resource realities 35

2.5.4 Research responsibilities 36

Stellenbosch University https://scholar.sun.ac.za

2.6 Enhancers to a positive clinical learning experience **37**

2.6.1 The patient care context 37

2.6.2 Teaching and learning 37

2.6.3 Administrative responsibilities and human resource realities 38

2.6.4 Research responsibilities 38

2.7 The differences that clinical experiences and clinical educators can make to the education and development of the student **39**

2.8 Summary **40**

2.9 Conclusion **41**

CHAPTER 3: RESEARCH METHODOLOGY **42**

3.1 Introduction **42**

3.2 Study setting **42**

3.3 Research design **42**

3.4 Population and sampling **43**

3.4.1 Inclusion criteria 44

3.4.2 Exclusion criteria 44

3.5 Instrumentation **44**

3.6 Pilot interview **45**

3.7 Trustworthiness **46**

3.7.1 Credibility 46

3.7.2 Transferability 46

3.7.3 Dependability 47

3.7.4 Conformability 47

3.8 Ethical considerations **47**

3.8.1 Right to self-determination 48

3.8.2 Principle of beneficence 48

3.8.3 Principle of non-maleficence 49

3.8.4 Principle of justice 49

Stellenbosch University https://scholar.sun.ac.za

3.8.5 Confidentiality and privacy 49
3.8.6 Informed consent 50
3.9 Data collection 50
3.10 Data analysis 51
3.10.1 Familiarising and immersion 52
3.10.2 Inducing themes 53
3.10.3 Coding 53
3.10.4 Elaboration 53
3.10.5 Interpretation and checking 54
3.11 Summary 54
3.12 Conclusion 54

CHAPTER 4: PRESENTATION OF FINDINGS 55
4.1 Introduction 55
4.2 Biographical data 55
4.2.1 Demographic data 55
4.2.2 Age 55
4.2.3 Gender 55
4.2.4 Highest qualification 56
4.2.5 Years of experience in clinical education 56
4.3 Themes and sub themes 56
4.4 The role of the clinical educator 57
4.4.1 Developing student competency 58
4.4.2 Being a role model for the student 58
4.4.3 Fulfilling related responsibilities 59
4.5 Clinical learning experience 60
4.5.1 Limited availability and time management concerns 60
4.5.2 Involvement of permanent unit staff in education of students 61
4.5.3 Theoretical knowledge and clinical experience of the clinical educator 62

Stellenbosch University https://scholar.sun.ac.za

4.6 Patient care **62**

4.6.1 Student lack of knowledge and experience 62

4.6.2 Holistic patient care 63

4.7 Teaching and learning **64**

4.7.1 Lack of time spent with students 64

4.7.2 Permanent unit staff involvement 65

4.7.3 Time available to spend with students 65

4.8 Administrative responsibilities **65**

4.8.1 Time spent on administration 67

4.8.2 Lack of resources 67

4.8.3 Administrative responsibility of the clinical educator 68

4.8.4 Improvements reducing the time spent on administration 69

4.9 Research responsibilities **69**

4.9.1 Research skills deficit 69

4.9.2 Availability of resources 70

4.10 Successful facilitation of student experience in the clinical environment **71**

4.10.1 Educational function of permanent unit staff and professional nurses 71

4.11 Summary **72**

CHAPTER 5: DISCUSSION, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS **74**

5.1 Introduction **74**

5.2 Discussion **74**

5.2.1 Objective 1: Reflecting on the critical aspects of the clinical nurse educator's role in the facilitation of student learning 74

5.2.2 Objective 2: Determining the barriers to a positive clinical learning experience in general and specifically as related to patient care, teaching and learning, administrative- and research responsibilities 77

Stellenbosch University https://scholar.sun.ac.za

5.2.3 Objective 3: Exploring enhancers to a positive clinical learning experience in general and specifically as related to patient care, teaching and learning, administrative- and research responsibilities 79

5.2.4 Objective 4: Exploring possible recommendations to facilitate students' clinical experience in the specific context 81

5.3 Limitations of the study 81

5.4 Recommendations 81

5.4.1 Teaching and learning 82

5.4.1.1 Qualifications of clinical educators 82

5.4.1.2 Job specification 82

5.4.1.3 Group size 83

5.4.2 Clinical practice setting 83

5.4.2.1 Work environment 83

5.4.3 Further research 84

5.4.3.1 Research 84

5.4.3.2 Undergraduate students 84

5.5 Conclusion 85

REFERENCES 86

Stellenbosch University https://scholar.sun.ac.za

APPENDICES

Appendix 1: Ethical approval from Stellenbosch University 91

Appendix 2: Permission obtained from institutions/department of health 93

Appendix 3: Participant information leaflet and declaration of consent by participant and investigator 94

Appendix 4: Instrument/interview guide/data extraction forms 105

Appendix 5: Confidentiality agreement with data transcriber/permission for use of an instrument 107

Appendix 6: Extract of transcribed interview 108

Appendix 7: Declarations by language and technical editors 125

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CHAPTER 1

FOUNDATION OF THE STUDY

1.1 INTRODUCTION

The South African Nursing Council (SANC) defines “clinical accompaniment” as a process, structured to give directive assistance and support to students by the clinical educator Regulation 173 of 2013 (SANC, 2013). The purpose of clinical accompaniment is to facilitate the development of competence, independence, and skills in nurses in the clinical environment in which they will be working after their studies, as contained in Regulation 173 of 2013 (SANC, 2013). For clinical educators, clinical accompaniment is an integral part of their responsibilities and duties.

The SANC is the legislative body that governs nursing practice in South Africa. The Nursing Act*,* 2005 (Act No. 33 of 2005) regulates the nursing profession and provide for matters that are related therewith. The Council performs various functions within nursing. Some of these functions include implementing policies as determined by the Health minister, removing and restoring members on the register, conducting examinations, appointing examiners, conducting inspections and investigations into nursing education institutions, and determining the scope of practice, to name just a view.

The Nursing Act (Act No. 33 of 2005) stipulates the requirements for education and training. The accreditation of a nursing institution is subject to the council providing and issuing a certificate of approval, in order for the institution to function accordingly.

These educators perform a crucial role in the way they encourage and motivate students to think and act independently in a very challenging environment that constantly changes (Lekhuleni, Van der Wal, Dirk & Ehlers, 2004:3). In this process, students learn to apply critical thinking skills in order to safe holistic patient care, which is essential in the recovery and well-being of the patient. Effective clinical teaching, therefore, is a critical component of the students’ ability to apply practically the theory and skills learnt in the clinical environment.

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However, the educators' multi-faceted work is hampered, and it seems to have a direct influence on student competency. Low levels of competence may be the result of factors hampering the clinical educator in the facilitation of effective clinical education in the clinical environment (Lekhuleni *et al*., 2004:2). Each clinical educator has approximately 50 new students per year group. Groups might be bigger due to the failing of certain students; therefore, numbers vary from year to year. Each clinical educator is allocated to a specific year and is responsible for that group. However, although the clinical educators are each responsible for a year group, they also help out with each others' groups as necessary.

The studies of authors have confirmed that skilled and knowledgeable students result from effective clinical teaching. One can argue then that clinical teaching lies at the heart of effective nursing (Eta, Atanga, Atashili & D'Cruz, 2011:1). Clinical teaching transforms the student from a person who has no knowledge or skills regarding his/her future work environment into a nurse that is competent and able to perform his/her duties as a professional nurse at graduation.

Effective clinical teaching supports students to develop their cognitive, affective, as well as psychomotor abilities, which are essential in the clinical environment (Okoronkwo, Onyia-Pat, Agbo, Okpala & Ndu, 2013:63; Hakimzadeh, Ghodrati, Karamdost & Mirmosavi; 2013:174). Through being taught the practical application of the skills needed in a controlled environment, future nurses are empowered to provide holistic and safe patient care independently in the future (Okoronkwo *et al*., 2013:63). The views of Okorokwo *et al.* support the views set out in 1.2.

The clinical educators that participated in this study work at public health institutions in three different rural areas in the Western Cape. In the experience of the researcher, the environment in which they work may pose many challenges relating to the lack of resources, such as access to information technology and additional text books. Traveling between the campus and hospitals at one of the institutions delay productivity and attention gets fragmented. Clinical educators are assigned various roles and responsibilities to fulfil different functions in their working environment, such as helping with the maring of papers or attending meetings. Their focus constantly have to shift from one task to the others. The ratio of student to clinical educator varies from 50:1 and often even more, depending on the year group.

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Within this context of skills learning, barriers and enhancers exist that respectively hinder and advance teaching and learning processes. Barriers and enhancers are experienced by both the educator and the future nurse. Owing to the researcher's experience in this environment, she was eager to explore the experiences of the clinical educator that may influence the quality of the learning opportunities of undergraduate nursing students from their first- to their fourth year of study.

1.2 RESEARCH PROBLEM

Clinical educators seem to face a variety of problems in the clinical environment, for example insufficient time spent by the clinical educator with the students, heavy workloads, and the confusion regarding the role clarification of the clinical educator (Williams & Taylor, 2008:899). Additionally, student-related matter such as student motivation, contributes to concerns in teaching in the clinical environment (Nasrin, Soroor & Soodabeth, 2012:1).

Inadequate training of students in the clinical environment might limit the students' acquisition of knowledge, skills and attitude. For this reason, it was necessary to investigate the barriers and enhancers experienced by the clinical educator. These barriers and enhancers influence the value of clinical learning opportunities of undergraduate nursing students from their first- to fourth year.

1.3 RATIONALE

The rationale behind the study was the need to understand what barriers exist in the clinical environment that hinder the effective transmission of skills between clinical educators and their students. Only if this learning experience is positive, students will be able to be optimally efficient and effective when carrying out their work.

This study attempted to increase the understanding that clinical educators currently have problems to overcome in the field of clinical education. The study was intended to shed light on the barriers and contribute to the development of enhancers to ensure a positive clinical learning experience. Patient care, teaching and learning, administrative and research responsibilities, as seen from the point of view of clinical educators were the focus.

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The intended role and function of the clinical educator needs to be optimised since the role that the clinical educator plays in the teaching and learning of nursing students is fundamental. These role players need to ensure that they practise within ethical and legal parameters (Waldock, 2010:2).

1.4 RESEARCH QUESTION

What are the experiences of clinical educators regarding barriers and enhancers in the facilitation of nursing students' clinical learning?

1.5 RESEARCH AIM

The aim of the study was to investigate the experiences of clinical educators on barriers and enhancers in the facilitation of nursing students' clinical learning.

1.6 RESEARCH OBJECTIVES

The specific objectives set for the study were:

- To explore critical aspects of the clinical nurse educator's role in the facilitation of students.
- To determine the barriers to a positive clinical learning experience in general and specifically as related to patient care, teaching and learning, administrative and research responsibilities.
- To explore the enhancers to a positive clinical learning experience in general and specifically as related to patient care, teaching and learning, administrative and research responsibilities.
- To explore possible recommendations to facilitate students' clinical experience in the specific context.

1.7 RESEARCH METHODOLOGY

A brief overview of the research methodology is given in this chapter. The methodology will be discussed in more depth in chapter 3.

1.7.1 Research design

An exploratory descriptive design with a qualitative approach was applied to explore the barriers and enhancers experienced by the clinical educator, that influence the

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quality of undergraduate nursing students' learning opportunities from their first year to their fourth year.

1.7.2 Study setting

The study took place in public hospitals in the Cape Winelands, Central Karoo and West Coast district.

1.7.3 Population and sampling

A population is referred to as elements derived from a larger pool from which the sample is drawn and according to which findings that can be generalised (Terre Blanche, Durrheim & Painter, 2006:133). The study population consisted of nine clinical educators working in public hospitals in the Cape Winelands, Central Karoo and West Coast district.

Purposive sampling was the method used to select the participants, as they represented similar characteristics to those of the population they were drawn from. (De Vos, Strydom, Fouche & Delport, 2011:392). Purposive sampling allowed the researcher to select participants who had experienced the phenomenon being studied and who were able to give an account of their experiences by means of interviews (Burns & Grove, 2007:344).

1.7.4 Data collection tool / instrumentation

The interviews were conducted with the use of a semi-structured interview guide, based on the objectives of the study. The interview guide consisted of four open-ended questions with sub-questions.

1.7.5 Pilot interview

For the purpose of this study a pilot interview was carried out on one participant and the data from this interview is included in the study.

1.7.6 Trustworthiness

In order to ensure trustworthiness, the researcher used the principles described by Lincoln and Guba (1985). The theory proposed by these researchers might seem

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outdated, but their work is still relevant because the four principles they propose are still widely used and recognised today (Papp, Markkanen & Von Bonsdorff, 2003:264).The four principles are credibility, transferability, dependability and conformability. These principles, as well as the application thereof will be thoroughly discussed in chapter 3.

1.7.7 Data collection

As the researcher was not affiliated with the public hospitals under study; the data was collected by the researcher.. The interviews were conducted at a venue, place and time that suited the participants. Data was collected by means of individual interviews and an interview guide was set up according to the objectives of the study. An audio recorder was used to record the interviews after permission had been granted by the participants. In addition to the recordings, notes were taken to highlight any important incidents or pertinent information divulged by any particular participant.

1.7.8 Data analysis

The researcher analysed the data by listening to the audiotapes and transcribing the interviews. The data was read and re-read to facilitate the researcher to become intimately acquainted with it. Data was analysed according to the five steps of Terre Blanche *et al.* (2006:322), which are: familiarising and immersion, inducing themes, coding, elaboration, and interpretation and checking.

1.8 ETHICAL CONSIDERATIONS

The clinical educators were contacted at the respective public hospitals after ethical approval had been granted. The consent of the clinical educators was obtained after they had been briefed telephonically about the intention of the study and their involvement in it. A consent form with all the information about the study's intent was given to the clinical educators. Consent was also obtained regarding the audio- and written recordings of the study. All nine clinical educators had held the position they held at the time of the study for more than six months.

Permission to conduct the study was obtained from the Health Research Ethics Committee of Stellenbosch University (Ethics Reference number: **S15/05/119**).

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The principles below were followed and included in the study:

1.8.1 Right to self-determination

The right to self-determination supports the ethical principle of respect for people to make their own choices (Searle, C., Searle, S., Human & Mogotlane, 2009:274).

1.8.2 Right to confidentiality and anonymity

Confidentiality and anonymity support the participant's right to privacy of information. In order to ensure anonymity, no information must be linked in any way to the participants' responses (Meyer, Naude, Shangase & Van Niekerk, 2009:392).

1.8.3 Right to protection from discomfort and harm

The right to be protected from discomfort and harm when participating in a study supports the ethical principle of beneficence, which states that one should attempt to do good and prevent harm (Searle *et al*., 2009:274).

The principles set out here will be discussed in more depth in chapter 3.

1.9 DEFINITIONS OF CORE CONCEPTS

For the purpose of the study, the following terms are defined:

1.9.1 Clinical educator

Coates and Fraser (2014:15) defines a clinical educator as someone with an additional qualification in nursing education, who has had additional training in the clinical teaching environment, and has expertise in speciality areas.

1.9.2 Clinical supervision

Clinical supervision refers to the professional nurse's offer of support and assistance to the students, with the goal to develop nurses who can work independently and with competence (SANC, 2013).

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1.9.3 Clinical accompaniment

Regulation 173 of 2013 refers to clinical accompaniment as the process applied by the nursing institution that facilitates directed assistance and support by the clinical educator to the student, to ensure that programme outcomes have been achieved in the clinical environment(SANC, 2013).

1.9.4 Clinical learning opportunities

Clinical learning opportunities are the range of learning experiences, made available to students in the health care setting in order for the student to gain the skills required (SANC, 2013)

1.9.5 Undergraduate nursing student

This term refers to a student at a university or college undergoing education for four years, to fulfil the SANC requirements to become a registered nurse (South African Nursing Council, 1992:7).

1.10 DURATION OF THE STUDY

The ethical approval for this study was obtained in 7 September 2015. Data was gathered during the months of October, November and December 2015. Data analysis was done between the months of January and June 2016. The thesis was submitted for examination on the 1st December 2016.

1.11 CHAPTER OUTLINE

Chapter 1: Foundation of the study

Chapter one provides the background and rationale for the study. Furthermore, reference is made to the problem statement, the literature, the research question, the aim and objectives of the research, the research methodology, the ethical considerations, the definitions of terminology, and the layout of the study.

Chapter 2: Literature review

This chapter aims to introduce and develop a theory that is relevant to the research at hand and it presents an in-depth review on the literature of the study.

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Chapter 3: Research methodology

This chapter contains a thorough description of the research methodology applied in the study.

Chapter 4: Results

The analysed findings are presented in this chapter. No discussion will take place in this chapter.

Chapter 5: Discussion, conclusions and recommendations

The findings of chapter 4 are discussed in this chapter, according to the objectives set out in chapter 1 of the study. A conclusion is made based on the discussion and recommendations are made based on the findings of the study. Limitations of the study are presented in this chapter.

1.12 SIGNIFICANCE OF THE STUDY

This study has the potential to make a positive contribution to the field of nursing education and training. As such, the researcher aimed to investigate the experiences of clinical educators regarding barriers and enhancers in the facilitation of nursing students' clinical learning. This study could potentially indicate the positive influence clinical educators could have on the outcome of the students' abilities to deliver safe, competent and quality care. The study will contribute to the research database in the Western Cape, and also other areas in the sense that it is applicable to facilitators and enhancers regarding the clinical facilitation of nursing students' clinical learning.

1.13 SUMMARY

The experiences of clinical educators on barriers and enhancers in the facilitation of nursing students' clinical learning were introduced. The rationale for the study, the significance of the study, the problem statement, the study aims and objectives, the ethical considerations and the research methodology were also briefly described.

1.14 CONCLUSION

Clinical accompaniment forms an integral part of students' development and growth in order to become competent and skilled nurses who would be able to deliver effective, safe, holistic, and patient-centred care.

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It is within this environment that the barriers and enhancers were explored to improve the development of students, to enhance their ability to work independently and to apply critical thinking skills.

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CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter the researcher sets out the findings from the literature, related to the barriers and enhancers of the value of the learning opportunities of the undergraduate nursing students from their first to fourth year. These barriers and enhancers are viewed from the clinical educator's point of view and form part of the clinical educators' working experiences.

The literature review was synchronised with the objectives of the study (Section 1.7) and both barriers and enhancers were assessed in terms of patient care, teaching and learning, administrative- and human resources, and research responsibilities. Key educational expectations of the clinical educator were explored. In addition, the work environment is discussed, along with considerations of clinical educators as role models in the context in which they work.

2.2 SELECTING AND REVIEWING THE LITERATURE

The review was based on a variety ofliterature sources and was conducted over a period of one year. The researcher evaluated approximately 100 journal articles. The Stellenbosch University library and information services were used for sourcing information and articles. The articles obtained had been published in the thirteen years previous to the study being carried out. This time frame was set to increase the likelihood of the relevance of the material sourced. The databases used included PubMed, Science Direct and CINAHL. Keywords included "clinical educator", "clinical supervisor", "clinical accompaniment" and "clinical learning opportunities".

2.3 BACKGROUND

Clinical education lies at the heart of nursing. By means of effective clinical teaching, students learn to be prepared for the work they will have to do once they qualify as professional nurses (Okoronkwo *et al*., 2013; Nigeria, 2013: 63). The teaching and learning in the clinical environment, therefore, plays an important role in the studies of students. Students become competent by means of participation. SANC refers to

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clinical supervision as a professional nurse's way of supporting and assisting students at the clinical facility. The goal of this support and assistance is to develop students so that they can become competent and independent practitioners. Clinical educators take on a supervisory and supportive role and fulfil their clinical role by developing students' competence in the practical environment of their future workplace (SANC, 2013).

Various researchers (Elcigil & Sarie, 2007:491; Hayajnah, 2011:23; Ali, 2012:15) concur that the clinical educator plays a vital role in the clinical education process and, through this role, sees to it that the process of education yields more competent and independent practictioners. Furthermore, the clinical educator increases the likelihood that safe, quality nursing will be delivered to patients as a result of the ongoing support and guidance that is given to the students in the clinical environment.

2.4 CRITICAL ASPECTS OF THE CLINICAL NURSE EDUCATOR'S ROLE IN THE FACILITATION OF STUDENTS' LEARNING

In the context of clinical education there are various critical factors that need to be considered in order to highlight the complexity of a clinical educator's clinical education accompaniment. The following factors will thus be discussed: the role and responsibilities of the clinical educator; the expectations students have regarding the role of the clinical educator; the key educational expectations of the clinical educator; the reflection on the work environment; and the clinical educator as a role model.

2.4.1 The clinical educator's role and responsibilities

Various researchers (Milner, Estabrooks & Humphrey, 2005:900; Lambert & Glacken, 2005:668; Conway & Elwin, 2006:2) indicate that the role of the clinical educator encompasses several facets . The main role of the clinical educator, as indicated by Mellish, Bruce & Klopper (2012:112), is to ensure that quality learning is promoted in the clinical environment and that the environment is developed in such a way that it is conducive to learning. The clinical eductor serves as a guide, as well as an advisor for the students, assisting them with various situations in the clinical environment. Certain expections accompany this role of the clinical educator, and it is assumed by various students that clinical educators will behave in a certain way while they fulfil their duties

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(Mellish *et al*., 2012:112; Armstrong, Bhengu, Kotze, Nkongo-Mtembu, Ricks, Stellenberg, van Rooyen and Vasuthevan, 2013:247).

Potgieter (2012:4) and Lambert and Glacken (2005:668) state that clinical educators spend most of their time in the clinical environment with the student to ensure that the student receives the one-on-one support and guidance that is required in the clinical environment. The clinical educator helps the student to apply the theoretical components learned to realistic context in practice clarifying misunderstandings and answering questions not previously understood. Therefore, learning needs in the clinical environment are addressed and rectified, and students are able to approach the clinical educator while practising their skills to perfection. The students are provided with the oppurtunity to ask about any uncertanties or concerns regarding related matters that occur in the clinical environment.

When clinical educators prepare the clinical environment for the student to make it more conducive to learning, they also demonstrate skills in the clinical skills laboratory and provide inputs such as lectures and presentations (Lambert & Glacken, 2005:668; Milner, Estabrooks & Humphrey, 2005:900; Waldock, 2012:2). It is the responsibility of the clinical educator to ensure that the students' practice is facilitated in a controlled and safe environment. In addition, this facilitation allows students to practise the skills learnedand apply the knowledge previously acquired, to become comfortable with performing the procedure in practice without supervision. Therefore, clinical educators that are skilled and knowledgeable in the field are required to transfer their knowledge and practical skills to the students in the clinical environment (Lekhuleni *et al.,* 2004:2; Milner *et al.,* 2005:900). According to Heshmat-Nabavi and Vanaki (2010:163), as opportunities arise, clinical educators ensure that students utilise these opportunties.

Clinical educators have various responsibilities to fulfil in the clinical environment, as identified by various researchers (Coates & Fraser, 2014:7; Milner, Estabrooks & Humphrey, 2005:899, Lekhuleni *et al.,* 2004:3). One of these responsibilities entails to act in such a way that they are able to support the reasons for their acts and omissions. As clinical educators are responsible for ensuring that students reach their desired outcomes in the clinical environment, they are held accountable in that they accept liability for the role they fulfil as professional nurses and also as clinical educators. Clinical educators must accept accountability for decisions made and they

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must be able to explain why certain measures were taken. In addition, clinical educators are obliged to act in a reliable, trustworthy and credible manner (Armstrong, Bhengu, Kotze, Nkonzo-Mtembu, Ricks, Stellenberg, Van Rooyen & Vasuthevan, 2013:132) and promote best practice by means of mentoring students and providing them with information. Policies and procedures are developed to introduce students to resources and encourage them to make use of these sources as part of their learning process (Milner *et al.*, 2005:900).

Lambert and Glacken (2005:666) found that clinical educators supply further education by providing in-service training on topics that contribute towards further education and learning experience within the clinical environment. In this way the students are supplied with valuable information, which they use and apply in the clinical environment. Clinical educators help the students to envision their goals and they ensure that students understand and experience nursing in its complexity. The clinical educator ensures that the clinical world and the theoretical world comes together and makes itunderstanding for the student nurses (Adelman-Mullally, Mulder, Mcarter-Spalding, Higler & Gaberson, 2013:29). Students are taught to act professionally at the patient's bedside (Adelman-Mullally *et al.*, 2013:29). When students are exposed to new ideas every day, they become aquainted with their environment and therefore also comfortable and able to work in this environment.

Finally, researchers are in agreement that the clinical educator's role is that of a teacher, a supervisor, an empowerer of students, a provider of resources, and a creator of a trusting relationship based on mutual respect and participation from both parties (Lekhuleni *et al.*, 2004:3; Smedley & Money, 2009:77; Adelman-Mullaly *et al.*, 2013:29-30; Ali, 2012:18-20 & Waldock, 2010:2). While there may be some predetermined roles and responsibilities assigned to the clinical educator, the role will evolve and adapt according to the expectations of the students. In Section 2.4.2, some of these possible expectations will be discussed in greater detail.

2.4.2 What do students expect from the role of the clinical educator?

The importance of the liaison role of the clinical educator was identified by a study done by Waldock (2012:2) in which the author found that students need to be supported positively. With positive support, students will possess a better

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understanding of the outcomes to be achieved as set out in their curriculum. Communication from the clinical educator, such as feedback given after every session, provides students with insight into the mistakes they made and how they can be rectified and prevented from happening again in the future. Furthermore, debriefing sessions should be carried out on a regular basis to prevent students from becoming frustrated as a result of not completing clinical practice requirements and not understanding the processes involved (Waldock, 2010:2). Communication enhances positive outcomes with the students as they comprehend the rationale behind the use of certain approaches and methods. Additionally, communication fosters a more inviting environment. Such an environment has been identified as playing a key role in the success of a student (Dale, B., Leland & Dale, J., 2013:2).

Dale *et al*., (2013:2) indicate that students want to feel welcome and appreciated in the clinical environment in order for them to have a positive start. , Unpreparedness and negative reactions from the ward staff foster feelings of displacement in the clinical environment among nursing students. Furthermore, a student-friendly attitude and atmosphere ensures that the students feel part of the team while they are only students (Dale et al., 20113:2).

Adelman-Mullally *et al*. (2013:31) found that students expected the clinical educator to act on their behalf, as an advocate, in the wards, when meeting with the operational manager and ward staff, to ensure that students are able to meet their goals. By means of advocating, the clinical educator helps to create a safe environment for the student to develop and work in. By means of mentorship, the student is guided and equipped, which will lower the risk of any harm being done to the patient as the result of incompetence, as the teaching of best practices is modelled and applied in the clinical environment (Adelman-Mullally *et al.* 2013:31).

Results presented by Ali (2012:15) indicate that it is imperative for students that a clinical educator should have a teaching style that is good-natured and uplifting, and contributes to a positive learning experience for the student in the clinical environment. Students aquire knowledge from a clinical educator that has relevant experience, is able to ask the right questions and can lead the student in the right direction. Enthusiasm and being open and friendly were key attributes for clinical educators to possess, as identified by Dale (2013:2). These attributes are generally required from

clinical educators to enable them to adapt to a wide variety of situations in the clinical environment.

While the importance of the provision of knowledge cannot be denied, it is imperative to motivate students to actively participate in their quest to become knowledgeable and skilled (Lekhuleni *et al*., 2004:2). Students become very despondent if they are not motivated and not made aware of their responsibility to be involved in their own learning process. Involvement in this process includes the use of any resources made available to students in the process of aquiring knowledge.The clinical educator should possess characteristics such as competence, concern and compassion (Searle, Human & Mogotlane, 2013:52). Such educators need to provide comprehensive training within legal and ethical parameters. In addition, they should remain calm and dignified under pressure, be good teachers and supervisors, and provide a health care climate that is conducive to learning (Searle *et al*., 2013:52).

2.4.3 Key educational expectations of the clinical educator

Within the context of educational expectations it is required from clinical educators to have an additional qualification in education. Furthermore, such educators should have sufficient experience in the clinical environment to be able to fulfil their duties. Experience in specialised fields enables clinical educators to use their clinical expertise to introduce the student into these complex areas. It is also in this environment that one has to reflect on what the student experiences and what the environment offers to the student (Heshnati-Nabavi & Vanakir, 2009:165; McHugh & Lake, 2010:277). Meeting these expectations will have a positive impact on the work environment.

2.4.4 Reflection on the work environment

While the clinical environment is the place where the student learns new processess and gains knowledge and insight into the practice, it is also in this environment that many challenges are experienced (Lambert & Glacken, 2005:665; Jamshidi, 2012:3336). Skilled and knowledgeable students are developed through participation in the work environment.

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The environment can be stressful and students require constant support and guidance to ensure that a favourable learning environment is created for student learning to take place (Smedley & Morey, 2009:76). Students can experience the clinical environment as unstable and might be unable to quickly adapt to change. Therefore, it is crucial for the clinical educator to help the students through this transition by providing support and being accesible to them (Forbes, 2010:787).

Furthermore, confusion created in relation to the role of the student adds more stress, as students are not certain what their role and functions are. Students are often utilised whenever they are needed to assist in times of staff shortage; that is, where an extra pair of hands is needed. Students are conflicted between the goals they need to fulfil and the educational expectations (Jamshidi, 2012:3337).

Within a clinical environment that is unstable, students find it difficult to adapt. The need for the clinical educator to be there becomes more aparent. Owing to to clinical experiences that are not identical, students have to make the most of the learning opportunities that arise in the clinical environment. The clinical educator is the person that provides the support and structure to students (Lamber & Glacken, 2005: 665). As echoed by Forbes (2010:787), support in the clinical environment helps students to develop to their full potential and at the same time it allows them to gain knowledge and insight.

2.4.5 The clinical educator as a role model

Students want to be able to identify with a person who represents a specific persona, someone that they can idolise and learn from in their everyday quest to become an effective and professional nurse when they qualify. As identified by Armstrong *et al.* (2013:248) and Perry (2009:37), a role model meets the expectations of the community in nursing, sets a positive example, and is worthy of imitation. The clinical educator ensures that the best approach is followed in managing patients. Role models share their knowledge with students and provide examples of how to take care of a patient and also how to reduce the risk of harm to a patient (Adelman, *et al.* 2013:29).

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2.4.6 Realities of clinical education in context

Clinical educators are seen as role models that uphold professional standards and act as socialising agents that actively participate in their profession. Comparative studies were carried out by Griscti, Jacono, B. and Jacono, J. (2004:85) and Conway and Elwin, (2006:5) in Britain and the United States. Both the British and the US study found that a lack of time, a lack of control over the clinical area, and diminished clinical competencies were the main reasons for clinical educators not being able to fulfil their duties. In these studies the clinical educators were overburdened with administrative responsibilities that they could not spend the desirable time with their students. Furthermore, clinical educators often undertake further studies, which shifts their focus from their students to their own studies.

2.5 BARRIERS TO A POSITIVE CLINICAL LEARNING EXPERIENCE

In the clinical learning environment, various barriers could potentially influence the clinical learning experience negatively. The barriers that are referred to in this chapter are discussed in relation to the patient care context, teaching and learning, administrative responsibilities, human resources realities and research responsibilities.

2.5.1 The patient care context

Taking care of patients requires skills, expertise and experience in order to fulfil the need requirements of patients. Students take care of patients in their daily routine in the hospital environment. The clinical environment becomes challenging, as the student does not necessarily possess the knowledge and skills to provide comprehensive patient care.

Jamshidi (2012:3336) and Waldock (2010:3) are in agreement that the influx of patients makes it difficult for students to properly take care of patients in their totality. The demands of an increased workload results in less time spent at the patients' bedside, further making it difficult to provide a desired level of patient care. Also, a shortage of nursing staff puts pressure on the remaining staff and the students; therefore, the quality of patient care might be compromised in the long run.

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2.5.2 Teaching and learning realities

Teaching and learning takes place within the clinical environment where the students apply what the theoretical, as well as the practical components taught. The student is equipped with the necessary knowledge and skills that are required if one wishes to become a professional nurse. Geyer *et al.* (2009:259) and Mellish *et al*. (2010:254) refer to teaching as a way of guiding the student within the clinical environment. The goal is to equip the student with the necessary knowledge, skills and decision-making abilities. The students develop interpersonal skills and learn to communicate effectively with the patient.

The realities of learning are that students needs to work through information, understand the information they have acquired, and become able to apply this information in the clinical environment. Mellish *et al*. (2010:254) and Muller, Bezuidenhout and Jooste (2015:651) indicate that learning is a process according to which knowledge is constructed, in a way that allows those who learn to process the information with the end result of stimulating clinical practice When this happens, learning has taken place and the students understand the process and can apply their knowledge.

Some students do not take learning seriously, however, and they jeopardise their learning performance, and fail to acquire the relevant expertise. When students fail, they also fail to comply with the objectives set out for them in their curriculum (Eta, Atanga, Atashili & D'Cruz, 2011:5). In addition, if students are not willing to learn and if they are disrespectful towards the clinical educator, patients and staff, they increase the reluctance of the clinical educator and hospital staff to help them. Clinical educators are required to help these students (Eta *et al*., 2011:5). Such students build up a reputation for being difficult and are guardedly dealt with.

Inadequate accompaniment from the clinical educator with not enough experience also hampers student growth and development. In addition, students might be ill-prepared for their professional careers and unable to deliver safe, holistic patient-centred care at the required level. Studies have shown that some students are not encouraged to think critically about situations that may occur in the work environment, as knowledge is merely transferred from one person to another. This type of teaching

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does not add any value to the students' learning processes (Lekhuleni *et al.*, 2004:2; Beckman & Lee, 2009:339).

2.5.3 Administrative responsibilities and human resource realities

From an administrative perspective, it was identified that in general, literature does not adequately represent the position description and what it requires the clinical educator to do. Therefore, the researcher looked at the position description of the participants as set out in their job specification (Cape Peninsula University of Technology, 2015).

Specifically, the key performance areas set out for the clinical educator cover four main objectives. The first objective relates to the coordination of clinical learning of nursing students between the university where they study and the clinical environment. This objective includes: setting up the schedule roster for clinical accompaniment in the respective areas; being involved in curriculum and teaching guides; and completing reports on student evaluation and assessments. The clinical educator ensures that the clinical register is set up and that correspondence is communicated to all involved (Cape Peninsula University of Technology, 2015).

The second key objective involves the supporting of the mission of the institution where the students study and the promotion of the institution's image. The responsibility of the clinical educator is to be a positive and competent role model for the students and to be involved in the recruitment and selection of prospective students who want to enrol as nursing students. Clinical educators also have to promote the institution (Cape Peninsula University of Technology, 2015).

The third key objective relates to the development and implementation of clinical strategies to determine if students are competent. This objective entails the clinical educator's compiling of workbooks that detail the outcomes the student must reach. Assessments are set up for clinical teaching. According to these assessments, students must be proclaimed competent in order to progressin their studies. Documents are prepared for the summative assessments at the end of each year. All practical reports are collated for the students. The clinical educator is also involved in the evaluations of the students, as part of the departmental requirements. . Furthermore, the clinical educator compiles reports for remedial sessions in the cases

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where students have failed to comply with standard requirements and prepare for moderation and appeal reports (Cape Peninsula University of Technology, 2015).

The fourth key objective relates to the exercising of principles that ensure that student administration and student wellness are maintained and looked after. This objective includes: the completion of the clinical-teaching contact sessions; the completion of the clinical placement registers; the completion of student progress reports; and the completion of student projects reports. Furthermore, educators have to ensure that all scheduled leave to be taken by students is up to date and that progress reports are completed and finalised. In addition, all counselling sessions with students should be recorded and follow-up sessions should be scheduled. Any disciplinary actions taken against students must be filed and recorded as required by the institution (Cape Peninsula University of Technology, 2015).

The works of Griscti *et al.* (2004:88) briefly refers to the administrative work of clinical educators. According to an international study done by Griscti *et al.* (2004:88), administrative work occupies a large proportion of the clinical educator's time. In the beginning of the 1990s, cost containment influenced clinical educators' roles as the educators moved away from the clinical environment and fulfilled more administrative duties (Gordon, Lorilla & Lehman, 2012:344). General administrative work became the work of the clinical educator.

2.5.4 Research responsibilities

To look at clinical educators' responsibility to base their practice on relevant research, is to see barriers to best practice teaching and learning at work (Milner, 2004:911). Clinical educators should depend more often on research in the ward, instead of depending on the staff. If this was the actual case, educators would bridge the communities of research and clinical practice, as indicated by Milner (2004:900), and they would accelerate the development of their student nurses, as well as their own professional development.. Professional development and best practice are facilitated by research.

The barriers that make clinical educators' use of current- and relevant research difficult are threefold. First, some clinical educators might not view carrying out research as an essential element of their jobs. Second, the lack of exposure to research tends to

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steer education away from research, even if some of the research they ought to do underpins their own practice. The third barrier is a possible lack of resources and time. The obligation to meet immediate job-related demands on the educator's time makes longer-term commitments not seem urgent.

2.6 ENHANCERS TO A POSITIVE CLINICAL LEARNING EXPERIENCE

2.6.1 The patient care context

Adelman-Mullally, Muller, Mccarter-Spalding, Hagler, Gaberson, Hanner, Oermann, Speakman, Yoder-Wise and Young (2013:30) report that the clinical educator ensures quality of patient care through their performance as clinical educators. Their technical skills, clinical judgment and ability to work as part of the healthcare team enable them to perform these tasks with ease. Patient-related situations are analysed and the best possible approach is decided upon, to ensure that the patient is taken care of in the best possible way. The student learns by observing the clinical educator and simulating tasks in a similar way. As identified by Forbes (2010: 786,), the technological advancements in equipment ensure more accurate readings of patient progress and it enhance patient care. Students are trained to use equipment properly and can understand the rationale behind the use of equipment and what it is supposed to measure. Students are also able to take better care of a patient when they have insight into patient care. The students appear more open, present and non-judgmental towards the patient when they treat and take care of the patient in the clinical environment.

2.6.2 Teaching and learning

D'Souza, Venkatesaperumal, Radhakrishnan and Balachandran (2013:25) and Lekhuleni, *et al.*, (2004:2) are in agreement about a study carried out on the teaching and learning processes of the student. With the rapidly changing environment, it has become essential to teach students to become independent critical thinkers. Instead of transferring knowledge, students are taught and stimulated to think critically by being given problem-based cases (D'Souza *et al.* 2013:25). Therefore, they become actively involved in the process of teaching and learning. The student is given cases to examine, query, clarify and evaluate, and they use these cases to check evidence, draw conclusions, and present solutions (Potgieter, 2012:5). Students develop to think

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independently and make decisions based on sound judgment, and not what they memorised from textbooks (Potgieter, 2012:5). When students are positively motivated by the clinical educator, they become more likely to be independent and make decisions while applying critical thinking. Students are prepared for the realities of life experience within the clinical environment and are able to improve their skills as they gain more experience and become competent.

2.6.3 Administrative responsibilities and human resource realities

The clinical educator has to provide proof that learning has taken place within the clinical environment as required by SANC. Therefore, clinical educators spend extensive time filling in forms to indicate that they attended to the student for a specific period of time. The student and the clinical educator sign these forms as proof before the documents is submitted to SANC. Continuous evaluations (formative and summative) are also carried out during the year to ensure that the student complies with the requirements as set out in the curriculum. The clinical educator obtains a good idea of the progress the student makes and whether or not the student has areas that need to be improved (Mellish, Bruce & Klopper, 2010:278). The objective is to have a student that is competent and that can be promoted to the following year.

2.6.4 Research responsibilities

Clinical educators consult research more often than staff in the ward and in this way they bridge the communities of research and clinical practice, as indicated by Milner (2004:900). As clinical educators fulfil an important role in the facilitation and professional development of the nursing students, it has become important to ensure that best practice is applied by the clinical educator. This is ensured through mentoring, policies and procedures, and through using research evidence to teach students in the best possible way to enhance learning (Milner *et al.*, 2004:911). When students are made aware of the advantages of research and are introduced to small-scale projects, they gain a better understanding of the outcome-based results pertaining to research, and of how research is used in the clinical environment.

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2.7 THE DIFFERENCES THAT CLINICAL EXPERIENCES AND CLINICAL EDUCATORS CAN MAKE TO THE EDUCATION AND DEVELOPMENT OF THE STUDENT

Clinical educators may have the ability and experience to educate students and develop them into becoming competent, skilled professionals. Students learn through clinical exposure and the assistance and support from the clinical educator.

Newton, Billett, Jolly and Ockerby (2009:316) and Lekhuleni *et al.* (2004:3) are in agreement that clinical educators should support and encourage students during clinical accompaniment. Students need to be assisted to help them to engage with their clinical environment in order for learning to take place. Knowledge needs to be transferred in a way that students can understand and apply what is learned in a safe, holistic manner that is focused on patient-centred care. Students need to be supported in the clinical environment, as insufficient attention can influence the education and development of the student as confirmed by Elicigil (2007:492). When students are not supported and guided in the clinical environment, they tend to merely observe rather than actively participating in patient care.

Newton *et al*. (2009:316) and Johnett and Benson-Soros (2006:45) found that when students do not have the assistance or presence of the clinical educator in the clinical environment, they lack active involvement in direct patient care. Students are afraid to take care of the patient; as a result, they are not exposed to performing tasks and lag behind in achieving their learning objectives. If the clinical educator is more visible, students feel more comfortable in performing tasks, knowing that somebody is there to help and guide them through their learning experience. Clinical educators need to be present with enough contact time in the hospital to ensure that students are exposed to task performance and not just observing. By means of support and availability, the clinical educator can identify studentneeds and act upon them. This quick intervention includes the integration of theory and practice in the clinical environment.

As identified by Newton *et al.* (2009:316) a gap appears to exist between theory and practice in the clinical environment. Students that fall in this gap are not able to integrate what was learned in the classroom and apply it in the clinical environment.

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Integration of theory and practice forms a crucial part of the students' learning and development. Clinical educators should teach students how to incorporate and apply both theory and practice in order to become competent skilled professionals. Students are assisted by the clinical educator to become knowledgeable, to connect with their clinical environment, and to be able to apply theory and practice in order to provide the best care to patients. Students develop from being dependent to being independent as indicted by Lekhuleni *et al.* (2004:3), according to whom the clinical educator allows students to make mistakes as part of their learning process. The clinical educators guide students about the mistakes made and help them to rectify those mistakes, without causing any harm to the patient. Students are provided with feedback during the process of enhancing the learning experience.

Further, Lekhuleni *et al.* (2004:3) indicate that students need to receive feedback soon after the event took place. Students should not be humiliated in front of other people, but shown in a constructive way where improvements need to be made. Students want to feel that they have learned something from the experience and not feel confused after the exercise.

2.8 SUMMARY

The literature review conducted showed that there are barriers and enhancers that have an effect on the learning experience of the student. The role that the clinical educator plays in the clinical environment is crucial, as it ensures that students become competent and skilled to fulfil their future role as professional nurses.

Students are taught to become independent skilled professionals. As a result, the clinical educator needs to apply best practice, provide feedback and uphold legal and ethical practice.

Barriers were identified in the clinical environment, which have an impact on the learning experiences of students and the ability of the clinical educators to fulfil their function optimally. These barriers include patient care, the limited experience that students have of taking care of patients in their totality, and factors that influence their ability or their willingness to learn. In addition, administration duties influence the availability of the clinical educators to spend the desired time with students.

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Enhancers identified by the clinical educators referred to in the literature were students' becoming more involved with the patient and treating patients in their totality and not in sections when they carry out a procedure. In addition, clinical educators identified that students need to learn by doing and to think critically about a case. Lastly, clinical educators have a research responsibility, although this responsibility cannot always be fulfilled.

2.9 CONCLUSION

Chapter 2 provided an indepth discussion of literature relating to the objectives set out in the study's first chapter. The literature indicated that various factors hamper the students' learning experiences while other factors enhance the learning opportunities in the clinical environment.

Chapter 3 will discuss the research methodology used to explore the barriers and enhancers experienced by the clinical educator, that influence the value of the learning opportunities of undergraduate nursing students from their first- to fourth year.

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CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The previous chapter consisted of a literature review that relates to the aim and objectives of the study. Chapter 3 focuses on the research methodology that was applied. Research methodology is a process that is followed by the researcher in order to carry out the research (Burns & Grove, 2009:719). The methodology set out in this chapter comprises of: the study setting, the research design, population and sampling, instrumentation, the pilot interview, trustworthiness, data collection process, data analysis and ethical considerations.

3.2 STUDY SETTING

The study setting was three public hospitals, one situated in the Cape Winelands, one at the West Coast and one in the South Cape Karoo district, where clinical educators are employed at all three hospitals. These hospitals are Level 2 training hospitals that accommodate the students for their practical placements and training. These hospitals are situated in rural areas, and provide extensive services which include a trauma unit and theatre facilities as opposed to Level 1 hospitals that only provide the basic services like treating patients for minor injuries. Therefore, these hospitals have additional/expanded facilities to provide more complex health care services.

In relation to the specific setting, a time was arranged with each participant in a professional, non-threatening and accessible environment that was quiet, to minimalize distractions.

3.3 RESEARCH DESIGN

The research design is the blueprint or overall plan that describes the type of study to be carried out. The factors that could interfere with the validity of the study are controlled by the research design (Polit & Beck, 2008:765).

As mentioned in chapter 1, a descriptive design was used. With such a design, real life situations were portrayed. In addition, a descriptive design allowed for more information to be gathered on the basis of occurrences that happen in the natural

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environment of the clinical educator (Burns & Grove, 2009:696). The clinical educators provided insight into their experiences, as well as the environment in which the students were exposed to during learning opportunities. Educators also reflected on the difficulties they encounter and overcome to make learning possible for the students (Burns & Grove, 2009:696).

An exploratory descriptive design as well as a qualitative approach was considered appropriate for exploring the barriers and enhancers experienced by the clinical educators that influence the quality of the learning opportunities of undergraduate nursing students in their first to fourth year.

3.4 POPULATION AND SAMPLING

"Population" refers to the entire set of individuals or objects that possess common characteristics. In the case of this study, all the clinical educators had been employed in their position for more than six months and had worked at the respective public hospitals in the Cape Winelands, the West Coast, and in the South Cape Karoo district (Polit & Beck, 2008:761). Once the population was identified, sample selection took place.

All elements (individuals, objects, events or substances) that meet the sample criteria for inclusion in the study are sometimes referred to as the "target population" (Burns & Grove, 2009:714). For the purpose of this study the target population were all the clinical educators employed by the public health care sector in the Cape Winelands, the West Coast, and the South Cape Karoo district. A total of nine clinical educators were working in the aforementioned geographical areas. Owing to the limited number of possible participants in the population, all nine educators were selected to meet the sampling needs of the study.

A "sample" refers to a selected group of individuals from the population that is included in the study (De Vos, Strydom, Fouche & Delport, 2011:223). Therefore, the researcher chose participants who met the aims and objectives of the study, as well as the stated inclusion criteria for participating in the study. In this instance, the clinical educators represented the group that would be most appropriate for achieving the desired study outcomes. It is, however, acknowledged that the inclusion of undergraduate students themselves would be important in a follow-up study.

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Purposive, all inclusive sampling was employed in this study so that participants could provide specific and relevant information pertaining to the research being conducted (Polit & Beck, 2008:763). The information to be given would likely be valuable based on personal work experience.

3.4.1 Inclusion criteria

Inclusion criteria can be defined as criteria that pertain to characteristics that are required for participants to be included in the sample (Burns & Grove 2011:291). For this study, clinical educators who facilitated the training of undergraduate nursing students from the first to fourth years, and had more than six months' experience, were eligible for selection and inclusion in the study. It is generally accepted that it takes more or less six months for a person to become acquainted and comfortable within their job role.

3.4.2 Exclusion criteria

Exclusion criteria as described by Burns and Grove (2011:699) are the criteria that exclude a person from participating in a study. No clinical educators were excluded from the study, as all nine participants were in the position of having been a clinical educator for more than six months.

3.5 INSTRUMENTATION

"Interview instruments" refers to the tools that are used during the interview, as a device to aid with the collection of data (Polit & Beck, 2008:755). In this instance a set of semi-structured questions relating to the focus of the research was used. The questions guided the researcher during the interview and provided structure.

The semi-structured interview guide was based on the objectives as set out in the study. The interview guide allowed flexibility of the researcher and the participants being interviewed, and the researcher was able to pose probing questions to the participants in order to gain more detailed information on matters already mentioned during the interview. Previous experience as a clinical educator aided the researcher in developing the semi-structured interview guide, and the supervisors as educational experts provided further inputs. The interview guide consisted of four questions. The first question related to the opinion of the clinical educators regarding their role of

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teaching students. The question was asked to obtain in-depth information about their understanding of their role and involvement in clinical education and teaching.

The second question related to what prevents positive learning experiences in general and was divided into sub-sections linked to patient care, teaching and learning, administrative responsibilities and research responsibilities. This question was asked to obtain an understanding of the clinical educators' views on how the specific sections are negatively influenced.

Question three focused on how clinical facilitators could improve a positive learning experience. This question was also subdivided into patient care, teaching and learning, administrative responsibilities and research responsibilities. The rationale was to obtain inputs and recommendations of the perspective of the clinical educator on what changes could be made to enhance the experience of positive learning.

The final question related to what makes the facilitation of the student experience in the clinical environment more successful. This question related to factors that the clinical educator could identify, that would improve the experience of the student in the clinical environment and enhance learning opportunities in a positive way.

3.6 PILOT INTERVIEW

Meyer *et al.* (2010:384) states that a pilot interview is an interview conducted on a smaller scale or as a trial run of the proposed study to be carried out after the literature review has been written. The methodology of the main study was used and applied to ensure that questions were clear and easily understandable. The pilot interview was carried out to identify any gaps or problems, before the actual study took place.

The pilot interview took place with clinical educators at a public hospital in a private room with comfortable seating, refreshments were provided. The participant was welcomed and made comfortable. The interview was included as part of the main study. No problems were encountered during or after the interview took place.

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3.7 TRUSTWORTHINESS

Trustworthiness in qualitative research refers to the credibility (the truth value), transferability (applicability), dependability (consistency) and conformability (neutrality) of how accurately the researcher interpreted the experiences of the particiants (Lincoln & Guba, 1985:290). Each of these factors is discussed in the subsections that follow.

3.7.1 Credibility

Credibility (Polit & Beck, 2008:539) refers to confidence in the truth value of data and the interpretation of the results that the data produces. Accurate descriptions and interpretations of the experiences, as presented by the participants were included. Also included were an in-depth description of the research process, the sample selection, the research setting, the data collection, and the data analysis

The researcher endeavoured to stay close to the voice of the participant and to put own assumptions and intepretations on hold. This process was followed throughout the data collection and analysis process. However, the researcher acknowledged that true objectivity is not possible.

As the researcher is proficient in both Afrikaans and English, she was able to interpret all transcripts. The supervisor verified a sample of transcripts for congruency.

“Member checking” is the process according to which participants verify the data and its interpretation (Lincoln & Guba, 1985:304). Participants reviewed and verified the transcriptions that were sent to them and indicated that they were satisfied with the data collected, the process of analysis, and the outcomes.

3.7.2 Transferability

Transferability refers to the way in which the findings from qualitative research can be transferred or generalised to groups and other settings, when a thorough description of the study is provided. Researchers can relate the information to other similar studies conducted (Polit & Beck, 2008:768). Transferability will be supported by providing sufficient descriptive data, in order for the reader to evaluate the applicability of the data to another context. The thorough description of data provided by the participants

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ensures that a idea can be formed of the context and intricacies of the study, which allows readers to compare the experiences with their own results.

3.7.3 Dependability

Dependability refers to the findings of a study that are logical and valid (De Vos *et al.* 2011:420). Participants had sufficient experience in the identified field under study, to produce data that would lead to dependable findings. The researcher also verified the information by comparing the transcripts with the recordings.

3.7.4 Conformability

Conformability refers to the way that overall findings can relate to, and support the data collected. Conformability does not support what the researcher thought the findings would be. Conformability ensures the integrity in a qualitative inquiry and the objectivity of data (Polit & Beck, 2008:750). The raw data from the recordings were used for data analysis and the tape recordings were transcribed verbatim to ensure conformability. According to De Vos *et al.* (2011:421), the results have to be evaluated by the supervisor to ensure conformability. The researcher also provided all transcripts of data analysis, coding and conclusions to another researcher to confirm objectivity.

3.7.5 Bracketing

Bracketing, according to Burns & Grove (2011:96) is to ensure that the researcher avoid misinterpretations of the data as experienced by the participants in particular instances. Therefore, the researcher attempted to lay aside pre-conceived ideas and knowledge known about the research under study, and only presented data as it was explained by the particpants.

3.8 ETHICAL CONSIDERATIONS

Ethics is concerned with what is right and wrong (Pera & van Tonder, 2012:5). As part of the code of conduct, research principles are applied when one is carrying out research. These principles provide guidance in our thinking processes and our acting upon those thoughts. Ethics justifies moral decision making and evaluates the morality of actions (Pera *et al.* 2012:53). These principles include the right to self-determination or autonomy, beneficence, non-maleficence and justice. Moral rules derived from

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these principles, including confidentiality, privacy and informed consent, are discussed in section 3.11.1.

3.8.1 Right to self-determination

The principle of autonomy refers to the respect one should have towards an individual, the actions of that individual and the unconditional worth of a person as an individual (Pera & Van Tonder, 2011:53). The researcher ensured autonomy by providing the clinical educators with all necessary information relating to the study, to enable them to make an informed decision regarding their participation. After ethical approval was granted by the Ethics Committee of Stellenbosch University, the clinical educators were contacted at the respective public hospitals. The consent of the clinical educators was obtained, after they had been briefed over the phone of the intention of the study and their involvement in it. A consent form with all the information regarding the proposed study was given to the clinical educators.

Participants were ensured that a pseudonym would be used in order to protect their anonymity. Participants were informed that should they feel upset or uncomfortable at any time, they would be referred to a counsellor should they wish to. It was also explained to the participants that if they wish to withdraw from the study at any time, they might do so.

It was explained that transcripts would not be made available to any person apart from the researcher and the supervisors. No names would be attached to the transcripts, to ensure anonymity of the participants. Participants were told that the transcripts would be kept in a locked area for five years, after which it will be destroyed.

3.8.2 Principle of beneficence

Beneficence is the moral obligation to act for the benefit of others. Furthermore, it relates to the duty to act for the greater benefit of other people (Pera & Van Tonder, 2011:55). Beneficence was ensured through the subtle approach towards questions asked, and by being sensitive towards the answers received from the participants. The participants were allowed to express and explore their feelings related to what they experienced in the clinical environment.

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3.8.3 Principle of non-maleficence

Non-maleficence can be defined as not doing harm to others (Pera & Van Tonder, 2011:55). A researcher has a duty to not cause harm, prevent harm and remove harm. Non-maleficence was applied to the study by not linking any names to information provided, to prevent harm caused on any person participating in the study. Codes were used to protect participants from being identified in any way, and the order of the interviews was not made known to anyone. In terms of reporting and publication, the research would be published according to the principle as described above.

3.8.4 Principle of justice

The principle of justice is a unifying principle in ethics and health, which includes fairness and just resource allocation (Burns & Grove, 2011:59). Furthermore, justice includes treating all people as equals. Justice was applied to this study in the way that all the participants were treated as equals during interviewing; the same questions were asked to all participants. Each participant was given an equal opportunity to relate to the questions and to provide any further inputs as necessary. The researcher reflected on answers given, together with the participants, in order to prevent any misunderstanding.

3.8.5 Confidentiality and privacy

Confidentiality and privacy refers to keeping information provided in confidence, and not disclosing any information without permission (Burns & Grove, 2011:61). Privacy, according to Grace (2009:97), is the right to be free from interference by others and from one's privacy being violated. Privacy was secured in the interviews by respecting the personal space of the participant taking part in the interview and ensuring that access to information was limited to only the researcher. Also, information was provided anonymously and respected the ownership of the information (Pera *et al.*, 2012:62).

Privacy refers to the right to be free from interference from others. Privacy is violated when one person gains access to information of another person (Burns & Grove, 2011:62). The obligation of upholding privacy includes respecting the personal space of another person and restricting access to information about them (Burns & Grove, 2011:62). Respecting personal space and restricting the spread of personal

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information was achieved by easing the participants into the interview. The researcher enquired about participants' general well-being in the most non-confrontational way as possible.

3.8.6 Informed consent

Informed consent implies that all relevant information about the study, including its purpose, be provided to the participants of the study (De Vos *et al*., 2012:117). In addition, information was provided about the duration of participants' involvement in the study. Further, any explanation of the potential advantages or disadvantages of the study was provided to the participants (De Vos *et al*., 2012:117).

Participation in the study was voluntary and informed consent was obtained from each participant by means of a participant information leaflet and consent form. This form contained the approval to conduct the study, granted by the Health Research Ethics Committee at Stellenbosch University, and contained the information relevant to questions and answers pertaining to the study. The participant information leaflet and consent form were made available to the participants in English and Afrikaans, in order to accommodate them in the language that they were more comfortable with. Information provided was clear as per the guidelines made available by Stellenbosch University and allowed the clinical educators to make an informed decision whether to participate or not.

The informed consent document was signed by the researcher and the participants after they had read the document and were satisfied with the information provided.

3.9 DATA COLLECTION

Data collection is the gathering of data in a precise, logical and systematic order. The data is therefore specific and relevant to the study that was carried out, in order to reach the objectives and aim (Burns & Grove, 2009:695). The data collection process included the instrumentation used while conducting the interview, the method used to collect the data, the process for obtaining the data, and the pilot interview that was conducted prior to the main interview (to test the method and questions used, in order to exclude and improve possible gaps identified).

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Participants were made aware that a voice recorder would be used during the interviews and that the interview would be transcribed word for word. The same process was applied during the pilot interview as was applied to the rest of the interviews that followed.

Interviews were conducted in a meeting room in the hospital where the participant worked. The voice recorder was tested in advance to see if it was in working order. A second recorder was available incase it was required. The approximate time for each interview was between thirty minutes and one hour. The information of each interview was transcribed and analysed according to the objectives set out in the study.

A semi-structured interview guide was used to conduct the interview and questions were based on the objectives set out in the study, to ensure that the answers were focused and related to the areas of concern. Probing words were used during the interview in order to encourage the participants to elaborate on the questions asked. Words used as probing mechanisms included "elaborate", "tell me more" and "clarify".

Field notes, according to De Vos *et al.* (2012:336), are notes made during the interview that are written by field workers or researchers themselves. The rationale was to obtain a comprehensive account of participants, events taking place, actual discussions and communication, and perceptions and feelings. Non-verbal behaviour was observed and documented by the researcher during the interview and also directly after the interview, as part of the field notes.

When data saturation was reached, it could be deduced that the questions posed had been meaningfully answered. The study objectives were then compared to the data collected (Terre Blanche *et al.*, 2006:326).

3.10 DATA ANALYSIS

The type of analysis used for this particular research involved inductive reasoning. According to Burns & Grove (2011:539), inductive reasoning is a process whereby reasoning takes place from the specific of a topic to the general. Instances of particular nature are observed, whereby they are combined into a general statement.

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When the data was gathered, the researcher familiarised herself with the data and became acquainted with the content, obtaining a deeper understanding of the information provided in the interviews. As the researcher worked through the data, themes became apparent and then sub themes emerged, which were then used to code the data accordingly. With further reading through the data, it became apparent that certain sections of the data belonged together and those sections were thus put together, which gave meaning to the data. The data were interpreted and checked, which placed the data in context. Transcripts were read and re-read in order for the researcher to become familiar with the text and the data gathered. Notes were made regarding the data, and interpretations were made based on the findings. Conclusions were made, based on the evidence.

The audio data was transcribed by a professional transcriber in English and Afrikaans. The data transcribed was then analysed according to the five steps of Terre Blanche *et al.* (2006:322), which includes familiarising and immersion, inducing themes, coding, elaboration, interpretation and checking. The processes described below do not necessarily follow the sequence as stated and are essentially a fluid and iterative.

3.10.1 Familiarising and immersion

By means of familiarising and immersion, preliminary understanding and ideas started forming around the phenomenon being studied, as well as the arrangements and context of the interviews that were conducted. During this phase, field notes were carefully reviewed and transcripts were read and re-read in order for the researcher to become familiar and engage with the text and data gathered. Notes were made on the data to assist in formulating ideas and understandings of the findings with regard to the experiences of the clinical educators. It slowly became clear which interpretations were supported by the data and which were not (Terre Blanche *et al.*, 2006:322). The researcher was therefore able to progressively grasp the barriers and enhancers experienced by the clinical educators that influenced the quality of the learning opportunities of the undergraduate students from their first to fourth year.

3.10.2 Inducing themes

With the inducing of themes, general rules were inferred from specific instances (Terre Blanche *et al.*, 2006:322). The data derived from the interviews was sorted into

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different categories; it was then examined and compared with other interview-derived data, to determine any similarities or differences. At this point themes emerged and sub themes derived from the main themes. These themes and sub themes were organised and ordered. An example of a theme was the main theme of the role of the clinical educator. The sub themes that emerged from this main theme included the competency of the student, the role model of the student, and other functions of the clinical educator. As advised by Terre Blanche *et al.* (2006:323), throughout the analysis of the data collected, the relationship between the research question and the collected data was considered.

3.10.3 Coding

Coding is the process according to which data are marked as different sections, based on the relevance to the themes (Terre Blanche *et al.*, 2006:324). With the coding in this study, phrases and text were marked according to the themes that related to it. Coding is performed at the same time as the themes are developed. Therefore, the text was grouped into meaningful sections, which were labelled. These grouped sections are referred to as “themes” and “sub themes”. In addition, the relationship between the objectives and the themes was kept in consideration throughout the process of coding (Terre Blanche *et al.*, 2006:324). To distinguish the data from the relevant participants, coding such as participant one, two, and three was used.

3.10.4 Elaboration

By means of elaboration, the themes were explored more closely. Sections of the text that might belong together were compared. Sub themes emerged from the main themes as data was explored. Finer differences that had not been captured previously regarding the meaning of facts, were now captured. Coding was continued until no further significant new insight appeared (Terrre Blanche *et al.*, 2006:324).

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3.10.5 Interpretation and checking

Checking includes the written account of the themes and sub themes, and placing them in context. Areas of biases or prejudice were identified, for example where the researcher was very familiar with the specific context or matter. Concerns of such nature were discussed with the supervisor and objectivity was maintained throughout the study to limit bias. Furthermore, the researcher reflected on her role in collecting the data and interpreting it (Terrre Blanche *et al.*, 2006:326). Data was grouped in an orderly manner to ascertain meaning. This method helps to prevent any information from potentially being left out or misinterpreted (Terre Blanche *et al.*, 2006:326).

3.11 SUMMARY

This chapter presented a detailed account of the process or plan conducted in the study. Included in the study appeared the aim and objectives, the study setting, the research design, population and sampling, instrumentation, the pilot interview, trustworthiness, the ethical considerations, data collection and data analysis. Chapter 4 contains the data analysis and interpretation of the research findings.

3.12 CONCLUSION

The study design resulted in obtaining meaningful information that supported the research objectives set out in the study. The information provided by the clinical educators was insightful and resourceful.

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CHAPTER 4
PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This chapter presents the description of the findings from the research carried out. The interviews were recorded and transcribed verbatim to ensure that the data collected was trustworthy. The formal study consisted of nine interviews. Data was analysed according to the steps described by Terre Blanche *et al*. (2006:322).

The biographical data presented provides insight into the background of the participants. Section 4.3 presents the themes and sub themes. For the sake of brevity, only the English translations of pertinent quotes are included in this chapter. The interviews transcribed in Afrikaans were translated into English. However, the English translation, as well as the original Afrikaans version can be found in Appendix 6.

4.2 BIOGRAPHICAL DATA

4.2.1 Place of employment

All participants were clinical educators working in the public health sector. The participants all worked in the Cape Winelands, Central Karoo and West Coast.

4.2.2 Age

The ages of the participants varied from 33 to 63 years. The oldest participant was 63 years of age.

4.2.3 Gender

Nine participants were involved in the research. All participants were women. There were no male clinical educators in the geographical area that could be included in the study.

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4.2.4 Highest qualification

Seven participants were in possession of a diploma in nursing education and two participants had no post qualification in nursing education. One participant had a qualification in general nursing. One participant had a degree in nursing plus an honours degree in critical care nursing. Most participants had a qualification in administration. One participant was in possession of a diploma in operating theatre nursing science.

4.2.5 Years of experience in clinical education

The length of the employment of the participants varied from just under a year to 10 years' experience in clinical education. Only one participant had worked in clinical education for 10 years. Three participants had five years' experience in clinical education. Two participants had 2,5 years' experience in clinical education. One participant had three years' experience. Two participants had less than one year's experience in clinical education.

4.3 THEMES AND SUB THEMES

Seven themes emerged from the interviews: the role of the clinical educator; the clinical learning experience – what prevents it and what improves it; patient care – what hinders it and what improves it; teaching and learning – what hinders these opportunitesand what improves them; administrative responsibilities – what hinders them and what improves them; research responsibilities – what hinders them and what improves them; and the successful facilitation of students in the clinical environment. Eighteen sub themes emerged from the seven major themes. These themes and sub themes are displayed in Table 4.1 and will be discussed from 4.3 to 4.9.

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Table 1: Themes and sub themes

Themes	Sub themes
The role of the clinical educator	Developing student competency Being a role model for the student Fulfilling related responsibilities
The clinical learning experience	**Barriers:** Limited availability and time management concerns The involvement of unit staff in the education of the student **Enhancers:** The theoretical knowledge and clinical experience of the clinical educator
Patient care	**Barriers:** Student lack of knowledge and experience **Enhancers:** Holistic care of the patient
Teaching and learning	**Barriers:** The lack of time spent with the students **Enhancers:** Permanent unit staff involvement The available time to spend with the students
Administrative responsibilities	**Barriers:** The cost of time spent on administration The lack of resources **Enhancers:** The responsibility of the clinical educator Improvements reducing the time spent on administration
Research responsibilities	**Barriers:** Research skills deficit **Enhancers:** Resource availability
Successful facilitation of student experience in the clinical environment	Educational function of permanent staff and professional nurses

4.4 THE ROLE OF THE CLINICAL EDUCATOR

This theme relates to the role that the clinical educator plays in the facilitation of student learning in the hospital environment. The participants had different views regarding this role of the clinical educator; they spontaneously addressed the different roles as experienced by each participant.

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4.4.1. Developing student competency

The competency of the student is, among other things, dependent on the ability of the clinical educator to lead and guide the student towards competence. In this case, competence refers to the ultimate goal of developing the student to become a professional nurse that can function independently.

P3: The clinical educator, he or she delivers competence-based programmes for nursing staff, and she also helps the nursing staff to focus upon improvement in the clinical area and field.

P5: The clinical educator must be a mentor for her students. She must be able to support them in their professional development so that at the end of the day she can say proudly that her student is competent and can progress to second year.

Considering the excerpts set out above, the clinical educator guides the student to competence by supporting the student to integrate theory and practice. They provide mentorship by supporting mastery learning, observing that requirements are met, and developing a safe and competent practitioner.

4.4.2 Being a role model for the student

The clinical educator serves as a role model to students. Students tend to follow actions, gestures and communication when they are observing the clinical educator's professional behavior. Students emulate the clinical educator, as she is the person who guides them through their professional development. As this person is the one they are in most contact with on aday to tday basis, they often mostly identify with her.

P2: *If we talk about the role of the clinical educator I would say myself, I must be a role model, because they must look at me. My way of talking, my whole conduct, plays an important role, my persona plays an important role, and my body language, because this is what they look at, they adapt the same style.*

P3: *I also think that her [the clinical educator's] role is to be a role model, and she needs to inspire students to strive to be the best professional nurse that they can be.*

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Clinical educators are seen to inspire students and motivate them to become the best they can be. Such educators emulate so-called "best behavior" practices in front of the student, the patient and colleagues. How the clinical educator addresses people in general needs to be professional, as it will act as an example for future registered nurses.

4.4.3 Fulfiling related responsibilities

While the main function of the clinical educator is to educate and guide the student in the clinical environment, she also fulfils other related responsibilities that are bestowed upon her.

P3: *The clinical educator also conducts assessments and she assists learners in the assessment of their needs and identification of outcomes, and I think she must also incorporate the principals of adult learning in her planning implementation and evaluation of education programmes.*

P5: *You as clinical educator, must be at all times aware of the latest protocols, the latest policies.Your role is also that you must look at the environment, especially the practical component, is it conducive to learning, which makes learning promotable, because in the facility we have patients and we have the student.*

The clinical educator aims to ensure that learning can take place in an environment that is conducive to learning. Students need the help of the clinical educator to conduct procedures and to clarify uncertainties about anything that might happen in this environment. Daily documentation of procedures in the clinical environment forms an integral part of the development of the student and how the newly learned skill is applied.

Extended responsibilities of the clinical educator include – but are not limited to – demonstrating procedures, giving lectures, formative and summative evaluations, and involvement in protocols and policies.

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4.5 THE CLINICAL LEARNING EXPERIENCE

Nursing students gain their clinical experience from the moment they are placed in the clinical environment. They learn by means of exposure to encounters with patients, families, clients and communities. Students meaningfully transfer their theoretical knowledge and apply it to practical experiences in the clinical environment; therefore, the integration of theory and practice take place. The integration of theory and practice helps students to develop their skills and to successfully apply what they have learned to practice as a professional nurse when they qualify. However, clinical educators find it difficult to accommodate all students in the allocated time. Therefore, the concerns regarding the limited time available and the management of time, which could influence the exposure of students in the clinical environment, is discussed in section 4.4.1. Coupled with the limited availability and time management, there is a need to ensure that unit nursing staff become involved in the education and training of students in the clinical environment.

4.5.1 Limited availability and time management concerns

This theme relates to the lack of time available to the clinical educators to spend with students in the clinical environment. Clinical educators can be assumed to spend most of their time available with the student in the clinical environment as they support, facilitate and guide students.

P3: *I think firstly it's a lack of time being spent with the students, because often the wards are very busy, and the students cannot be withdrawn from the clinical setting facilitation, and also lack of time in the sense that we are short of clinical educators in this country, because it's a skilled requirement.*

P9: *I would say the time, there must be enough time to teach the student, and if you don't, as an educator, as a mentor, if you don't have enough time to really make sure that the student knows what is expected of him, demonstrating, allowing the student to practice.*

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Time is influenced by various aspects impacting on the availability of the clinical educator to the student. Owing to the ratio of students' allocation to facilitators, it seems as though there are too many students for one clinical educator. As a result, the student gets less time with the clinical educator. Demonstrations take time and students then still have to practice the skills learned. Therefore, the students do not have enough time to practice a procedure properly. Whenever clinical educators are instructed to perform functions other than facilitation, it is time utilised to fulfil duties that do not include the students and their training.

4.5.2 Involvement of permanent unit staff in the education of students

This theme emerged from the opinions voiced by the participants that noted the clinical unit staff being negative towards students. Lack of communication was given as a possible reason for this behaviour, as well as misunderstandings between the unit staff and students. Problems such as these impact on the student and how they experience the negativity in the clinical environment.

P1: *Does not work together as a team with the students and move aside to let the students do the work. The students then often do not do or get the time to practice what they are supposed to do on their level of training. In addition, the student works much slower which aggravate the situation even more.*

P2: *The ward sisters and staff are not always aware what the scope of practice is of each student. Behaviour of the staff and the doctors is also a disadvantage for the student.*

In relation to the excerpts from transcripts set out above, it seems as though the lack of involvement of clinical unit staff may be the result of factors such as miscommunication, the unawareness of what the scope of practice of the student entails, and not effectively working together as a team.

4.5.3 Theoretical knowledge and clinical experience of the clinical educator

The clinical educator needs to have the necessary knowledge and experience to be able to assist the student on a daily basis. Theoretical knowledge is based on the ability of the educator to transfer knowledge to the student and to integrate the practical component into context for the student.

P5: Y*ou must know if someone talks about a stent tube, know what it is… you must be skilled in your area.*

P2: The educator, or mentor sister, must have a couple of years' experience herself, to be able to give teaching.

Based on the excerpts from transcripts set out above, it seems as though consistency throughout would help not only the students, but also the clinical educators to gain experience and learn from each other. This experience would ensure that the education and training of students are consistent and that any gaps identified could be addressed.

4.6 PATIENT CARE

Patient care forms an integral part of the students' daily routines; taking care of the patient physically, mentally and emotionally. Nurses in general have to ensure that they provide safe, effective and efficient care to the patient that will improve health outcomes. This theme relates to the influences on patient care and how care impacts on the patient and explores what hampers this care, and what can be done to improve the outcome. Ultimately, it is the patients' health that matters; ensuring that patients are taken care of in the best possible way. Students have limited knowledge of patient care in its totality and therefore guidance and exposure are necessary as the students progress in their training.

4.6.1 Student lack of knowledge and experience

Students may have some knowledge regarding patient care, when they first start out as nursing students. During the first few months students learn in simulation what it

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means to take care of a patient and how to carry out basic procedures. However, it is only by bridging from simulation to the actual clinical environment that they would be able to become fully equipped nurses. The process, though, is often a very complicated one.

P2: Students in their first year do not know what to expect; simulation classes are not enough. Therefore, patients will not receive the amount of care that they should get. There is not enough guidance for the student to tell them how something should be done.

P9: When it comes to patient care, especially before, for the student when they go to hospital the first time, they know nothing about nursing care, they only know what they have learned in the simulation area, during lectures. So, they practice on a doll and then they go into the real situation, in a way, it is a bit of a, what I have seen is, it's like they want to go back to the simulation area sometimes.

From the excerpts of transcripts set out above, it can be assumed that knowledge is necessary to apply to the practical environment. Theory and practice are intrinsically linked with each other and cannot be applied in isolation, but should rather complement each other. However, the concern is that nursing students focus too heavily on one aspect of their practical knowledge, without adequate consideration for holistic patient care.

4.6.2 Holistic patient care

This theme relates to patient care and how it can be enhanced. Holistic care refers to the patient being treated holistically, which includes the physiological, emotional, psychological and physical needs of the patient (Heshmati-Nabavi & Vanaki, 2010:165). These aspects are all important when the patient is being treated to ensure that the patient makes an adequate and speedy recovery.

P2: The students will be [the primary] care givers [to the patient]. They will be more hands-on with the patient. This will include your physical needs and the patient can be

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nursed holistically. They would be able to make decisions on their level [as student nurses].

P4: That if one changes your attitude to patient care, it will be more satisfying and getting the care culture back and therefore also more holistically towards the patient.

In relation to the excerpts from transcripts set out above, the patient is the main focus of holistic care. Although students are still learning, they are there to take care of the patient in their totality. Students can apply what they learn in the classroom to the patient in the clinical environment.

4.7 TEACHING AND LEARNING

Teaching within the clinical environment involves helping the students to become competent, as they learn the different practices while caring for patients. The student acquires knowledge through learning and application within the practical environment. This theme relates to how teaching and learning relates to the students within the clinical environment and what prevents teaching and learning from taking place. Once again participants indicated improvements to help with teaching and learning.

4.7.1 Lack of time spent with students

This sub theme relates to aspects that may have an impact on the clinical educators' time spent with students. The clinical educators spontaneously addressed this point, also how their time was divided, and the importance of spending much needed time with students in the clinical environment.

P3: *The more time that is spend with the student, the more competent they will become. Bringing theory and practical together involves teaching and learning.*

P6: *Again, more time is needed to efficiently deal with the student; therefore, the clinical educator needs more time with the student. Time is influenced by tea times and lunch times and the hours that the students must work. Sometimes you only get to one student, so therefore it influences teaching and learning. Preparation time also takes up a lot of the time of the clinical educator.*

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From the excerpts from transcripts set out above, effective utilisation of time is needed to ensure that students master the necessary skills. If adequate guidance was provided to each student during the time allocated, clinical educators could more likely effect change and help the student to improve their clinical skills where points of concern was noted. The assessments and the time that is required to spend with students are time consuming and to properly assess students, the clinical educator needs even more time with the students.

4.7.2 Permanent unit staff involvement

Clinical unit staff in the hospital have a duty to be involved in the training and education of nursing students, as they interact with the students on a daily basis. The clinical educator is there to teach the student, so the staff do not get involved in the training of the students. This theme relates to the involvement of the clinical unit staff (or the lack thereof) in the training and education of the students.

P2: *The permanent staff does not pay attention to the students; therefore, it is important for the clinical educator to have a good relationship [with the staff], having the courage to speak to the ward sister in private and to ask about gaps identified, and if anything negative comes up, and that it can be brought to her attention, to say that it is not acceptable that the student is exposed to this and that.*

P4: People working together as a unit, us and the nursing staff in the ward; everybody has an educational function towards the students that will make it positive for the students.

It is evident that the clinical unit staff's involvement in education and training may greatly influence the students positively within the clinical environment. Their contribution can add value to the successful completion of their programme.

4.7.3 Time available to spend with students

Clinical educators often have multiple tasks to perform and have to divide the available time between all the tasks. The clinical educators addressed this sub theme based on

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the facts as indicated by them that might have an impact on the time spent and how to address these concerns that they experience.

P3: I think if we can have a little bit smaller groups, if we can have smaller groups of students, if we can have smaller yes, smaller groups of students in the wards, then teaching and learning can be a lot better. Also the use of the simulation class at campus, I think we need to use the simulation class more, it needs to be incorporated more into the whole clinical facilitation, and the students need to practice there a lot more.

P6: *Time plays an important part in teaching and learning. Equipping yourself, we need to equip ourselves, grabbing the book sometimes, knowing that you must go through it, but that is all you do.*

The importance of having smaller groups may result in more attention being paid to students. The incorporation of the simulation laboratory for practice purposes can prepare the student more effectively for the real-life procedures they have to perform on patients. If the students are able to practice procedures more often, the outcomes might be better, as well asthe students' preparation for the ward.

4.8 ADMINISTRATIVE RESPONSIBILITIES

Administrative responsibilities involve the recording and documentation of records on student progress in the clinical environment. With regards to administrative responsibilities, the clinical educator has to record everything that is done with the student during their training at the tertiary institution. In addition, these records have to be submitted as proof of the student's academic record. SANC requires tertiary institutions to keep records of all students. This theme relates to the responsibilities involved in the administrative work on a student's progress and what methods the clinical educator uses to ensure records are kept as proof.

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4.8.1 Time spent on administration

Concerns regarding time spent on administration were noted by the clinical educators. They pointed out factors that influence the administrative responsibilities that they have to deal with on a daily basis.

P7: With regard to us, our administrative responsibilities, we have our records that we must keep of the students and if you have seen fifty students in a week, you don't get to your admin. So, only afterwards do you get a chance to write it up in the practical books.

P9: *We as the clinical educators have quite some administrative duties, which take a lot of our time, and that time is time that you could have used with the students. So the students are actually losing some time that is supposed to be allocated to them.*

The administrative tasks might be overwhelming for the clinical educators and they might find it difficult to keep up with the recording of the students' work. Time spent on sundry administrative responsibilities reduces the time that could have been spent with a student in the clinical environment.

4.8.2 Lack of resources

Resources contribute positively to the effective functioning of the clinical educator. The lack of resources may cause delays in providing learning to the students and completing work on time.

P2: *In the first place, Sister, we don't have a computer that works. We don't have internet. The computer was only set up yesterday. You make short summaries, which means that on a Friday actually, you have to do administration. You then have to catch up on the whole week's work. The college is about, from the hospital I would say 8km from the hospital, so anything you need, you have to go and fetch it. For example, your results of students, copies of the students. I think the system is not good enough, Sister.*

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P3: *So that was very frustrating, and it took a lot of time out of our day. I think if the administrative responsibilities were a lot less, then I think there could definitely be more time for clinical facilitating with the students.*

Having a good system in place that can support the clinical educators to capture results much faster might reduce the time that is spent on systems that are not working. In the era that we live in it is imperative to have electronic equipment that is in good working condition, to enable effective administration. Additionally, not having the necessary resources at hand and having to travel just to gain access to these resources, is also not realistic and should therefore be revised.

From the above quotes it is evident that the clinical educator has more than just the normal administrative work to pay attention to; student issues need to be dealt with in a professional way and the student must get the correct help. Also, the whole process needs to be documented and followed up. This administration also deducts time from the clinical educator's clinical work.

4.8.3 Administrative responsibility of the clinical educator

Clinical educators have responsibilities towards the patients in the hospital, the students, the tertiary institution for which they work, and also to themselves, for maintaining standards and ensuring that the students get the necessary guidance and support that they need.

P3: *Documentation must be kept of education given and the outcome thereof.*

P2: Progress report of students. We give a lot of attention to that.

P1: *Any disciplinary actions what we do, we must send to administrative clerk a copy.*

It is evident from the participants that they have administrative responsibilities to fulfil. Every interaction with a student is documented to ensure that proof can later be provided in cases where there are queries that arise. With every disciplinary action a process is followed whereby copies are kept in students' records.

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4.8.4 Improvements reducing the time spent on administration

Time spent on administration can influence the clinical educators' time. Finding solutions to reduce the time spend on administration can help with enhancing ways to improve time management.

P4: We must try to plan better, see if you can't do your admin during the time that your students are placed. We try, we try really hard, you book the student say ten to eleven, but now it doesn't always work like that, there is something unforeseen that happens, now you only get to the student half an hour later, or an hour, then you have to start with the other student again. So I think, planning from our side, if only we can have more time. I suppose I can't say time, certainly more staff, because the time will stay the same.

P9: *I would say from the mentor side, if they can take those duties to the clerks, and maybe a more streamlined approach when it comes to the administration things for the students.*

If certain aspects of the administrative function of the job of the clinical educator can be transferred to other staff, the clinical educator will be able to focus on the students. Facilitating in the clinical environment may ensure that clinical educators get the time and guidance they need. With proper systems in place the administrative processes may improve and time spent on this may reduce.

4.9 RESEARCH RESPONSIBILITIES

This theme relates to the responsibility clinical educators have to involve themselves in research, as well as the students' participation in research and how research should be incorporated in the life of the clinical educator and the student.

4.9.1 Research skills deficit

Nursing is based on practice and research that is evidence-based, and it therefore forms the basis of all practices.

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P7: A lot of the clinical educators cannot do research. If you let them do research, you need to have the skills and knowledge to do it. It is necessary for the clinical educator to gain experience in research first, in order to teach students how to do research.

P4: "*I don't think we have time for research, but there is no particular research that is expected of us".*

It is evident from the excerpts of the transcripts set out above that research does not take precedence as part of the clinical educators' responsibilities. Although students are given assignments and case studies to do, research is not considered as something to expose and introduce the students to. The clinical educators did, however, indicate that they had a research responsibility, but that resources were scarce and time is once again a major problem. The lack of funds available to do research was also a barrier.

4.9.2 Availability of resources

In order for the clinical educator to fulfill her duties to the best of her abilities, resources such as fully functional computers with internet access need to be available. As the students are dependent on the clinical educator for assistance, the access to resources is needed in order for the students to be provided with the necessary tools for research.

P3: I think if it's easier for the clinical educator to actually do research, if she gets the necessary support, if she gets the tools, if she gets equipped, maybe workshops can be arranged, or maybe we can be sent on courses without paying it out of our own pockets. Then, definitely it will make it a lot better for us, because we want to do research, we want to be kept updated, and we want to be into the field of research, but we simply can't because there are too many barriers.

P6: *I think research makes everything better, because it is because of research that there are now clinical educators. It is because of research that certain things are in place and that systems exist. I think that there should be, in our busy schedule, time for research. The facilitators, all facilitators that are involved should be exposed to*

research... It must make out part of facilitator research. "We must be part of that as we are in this field. "Even the students must be drawn in, because they can give us ideas again.

The importance of research is emphasised here, as it contributes to evidence-based practice in nursing, but also in general as we move forward, advancing in technology. Furthermore, it is necessary to include the students in research projects, as they can contribute in making the future of nursing better, by identifying possible topics for future research within the clinical environment.

Resource availability could impact on the clinical educator's ability to perform her duties with care and accuracy. For this reason, the necessary resources must be available for assisting the students and guiding them in the right direction. With the absence of resources this duty cannot be fulfilled.

4.10 SUCCESSFUL FACILITATION OF STUDENT EXPERIENCE IN THE CLINICAL ENVIRONMENT

The learning environment is the place where the students are placed during their practicals, and where the clinical educators teach the students. It is within this environment that the students gain experience and apply the knowledge of what they have learned under the guidance and supervision of the clinical educator. This theme relates to what is needed to successfully incorporate clinical learning in the clinical environment to make the experience of the student more successful.

4.10.1 Educational function of permanent unit staff and professional nurses

Apart from the clinical educator, permanent clinical unit staff, including professional nurses, has to have an educational function responsibility.

P2: Sister, she must carry confidence toward the people she educates. Once again, she must be flexible. There must be high professional standards, honesty, and integrity. She must be objective as well, to interpret norms and values, and she must make it part of her lifestyle. I would also say that she must have a sense of humor.

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"She must be approachable, so that students have courage to go to her, accept responsibility and accountability. She must adapt her program to fit the patients' and students' needs. She must have knowledge of the day-to-day happenings in every ward, the patients' needs and practical opportunities of the students must be noticed, and very important, equal opportunities to every student which is placed with her.

P3: Then I think if professional nurses in the clinical environment will acknowledge the fact that they also have an educating function, the student will definitely experience that we are working as a team and not working separately, because a lot of times when you bring the student back to class and you ask them how did you experience the clinical field they will say, "I felt like I was in the way of the sister because I couldn't do anything." So I think if you take that student with you and you make it your point and you mission to show that student, if you have time, obviously, then the student will experience it a lot more positively.

If the clinical ward staff can make the first impression of the clinical environment more approachable and conducive to learning, making the student part of the experience, the student might have a different perspective and will result in having a more positive feeling of the clinical environment that will create a feeling of wanting to learn more.

4.11 SUMMARY

This chapter comprised the discussion of the findings of the study, the biographical data, and the information obtained during the interviews. The findings of the study revealed that the clinical educator has an important role to play in the clinical environment, and makes a difference in the lives of the students in the clinical environment. Further, the clinical educator does not merely fulfill a teaching role, but is able to influence the success of training, which results in students becoming competent professional nurses. However, the unfortunate reality is that clinical educators also have to fulfil other responsibilities bestowed upon them, which in turn also influences their available time for spending with students in the clinical environment. Various components were discussed in this chapter that impacted on the clinical educator's good influences on the learning opportunities of the undergraduate nursing student from their first- to fourth year.

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Addressing each of the limiting factors mentioned in the study might remove barriers to learning in the clinical environment. The removal of the discussed barriers is likely to impact positively on the clinical educator's ability to fulfill the work requirements as they relate to clinical education. Additionally, the improvements mentioned in this chapter are guidelines provided by the clinical educators, aimed at aiding them in clinical education. Chapter 5 contains a discussion of the findings of the study and recommendations are based on these findings.

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CHAPTER 5

DISCUSSION, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The previous chapter comprised a description of the data collected and an in-depth analysis and interpretation of the data. This chapter discusses the barriers and enhancers experienced by the clinical educator that influence the value of the learning opportunities of undergraduate students from their first to their fourth year. Recommendations will be made for each objective, based on evidence.

5.2 DISCUSSION

5.2.1 Objective 1: Reflecting on the critical aspects of the clinical nurse educator's role in the facilitation of student learning

The clinical educator plays a vital role in the facilitation of student learning in the clinical environment, ensuring that the students reach the outcomes set out in their practical guidelines. This objective reflects the critical factors that influence clinical educators in fulfilling their role. As noted by Bruce, Klopper and Mellish (2012:112) and Andrews and Roberts (2003:476), the environment must be developed in such a way that it is conducive to quality learning. As such, the clinical educator has an important teaching and assessment function to fulfil in the clinical environment. It was found in the study that most participants felt that the clinical field poses challenges and students are not given sufficient opportunities to practice their skills.

Elcigil and Sari (2007:491) emphasise this point in their claim that the clinical environment forms a vital and indispensible part in the education of nursing students and the role that the clinical educator plays in ensuring that students successfully complete their course requirements. It is within this environment that the clinical educator takes on a guiding function and advises the students in various situations

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that occur in the clinical environment. As Potgieter (2012:4) and Glacken (2005:668) noted, in order for the students to receive one-on-one guidance and support in the clinical environment, it would be necessary for the clinical educator to spend most of their time in the clinical environment. This lack of spending time in the clinical environment corresponds with the findings of this study, in which most clinical educators failed to fulfil the clinical training needs of the students in the clinical environment, as they were required to perform auxilliary functions as well.

According to Elcigil and Sari (2007:491), clinical educators may have an influence on the student through the transferrance of their knowledge, which is then applied in the clinical environment by the student. As emphasised by Hanson and Stenvig (2008:38), to be a proficient clinical educator in the field, the individual needs to have sufficient knowledge and qualifications to be able to assist students with practical and theoretical applications. Further, the above authors maintain that the clinical educator's approach regarding interactions with the students and also their experience in the field of nursing, especially clinical nursing ensures optimal guidance to the nursing students they train. The clinical educators that participants indicated that they needed to be up to date with the most recent policies and procedures and should be able to provide the necessary support in assisting the students to become competent nurse professionals.

These participants were all in agreement regarding competency and indicated that a student must first master a skill before the clinical educator can declare the student competent in a certain procedure. In addition, as indicated by several participants, competency forms an integral part of the evaluation process of the students and is based on competency-based programmes that allow students to progress to the next year. Bimray, Le Roux and Fakude (2013:118) found that competency-based education in the clinical environment is also outcome-based orientated and therefore ensures that the performance of the student is evaluated accurately. Competency-based education tests the knowledge and skills that are applied in the clinical environment. Students learn to demonstrate their understanding of what it is they are doing and why, which enables them to be regarded as competent. In doing so, the students are able to perform a task or procedure up to standard every time (Bimray *et al.*, 2013:118). Hickey (2010:35) indicates that in order for students to be regarded as

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competent, they need to apply their theoretical and practical knowledge, in this way incorporating their problem-solving- and psychomotor skills. This blend of skills equips students to take care of a patient safely. Competency is developed over time as the student progresses through various levels of proficiency and in this way they gain experience.

Clinical educators act as role models to students, since they are the ones that are in close contact with the students every day. As noted by Armstrong *et al.*, (2013:248) and Perry (2009:37) a role model is somebody that meets the expectations of the community in nursing and sets a positive example and is therefore, worthy of imitation. Also, one clinical educator felt that as a role model, she had to inspire students to strive to be the best professional nurses possible. As noted by Elcigil and Sari (2007:492), the most effective trait of a clinical educator is being a good role model to students. As re-itterated by Heshmati-Nabavi (2009:163), clinical educators' skills and expertise make them a role model to the students. In addition, clinical educators must have good interpersonal skills, as such skills represents the persona of a worthy role model. This view was reinforced by another particpant who emphasised the lack of pertinent role models and the resultant need for the clinical educator to fulfil this role.

The participants all mentioned that there are many functions that they fulfil on a daily basis in their role as clinical educators. They mentioned that they have to carry out assessments and identify the outcomes that the students have to reach in order to be able to progress to the next year. In addition, one participant mentioned that adult learning should be incorporated into the programme planning and implementation as well as the evaluation of educational programmes for the student. Additionally, the clinical educator has to ensure that the clinical environment is conducive to learning by making sure that learning opportunities are granted and that practical sessions are scheduled for the executions thereof. Clinical educators need to represent the relevant institutions at higher educational levels and should form part of the development of documents and the accreditation thereof.

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5.2.2 Objective 2: Determining the barriers to a positive clinical learning experience in general and specifically as related to patient care, teaching and learning, administrative- and research responsibilities

The themes emerged from the above objective were discussed and included barriers that comprised of the limited availability and time management concerns, and the involvement of permanent unit staff regarding the education of students.

The allocation of student teacher ratio was mentioned as a barrier by various participants. One clinical educator had about 35 students allocated to her at random times and as the time often overlapped with the different groups in the clinical environment, the number increased. The participants mentioned that there are not enough clinical educators to accommodate the number of students; therefore, the clinical educator struggles to pay attention to all the students allocated to her and to accompany the students in the clinical environment.

The participants were all in agreement regarding the involvement of permanent unit staff in education and felt that there may be staff that are not involved when it comes to the students. Such a situation results in a negative perception from the viewpoint of the students when they enter the clinical environment, as well as during their training. The clinical educators noted that there is a misunderstanding regarding the students and what is expected of them from some staff. It was further noted from the participants that some of the permanent unit staff in the wards might not be aware of the content of the curriculum and cannot help or understand the students. In addition, it was also noted that the behaviour of some of the staff was of such a nature that it may influence the students negatively. Waldock (2010:3) indicated that as a result of increased workloads and limited time available to complete work, permanent unit staff are reluctant to spend time with students in the clinical environment.

In relation to patient care, it was noted by the clinical educators that students' lack of knowledge and experience has an influence on patient care. As explained by the clinical educators, for a patient to receive care, the students need to gain knowledge and experience, which only occur once they have had exposure to the patient. Emanuel and Pryce-Miller (2013:18) indicate that students might not be familiar with

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caring for patients when they first enter the world of nursing, and are likely to experience fear of making mistakes in the clinical environment. This fear might be the result of the lack of knowledge and uncertainty of what exactly the role of the professional nurse entails. Then, of course, when the students have to make the shift from the safety of the simulation laboratory to taking care of a real-life patient, they might feel insecure. They are not sure of what to do and could be scared that they might hurt the patient in the process of taking care of them. It was also mentioned that when students perform procedures, they tend to focus only on one aspect of taking care of the patient and they do not take care of the patient holistically.

The participants (the clinical educators) indicated that according to the rules set out for them, about twenty to thirty minutes should be spent on each student per week in the clinical environment. This time with students is however not allocated in reality, as the clinical educator's time available for students is determined by all the other functions she has to fulfil. In addition, formative assessments are performed throughout the year and, as a result, take up a sizeable "chunk" out of the educator's time. Also, first-year students take much longer to evaluate than the second- or third-years, for example. This lack of time is supported by the findings of Lambert and Glacken (2005:666), who state that classroom priorities, workloads, meetings, time shortages and the pressure of developing professionally are all barriers to the learning opportunities of nursing students.

As participants noted regarding administrative responsibilities, the time-consuming nature of administrative tasks, set out to fulfil the requirements of this function reduces the time available to be spent supervising the training of students in the clinical environment. Participants explained that they have to keep records of everything that is done with the student and that this process is manually done. Often, as noted by participants, interruptions such as planning, or a call, can decrease the quality of time as well as the amount of time spent with the students. Additionally, every conversation, every counselling session and every interaction with the student must be recorded. Griscti *et al.* (2005:88) found, similarly, that responsibilities such as administration and co-ordination of students takes up a large proportion of the clinical educators' time and it impedes their time to spend with the students in the clinical environment.

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Coupled with this lack of time is the lack of resources that hamper the effectiveness of the clinical educator in fulfilling her job functions. The lack of resources, as indicated by participants in one area, identified that they did not have a computer at their disposal. Only recently a computer had been obtained, which made it difficult for the participants, as they had no system to work on, no internet and no communication. As a result of this lack of resources, research skills cannot be adequately developed, which results in the neglecting of research responsibilities. The participants identified that they as clinical educators were not comfortable to engage in doing research, that they did not have the time, but knew that they had a research responsibility. The lack of financial resources limits the educators' ability to fulfil their research responsibility. Simply put, the lack of resources and the time spent on administrative responsibilities, coupled with the time required for teaching have resulted in a neglect of the development of research skills. This view is supported by Mehrdad, Salsali and Kazemnejad's (2008:2194) finding that time is not available to work through research – let alone to carry out research – and find the resources to apply it usefully.

5.2.3 Objective 3: Exploring the enhancers to a positive clinical learning experience in general and specifically as related to patient care, teaching and learning, administrative- and research responsibilities

The exploration of enhancers that could possibly influence the clinical learning experience positively was to attempt to facilitate greater efficiency in the clinical teaching environment. The theoretical knowledge and clinical experience of the clinical educator ensure that gaps are identified, where students need extra attention and guidance. When a nursing student poses a question to the clinical educator the educator has to know what the student is referring to. Clinical educators should at least have two to five years' experience in order to teach students properly and comfortably in the clinical environment.

Participants identified that for a patient to be treated holistically, a student should apply what they have learned in class in the clinical environment. The students are the primary caregivers of the patients and should therefore be able to take care of them. Many times these students fill roles when staff are limited. Such role filling allows for more holistic care of the patient.

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Participants however indicated that often the permanent unit staff are not pleased about the presence of student nurses. In response, participants explained that when there are not enough staff members in the clinical environment, students are there to help. For this reason the student nurses should not be seen as a threat to regular staff nurses, but rather as an additional resource in the provision of holistic patient care.

Clinical educators felt that permanent unit staff should be involved in the students' learning, because the permanent staff work in close contact with the students every day. Participants indicated that the permanent unit staff might not be paying attention to the learning needs of students as they should due to their heavy workloads. As a result there may be no collaboration amongst the students and the permanent unit staff as a result of the workload and the lack of sufficient personnel. The availability of time to spend with the students can be improved by making time available for students to practice their skills.

Smaller groups would contribute towards better management and control to ensure that all students are attended to properly. The use of the simulation laboratory would increase the likelihood of a positive outcome for practical procedures.

The responsibility of the clinical educator in relation to administration is to make sure that all reports related to the student are recorded. Records are kept to ensure that evidence can be presented should it be required.

Improvements on time spent on administration could help clinical educators to focus on the student. One participant suggested deferring administrative tasks to a clerk.

The availability of resources is intrinsic to the education and training of the student. Clinical educators should have resources at their disposal that would enable them to prepare properly for the teaching of students. In turn, students would be taught how to use resources made available to them by the clinical educator.

The responsibility of the clinical educators is to prioritise training first and foremost. If the educators had fewer students assigned to them they could possibly facilitate more effective training. This is supported by the findings of Okoronkwo *et al.* (2013:63), that

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effective clinical teaching is necessary to ensure that knowledgeable and skilful professional nurses are produced, who can deliver safe quality care to patients.

5.2.4 Objective 4: Exploring possible recommendations to facilitate students' clinical experiences in the specific context

The overall response from participants was that they felt that the permanent staff and professional nurses have an educational function to fulfil in the clinical environment. A shift in attitude and behaviour towards students is necessary for students to have a more positive experience when they enter the clinical environment for the first time. When the permanent unit staff include the students and make them part of the learning experience in the clinical environment, the students' ability to successfully carry out their objectives and to practice their skills will be enhanced.

5.3 LIMITATIONS OF THE STUDY

The study was conducted at three undergraduate nursing facilities in the Cape Winelands, Central Karoo and West Coast and included participants working in the public health sector of these areas.

A possible limitation could be the bias or the subjectivity related to the study, as the researcher knows the field very well. Familiarity with a specific field could potentially cause a person, for example, to lead participants in a specific direction or to focus on matters that lie close to the heart of the researcher. This is especially difficult when doing qualitative research in an area known and of great interest to the researcher.

5.4 RECOMMENDATIONS

Section 5.4.1.1, 5.4.1.2 and 5.4.1.3 discusses the recommendations that were made to address the problems identified in the public health sector with regard to the barriers and enhancers as experienced by the clinical educators that influence the value of the learning opportunities of undergraduate nursing students from their first- to fourth year. The recommendations included the resources as identified by the clinical educators to improve clinical facilitation in the hospital environment.

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5.4.1 Teaching and learning

5.4.1.1 Qualification of clinical educator

Only a clinical educator who meets the criteria to educate students in the clinical environment should be in this type of position. In addition, the clinical environment plays a vital role in the education and teaching of the student, in the attitude (positive or negative) of the student, and in a student's outcome. The clinical educator needs to possess the ability to teach the student in the clinical environment and he/she needs to be familiar with this environment and comfortable enough to assist the student to become proficient in the skills they need to acquire to be able to take care of patients (Hickey, 2010:37). Also, the clinical educator needs to be professionally competent, have good interpersonal skills for collaborating with the hospital staff, and be able to teach the students in order for them to become competent skilled nurses that can function independently (Hickey, 2010:37).

As mentioned earlier, the clinical educator should have a postgraduate qualification in nursing education and also enough experience in the specialised field. Williams and Taylor (2008:900) indicated that in order for clinical educators to fulfil their roles, their knowledge of practice must be current and they must maintain clinical competence by spending physical time in the clinical environment, providing care to the patients. The physical involvement of the clinical educator in the clinical environment may ensure that clinical competence is maintained throughout, and that the students are guided by a competent and skilled clinical educator.

5.4.1.2 Job specification

For the clinical educator to fulfil her role and responsibilities, the duties and job specification must be clearly outlined. This may ensure less confusion regarding the duties to be fulfilled and it might ensure that the focus is on the facilitation of the student in the clinical environment, and that less time are spent on other tasks not related to the student. Jowett and Mcmullan (2007:268) found that clinical educators need to be accessible and flexible in their role, making themselves available to the student to support them in the clinical environment. Andrews and Roberts (2003:476) state that the role of the clinical educator entails a person who is supportive in the clinical

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environment, guides the student to competence, and is a good role model and teacher, who has the students' best interest at heart.

5.4.1.3 Group size

Participants confirmed that group size is difficult to manage, as the clinical educator has to rush through demonstrations in order for all the students to be able to practice the skill. Students do not experience enough supervision from the clinical educator to properly master the skill, as time with each student is limited. Students do however have expectations regarding the role of the clinical educator. As it is indicated by Lekhuleni *et al*. (2004:3), students want to spend more time with the clinical educator in the clinical environment. In order for this to happen, more clinical educators are required with the necessary knowledge and experience to be able to assist and guide the students. Furthermore, a smaller group of students should be allocated to a clinical educator, to enable them to properly facilitate and to allow for more time with each student.Additionally, small groups would be easier to plan and manage, as there would be more time available to dedicate to the student in order to practice procedures under supervision.

5.4.2Clinical practice setting

5.4.2.1 Work environment

It was identified by Lambert and Glacken (2005:667) that the work environment is an ever-changing and very challenging area, which requires constant adaptation. As noted by Emanuel *et al*., (2013:20), students learn most effectively when they are supported in the clinical environment by the permanent staff, as well as the clinical educator, which would make them feel part of the team.

The student must learn to adapt and change in this environment. The work environment will improve only if the permanent unit staff embrace the students as part of the ward and support them. Students need to learn and should be given the opportunity to practice their skills in this environment under supervision. As mentioned by Williams and Taylor (2008:34), the clinical learning experience should include opportunities to practice skills, as part of the team. The clinical educator should work together with the ward staff to make the clinical environment more conducive to

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learning for the student, by being more visible and by creating opportunities where the student can learn skills and ask questions.

The involvement of permanent unit staff in the hospital environment can greatly contribute to the students' growth and development. Unfortunately, as a result of circumstances, the permanent unit staff might not pay adequate attention to the students. It is imperative for the clinical educator to build a good relationship with the staff in the hospital, in order to be able to speak with the ward sister at any given time should problems arise. This relationship with permanent ward staff is likely to enhance and help the student to develop and grow in the clinical environment. In order for the student to have a positive experience, the staff, together with the students, should work together as a team and support the students by means of educating them. Students need the support of ward staff in order to be exposed to clinical experiences.

5.4.3 Further research

5.4.3.1 Research

Research plays a positive role in the nursing environment, as indicated by participants, as it contributes to evidence-based practice. Time and resources should be made available to do research. Learning material should be made more available so that students and permanent ward staff can access the material to read up on certain conditions. The reading of material will enhance and broaden their insight and knowledge into patients' diseases. If support were provided by management, clinical educators could more easily engage with research. Therefore, having workshops and time made available would positively contribute to the involvement in research.

5.4.3.2 Undergraduate students

Students are involved in their training and daily interact with the clinical educators, experiencing the potential barriers that influence their training. Exploring this from the viewpoint of the undergraduate student can potentially add valuable information in a study project of this nature. A further recommendation would be to interview students

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regarding the depth of education they require and the language barrier that exist as a result of the educators who do no speak the mother tongue of the student.

5.6 CONCLUSION

In this chapter the findings of the study were discussed in relation to the study objectives.

The aim of the study was to explore the barriers and enhancers as experienced by the clinical educator that influence the value of the learning opportunities of undergraduate students from their first to their fourth year.

Clinical education plays a vital role in the lives of undergraduate nursing students; therefore, the clinical educator may influence the successful outcome of the student in the clinical environment. The clinical environment must be developed in such a way that it is conducive to learning for the student. The clinical educator therefore has an important function of teaching and assessing the student in the clinical environment. However, faced with challenges, students do not always get the opportunity to practice their skills.

Barriers can be overturned into enhancers, as indicated by the respective participants. With the necessary planning, support and structural changes within the role, the clinical educator could greatly contribute to the success of the student in the clinical environment and in the health sector in general.

Further research is recommended as an exploration into the private sector and perhaps the comparison between the public and private sectors can further reflect on the clinical educator and her role in the development of nursing students.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice

Response to Modifications- (New Application)

07-Sep-2015
Shipman, Reinet R

Ethics Reference #: S15/05/119
Title: Barriers and enhancers experienced by the clinical educator that influence the learning opportunities of students.

Dear Ms Reinet Shipman,

The **Response to Modifications - *(New Application)*** received on **04-Sep-2015**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **04-Sep-2015** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **07-Sep-2015 -06-Sep-2016**

Please remember to use your **protocol number** (**S15/05/119**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

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If you have any questions or need further assistance, please contact the HREC office at 219389819.

Included Documents:
CV R Shipman
Checklist
Declaration A. van der Merwe
MOD2_Participant info leaflet & consent form
MOD2_Cover letter_response to modifications
MOD3_Protocol
MOD2_Application form
MOD2_Semi-structured interview guide
MOD_Cover letter_Response to modifications
CV A van der Merwe
Declaration C Klopper
MOD_Interview guide
MOD_CV R Shipman
MOD3_Application form
MOD_Consent form
MOD2_CV R Shipman
MOD_Application form
Application form
MOD3_Cover letter response to modifications
Protocol Synopsis
MOD3_Consent form
Protocol
CV C Klopper
Participant information leaflet & consent form
MOD_Protocol
Declaration R Shipman
MOD2_Protocol

Sincerely,

Ashleen Fortuin
HREC Coordinator
Health Research Ethics Committee 2

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Appendix 2: Permission obtained from Ethics Committee

Western Cape Government
Health

DIRECTORATE: WESTERN CAPE COLLEGE OF NURSING
Julia.Davids@westerncape.gov.za

REFERENCE: PB LETTER
ENQUIRIES: MRS. J.M.DAVIDS

25 SEPTEMBER 2015

MS. R. SHIPMAN

Dear Ms. Shipman,

FEEDBACK FROM THE RESEARCH: ETHICS COMMITTEE

Your proposal and the information that you provided to Dr E. van Wijk has been investigated by the members of the ethics committee.

Permission is hereby granted to you go ahead with your data collection.
We wish you well with your study.

Yours sincerely,

Davids

MRS J.M.DAVIDS
HEAD OF DEPARTMENT: POST BASICS
DEPUTY FOR MRS B. RAFFERTY (HOC)
For
MR. D.GOVIN
DIRECTOR: WCCN
Letters 2015

Klipfontein Road Athlone 7764 Private Bag SURWELL 7762
TEL: 021 6841202 Fax: 021 638 6988

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Appendix 3: Participant information leaflet and declaration of consent by participant and investigator

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

"Barriers and enhancers experienced by the clinical educator that influence the value of the learning opportunities of undergraduate nursing students"

REFERENCE NUMBER: #S15/05/119

PRINCIPAL INVESTIGATOR: Reinet Shipman

ADDRESS: Nr. 34 Viridian Square
Burgundy Estate
Cape Town
7441

CONTACT NUMBER: 071 400 9337

You are invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Feel free to ask the principal investigator any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails, and how you would be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

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This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- The research study is about the clinical educator, her experience of any barriers and enhancers that influence the learning opportunities of students.
- Questions will also relate to patient care, teaching and learning, administrative- and research responsibilities in relation to the barriers and enhancers to the mentioned sub themes.
- You will be asked about the critical aspects of your role as a clinical nurse educator in the facilitation of students.
- You will be asked about possible enhancers that can facilitate students' clinical experience in the specific context.
- The study will be conducted at the hospitals where the clinical educators work; nine participants from three different hospitals will be interviewed. .
- Interviews of approximately 45 minutes each will be conducted with participants and it will be recorded. These recordings will be transcribed.
- Interviews will be conducted in private venues that are comfortable and familiar to the interviewees.
- No use of medication is involved in this study.

Why have you been invited to participate?

- You have been invited to participate in this research study because you are a nurse educator with more than six months' experience in the field under study.

What will your responsibilities be?

- You will be interviewed and asked questions about your experience as a clinical educator in relation to patient care, teaching, learning and research.

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Interviews of approximately forty five minutes each will be conducted with the participants and it will be recorded. The recordings will be transcribed.

Will you benefit from taking part in this research?

- The clinical educators will not personally benefit from the study.
- Hospitals utilising clinical educators may benefit from the study as they would be able to use the research done to improve the quality of nursing and patient care.
- The research may provide insight and understanding into the barriers and enhancers experienced by the clinical educator.
- Clinical educators and hospitals may benefit from the study as it will shed light on the barriers and thus may contribute to the development of enhancers to ensure a positive clinical learning experience.

Are there any risks involved in your taking part in this research?

- Minimal risks are involved for participating in this study.
- There is the possibility that the participants feel upset or uncomfortable and should this occur, referral to a counsellor will be arranged.

If you do not agree to take part, what alternatives do you have?

- You are under no obligation to participate in this study and you can withdraw at any stage should you wish to do so.

Who will have access to the transcriptions of your interview?

- The information collected will be treated confidentially. If it is used in a publication or thesis, the identity of the participant will remain anonymous. Only the researcher and her supervisors will have access to the information. The researcher will keep all information in a locked safe to which nobody else will have access to.

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What will happen in the unlikely event of any form of injury occurring as a direct result of your taking part in this research study?

- There is no likelihood that injury will occur as there are no patients involved in the study and no physical activities are required.

Will you be paid to take part in this study and are there any costs involved?

- No, you will not be paid to take part in the study but your transport and meal costs will be covered for each study visit.
- There will be no costs involved for you, if you do decide to take part.

Is there anything else that you should know or do?

- There is nothing else you should know.
- You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately dealt with.
- You will receive a copy of this information, as well as a consent form for your own records.

Declaration by participant

By signing below, I, …………………………………..…………., agree to take part in a research study entitled "Barriers and enhancers experienced by the clinical educator that influence the value of the learning opportunities of undergraduate nursing students".

I declare that:

- I have read or had read to me this information and consent form, and that it is written in a language in which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.

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- I understand that I may choose to leave this study at any time and that I will not be penalised or prejudiced in any way.
- I understand that I may be asked to leave this study before it has been finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as I agreed to.

Signed at (*place*) .... on (*date*) …………...………. 2015.

....	....
Signature of participant	**Signature of witness**

Declaration by investigator

I, Reinet Shipman, declare that:

- I explained the information in this document to ……………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) .... on (*date*) …………...………. 2015.

....	....
Signature of investigator	**Signature of witness**

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DEELNEMERINLIGTINGSBLAD EN – TOESTEMMINGSVORM VIR NAVORSING TEN OPSIGTE VAN GENETIESE STUDIES

TITEL VAN DIE NAVORSINGSPROJEK:

"Hindernisse en verbeteringe wat deur die kliniese opvoeder ondervind word, en wat die waarde van die leergeleenthede van die voorgraadse studente van hulle eerste- tot hulle vierde jaar beinvloed"

VERWYSINGSNOMMER: #S15/05/119

HOOFNAVORSER: Reinet Shipman

ADRES: Nr. 34 Viridian Square
Burgundy Estate
Cape Town
7441

KONTAKNOMMER: 071 400 9337

U word genooi om deel te neem aan 'n navorsingsprojek. Lees asseblief hierdie inligtingsblad op u eie tyd deur; die inhoud van die navorsingsprojek word daarin verduidelik. Indien daar enige deel van die navorsingsprojek is wat u nie ten volle verstaan nie, is u welkom om die primere navorser of dokter daaroor uit te vra. Dit is baie belangrik dat u ten volle moet verstaan wat die navorsingsprojek behels en hoe u daarby betrokke sal wees. U deelname is ook **volkome vrywillig** en dit staan u vry om deelname te weier. U sal op geen wyse hoegenaamd negatief beïnvloed word indien u sou weier om deel te neem nie. U mag ook te eniger tyd aan die navorsingsprojek onttrek, selfs al het u ingestem om deel te neem.

Hierdie navorsingsprojek is deur die **Gesondheidsnavorsingsetiekkomitee (GNEK) van die Universiteit Stellenbosch** goedgekeur en sal uitgevoer word volgens die

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etiese riglyne en beginsels van die Internasionale Verklaring van Helsinki en die Etiese Riglyne vir Mediese en Genetiese Navorsing van die Mediese Navorsingsraad (MNR) van Suid Afrika.

Wat behels hierdie navorsingsprojek?

- Die studie behels die kliniese opvoeder se ondervinding van hindernisse en versterkers in die kliniese omgewing wat die leergeleenthede van studente beï nvloed.
- Vrae sal gevra word met betrekking tot pasië nt sorg, leer en onderrig, administatiewe- en navorsingsverantwoordelikhede ten opsigte van die hindernisse en versterkers van die voorafgaande sub temas.
- U sal gevra word rondom die kritiese aspekte van u rol as kliniese opvoeder betreffende die fasilitering van studente.
- U sal ook gevra word rondom moontlike versterkings met betrekking tot die fasilitering van studente se kliniese ondervinding in die spesifieke konteks.
- Die studie sal uitgevoer word waar die kliniese opvoeders werk; drie hospitale in totaal en nege deelnemers sal onderhoude mee gevoer word.
- Onderhoude van sal ongeveer 45 minute elk duur en sal ook opgneem word.
- Onderhoude sal in ’n private vertrek gevoer word wat gemaklik en bekend is vir die deelnemers.
- Geen gebruik van medikasie is betrokke by hierdie studie nie.

Waarom is u genooi om deel te neem?

- U word genooi om deel te neem aan hierdie studie omdat u ’n kliniese opvoeder is meet meer as ses maande se ondervinding in die veld wat nagevors word.

Wat behels u verantwoordelikhede?

- ’n Onderhoud sal met u gevoer word rakende u ondervindings as ’n kliniese opvoeder ten opsigte pasiëntsorg, leer en onderrig, en navorsing. Onderhoude van om-en-by 45 minute sal gevoer word met elke deelnemer en dit sal ook

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opgeneem en getranskribeer word. Die onderhoude sal in vertrekke gevoer word wat privaat is, en gemaklik en bekend aan die deelnemers is.

Sal u voordeel trek deur deel te neem aan hierdie navorsingsprojek?

- Die kliniese opvoeders sal nie persoonlik voordeel trek uit die studie nie.
- Hospitale wat gebruik maak van kliniese opvoerders sal baat vind uit die studie deur die resultate te gebruik om die kwaliteit van verpleging en pasiëntsorg te verbeter.
- Die navorsing mag insig lewer rondom die hindernisse en versterkings wat deur die kliniese opvoeders ondervind word.
- Kliniese opvoeders en hospitale kan baat vind by hierdie studie siende dit insiggewende inligting behels rondom die hindernisse in die kliniese omgewing, en kan bydra tot die ontwikkeling van verbeteringe om te verseker dat positiewe kliniese leerondervindinge plaasvind.

Is daar enige risiko's verbonde in u deelname aan die navorsing?

- Minimale risiko's is verbonde aan u deelname in hierdie studie.
- Daar is die moontlikhied dat deelnemers ongemaklik of ontsteld mag raak, indien dit sou gebeur, sal hulle na 'n berader verwys word.

As u nie saamstem om deel tee neem aan die navorsingsprojek nie, watter alternatiewe het u?

- U is onder geen verpligting om deel te neem aan hierdie studie nie en kan ter enige tyd onttrek indien u dit so sou verkies.

Wie sal toegang he tot die mediese rekords?

- Die informasie wat versamel word sal konfidensieel hanteer word. As dit in enige deel van die tesis gepubliseer word, sal die identiteit van die deelnemers nie bekend gemaak word nie. Slegs die navorser en haar studieleiers sal toegang tot die informasie hê. Die navorser sal die informasie in 'n area hou waar dit toegesluit word en geen ander persoon toegang daartoe kan verkry nie.

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Wat sal gebeur indien 'n vorm van besering opgedoen word, as 'n direkte gevolg van u deelname in die navorsings projek?

- Daar is geen kans dat enige beserings opgedoen sal word nie aangesien daar geen pasiënte betrokke is nie en die navorsing geen fisiese aktiwiteite behels nie.

Sal u finansieel voordeel trek uit hierdie navorsingsprojek?

- Nee, u sal nie betaal word vir u deelname aan hierdie navorsingsprojek nie, maar u reiskoste mag moontlik terugbetaal word.
- Daar sal geen kostes verbonde wees aan u deelname, indien u sou deelneem nie.

Is daar enige iets anders wat u moet doen of weet?

- Daar is niks anders wat u moet weet nie
- U kan die Gesondheidsnavorsing Etiese Kommittee kontak by 021-938 9207 indien u enige vrae of bekommernisse het wat nie behoorlik gehanteer is nie.
- U sal 'n kopie van die inligting ontvang, asook 'n toestemmingsvorm vir u eie rekords.

Verklaring deur deelnemer

Met die ondertekening van hierdie dokument onderneem ek, ...…….....................……….....…….. om deel te neem aan 'n genetiese navorsingsprojek getiteld, "Hindernisse en verbeteringe wat deur die kliniese opvoeder ondervind word, en wat die waarde van die leergeleenthede van die voorgraadse studente van hulle eerste- tot hulle vierde jaar beinvloed".

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Ek verklaar dat:

- Ek hierdie inligtingsvorm en toestemmingsvorm gelees het of dat dit aan my voorgelees is, en dat dit in ’n taal geskryf is waarin ek vaardig is en gemaklik mee is.
- Ek die geleentheid gehad het om vrae te stel en dat al my vrae bevredigend beantwoord is.
- Ek verstaan dat deelname aan hierdie navorsingsprojek vrywillig is en dat daar geen druk op my geplaas word om deel te neem nie.

Geteken te *(plek*) .... op *(datum*) ....

....

Handtekening van deelnemer **Handtekening van getuie**

Verklaring deur navorser

Ek, Reinet Shipman, verklaar dat:

- Ek die inligting in hierdie dokument verduidelik het aan ....………..
- Ek hom/haar aangemoedig het om vrae te vra en dat ek voldoende tyd gebruik het om dit te beantwoord.
- Ek tevrede is dat hy/sy al die aspekte van die navorsingsprojek soos hierbo bespreek, voldoende verstaan.
- Ek nie ’n tolk gebruik het nie. (*Indien ’n tolk gebruik is, moet die tolk die onderstaande verklaring teken.)*

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Geteken te *(plek)* .... op *(datum)* ....

....

Handtekening van navorser **Handtekening van getuie**

Verklaring deur tolk

Ek *(naam)* ……………………………………………… verklaar dat:

- Ek die navorser *(naam)* ……….......................................………………… bygestaan het om die inligting in hierdie dokument in Engels/Xhosa aan *(naam van deelnemer)* ……...……………………........................ te verduidelik.
- Ons hom/haar aangemoedig het om vrae te vra en voldoende tyd gebruik het om dit te beantwoord.
- Ek 'n feitelik korrekte weergawe oorgedra het van wat aan my vertel is.
- Ek tevrede is dat die deelnemer die inhoud van hierdie dokument ten volle verstaan en dat al sy/haar vrae bevredigend beantwoord is.

Geteken te *(plek)* .... op *(datum)* ....

....

Handtekening van tolk **Handtekening van getuie**

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Appendix 4: Instrument / interview guide / data extraction forms

<u>Semi structured interview guide</u>

Question 1:

What do you think is the role of the clinical educator when facilitating the students?

Question 2:

2.1 What do you think prevents a positive clinical learning experience in general?

2.2 Can you elaborate in relation to patient care?

2.3 Can you tell me more with regards to teaching and learning?

2.4 Can you tell me with regards to the administrative responsibilities?

2.5 Can you tell me with regards to research responsibilities?

Question 3:

3.1 What do you think can make a positive learning experience better in general?

3.2 Can you elaborate in relation to patient care?

3.3 Can you tell me more in relation to teaching and learning?

3.4 Can you tell me more in relation to administrative responsibilities?

3.5 Can you tell me with regards to research responsibilities?

Question 4:

What do you, as a clinical educator, think can make the facilitation of students' experience in the clinical environment more successful?

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Semi-gestruktureerde onderhoudgids

Vraag 1:

Wat dink jy is die rol van die kliniese opvoeder met betrekking tot die fasilitering van die student?

Vraag 2:

2.1 Wat dink jy verhoed 'n positiewe leerervaring oor die algemeen?

2.2 Kan jy uitbrei met betrekking tot pasiëntsorg?

2.3 Kan jy meer vertel met betrekking tot leer en onderig?

2.4 Kan jy meer vertel met betrekking tot administratiewe verantwoordelikhede?

2.5 Kan jy meer vertel met betrekking tot navorsing?

Vraag 3:

3.1 Wat dink jy kan 'n positiewe leerervaring beter maak in die algemeen?

3.2 Kan jy uitbrei met betrekking tot pasiëntsorg?

3.3 Kan jy meer vertel met betrekking tot leer en onderig?

3.4 Kan jy meer vertel met betrekking tot administratiewe verantwoordelikhede?

3.5 Kan jy meer vertel met betrekking tot navorsing?

Vraag 4:

Wat dink jy, as 'n kliniese opvoeder, kan die fasilitering van studente-ondervinding in die kliniese omgewing meer suksesvol maak?

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Appendix 5: Confidentiality agreement with data transcriber/permission for use of an instrument

CONFIDENTIALITY AGREEMENT

I, the undersigned LEIGH STOREY

1. herewith undertake that all information disclosed or submitted, either orally, in writing or in other tangible or intangible form by Reinet Shipman to me, or made available to me, or details of Reinet Shipman's business or interest of which I may become aware of in respect of transcriptions being done by myself for Reinet Shipman, to keep confidential and not to divulge to anyone for which Reinet Shipman did not give written consent;

2. guarantee that I will apply the information, detail or knowledge in **clause 1** only for the purpose of the intended research;

3. indemnify Reinet Shipman against any claims that may be instituted against Reinet Shipman, amounts that may be claimed or losses that Reinet Shipman may suffer in consequence of a violation by me of any provision included in this agreement.

SIGNED at Cape Town on 12 OCTOBER 2015

____

Witnessed by:

____

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Appendix 6: Extract of transcribed interview

Rec001 Redo (Participant 1)

Spreker Sleutel

RS Reinet Shipman
VS Vroulike Spreker

RS Goeie môre, my naam is Reinet Shipman. Welkom by die onderhoud. Dit is deelnemer nommer een, wat ek gaan die onderhoud mee voer vanoggend. Hoe gaan dit vanoggend?

VS Met my gaan dit baie goed, nadat ek ʼn lekker rustige naweek gehad het. Weer terug op my pos, my posisie, as *clinical educator* by die hospitaal by die studente.

RS Sê gou vir my, hoe lank is jy nou al ʼn kliniese opvoeder?

VS Sedert 2010 het ek in die veld inbeweeg, tot en met vandag en hierdie datum. So dis 2015, so dis basies nou vyf jaar wat ek nou in die veld is.

RS *Okay*, en geniet jy dit baie?

VS Ek geniet dit baie, want dit is my hart-klop en dit is my passie. Dit was nog al die pad my droom om studente te kan mentor. Veral, ek is ʼn baie praktiese mens, en dit is hoekom ek dit so geniet, want ek kan my ervaring wat ek deur die jare opgedoen het, kan ek nou aan die studente oordra.

RS *Okay*, dit is fantasties!

VS En ek geniet dit geweldig. Ek geniet dit, dit is vir my ʼn liefde, en daar is nie eintlik vir my tyd verbonde aan. As ek besig is met die studente dan raak ek weg, dan vergeet ek ek moet van af diens af gaan.

RS Dis lekker.

VS Baie lekker. Ek geniet dit geweldig.

RS Dis lekker as ons sulke mense in die beroep het.

VS Ja nee, dit is my passie, en ek moes al afgetree het. Ek is nou al 60 jaar oud, maar ek voel dit wat ek nog het, kan ek mos nog steeds ʼn student begelei en mentor, en ek sal graag wil sien dit wat ek geleer het, en waarvandaan ek kom, dat daardie selfde beginsels en waardes en norms, ook die vaardighede, dat die studente dit kan vat en daarmee kan "aanhardloop". Soos ek ook gesê het vir die studente as ek met hulle ʼn praatjie hou, ek wil graag die baton afgee, maar ek wil ook weet vir wie gee ek dit af, en ek gaan ook baie trots voel as ek die dag uitstappe doen, verpleging, dat ek weet daar is iemand buite wat geleer het wat ek vir hulle geleer het.

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RS Dis goed, dis baie goed. *Okay*, so ek gaan nou die onderhoud begin, en my eerste vraag aan jou, en ek gaan in Afrikaans die onderhoud voer, want jy is mos gemaklik met jou Afrikaans eerder, nè?

VS Ja.

RS Goed. Die eerste vraag dan, wat dink jy, in jou opinie, is die rol van die kliniese opvoeder? Met ander woorde, wat dink jy doen sy, wat moet sy doen, hoe moet sy te werk gaan, wat is haar rol? Wat sien jy dit as?

VS Ek sal sê die rol van 'n *clinical educator* is om deelname te hê in die ontwikkeling van kliniese standaarde, ook haar *input* te kan gee wanneer daar protokolle of beleide opgestel word. Indien ons as *clinical educators* 'n leemte ervaar, dan kan ons ook deelname hê in die ontwikkeling van standaarde wat dan geïmplementeer kan word in die kliniese omset in die hospitaal.

RS *Okay*, met ander woorde, dinge kan aanpas byvoorbeeld?

VS Dinge kan aanpas, dat ons dit beter kan doen, want dié manier werk nou nie meer uit nie, dan kyk ons nou om 'n ander plan in aksie te sit, om ook dan deelname te kan hê saam met hulle wat nou die reëls opstel.

RS Is daar nog iets wat jy dink oor die kliniese rol wat nog kan bydra of wat dit nog behels?

VS Ek dink ons het ook 'n rol in die *simulation lab* om die student daar te oriënteer, en die student daar bloot te stel. Dit is hoe ons byvoorbeeld 'n demonstrasie doen, dan doen ons hom eers in die *simulation laboratory*, en ons skep 'n *environment* in die *sim lab* sodat die student min of meer 'n idee het, sodat die student in die praktyk kom, dan het die student alreeds 'n voorsmakie gehad van hoe dinge gedoen moet word.

Ons gaan nie sommer direk na 'n pasiënt toe en daar die demonstrasie doen of op 'n pasiënt nie. Ons werk eers vanaf die *sim lab*, sodat die pasiënt nie so, dat dit nie so iets nuuts is as die pasiënt in die praktyk inkom nie. So ek dink dit is ook belangrik dat 'n mens eers die student oriënteer.

RS Om hulle gemaklik te maak?

VS Om haar of hom gemaklik te maak, en voor te berei vir wat van hulle gaan verwag word as hulle in die kliniese area inbeweeg, want daar is 'n groot verskil om op die kollege te wees en om in 'n klas te sit, en dan nou skielik in 'n professionele hoedanigheid in te beweeg in 'n hospitaal, want daar is baie reëls en regulasies wat hulle moet dan kan aan *abide*. Ek dink as mens hulle, ons rol moet ook wees om hulle voor te berei wat van hulle verwag word in die praktyk, *and how to behave themselves, how to conduct themselves in the clinical environment*.

Ek sal ook sê ons as *clinical educators*, ek praat nou van in die praktyk, ons rol moet ook wees om die leemte van die student te kan identifiseer, en om dit te kan waarneem, en hoe kan ek sê, om dit nou te kan *adress* en die student aan die hand

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te kan vat, waar jy ʼn leemte identifiseer, en dan die student dan *coach* and *guide*, om die ding dan reg te doen, want as ʼn student wat mos nou gelei word, wat niks geweet het nie, van die onbekende, en om die student te kan vat na die onbekende sodat die student ook daardie vaardigheid kan hê, want dit kan nie oornag gebeur nie.

ʼn Vaardigheid moet geoefen word, en dit is ook my rol dat die student baie praktiese, *practical*, te oefen, te oefen, te oefen totdat jy kan sien die student is op ʼn *competency level*. ʼn Mens moet die student kan bring na *competency* toe. Ons werk is ook om rekords te hou, baie belangrik om *evidence-based* te wees. So met elke besoek moet die student *accompany*. Ons praat van ʼn *clinical accompaniment*, om daar te wees, want dit is hoekom ek aangestel is; om die student te kan *accompany* in die hospitaal, en dan my administrasie; alles wat ek doen met die student, wat ek met die student gepraat het, moet ek kan dokumenteer dat ek *evidence* het, dat ek by die student was, ons het daaroor gesels, en die student se vordering kan monitor.

Ek moet ook die student kan *assist* in *lifeskills*, want baie van ons studente kom uit die skool uit, hulle het nog geen ervaring van die lewe nie, daar is baie *lifeskills* wat hulle nie het nie, en mens *observe* onmiddellik die *shortcomings*, en dan moet jy daardie student dit ook leer. Jy moet hom dissipline leer, en jy moet hom leer hoe praat ʼn mens, hoe praat ons oor ʼn telefoon, hoe adresseer ons medekollegas, hoe praat ons met senior personeellid. So daar is baie leemtes wat ons as *educators* moet vervul om die student op daardie vlak te bring, waar die student kan ontwikkel, want as ons praat van professionele ontwikkeling, dan is dit my, ons werk om te sien dat die student ontwikkel, en nie die student aan haar eie lot oor te laat nie.

Ons moet ook die student kan monitor, haar aktiwiteite in die saal, sou daar klagtes kom van die *unit managers* of die susters, dat ons dit op daardie vlak kan oplos, en die student op ʼn mooi manier benader. Dis maar ook ons rol, want ʼn student, ons het mos ʼn, hoe sê mens, ʼn *disciplinary code*, waar as studente nou nie hulle gedra het *according to* die reëls nie, dat ons hulle kan dissiplineer. Maar ek dink nie die dissipline gaan daaroor om hulle te straf nie, maar dis om vir hulle nou reg te trek sodat hulle ook nou kan aan die einde van die dag, van die vier jaar, dan kan uitstaan as professionele verpleegkundiges.

RS So julle *mould* hulle, en julle ontwikkel hulle om te groei tot daardie punt.

VS Ons ontwikkel hulle om te groei. Dissipline is baie belangrik. Ons het ʼn *transgression* waarvolgens ons hulle *discipline*, en as daar enigsins aan ons gerapporteer is dat die student se gedrag, of byvoorbeeld die studente was afwesig sonder kommunikasie, het ons ʼn *code* waar ons die student dan inroep met ʼn *witness*, en ons *counsel* die student en ons verduidelik aan die student dat dit nie toelaatbaar is nie.

ʼn Mens stel jou saal in kennis, jy was afwesig sonder kommunikasie, en daardie is nou ʼn *minor offense*, en ons wil graag hê dit moenie weer gebeur nie, want ons lui u nou op as ʼn professionele verpleegkundige, en u gaan dan oor vier jaar ʼn saal vat, en hoe gaan u voel as u personeel nie opdaag nie. So u moet van die begin af leer, ons

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kommunikeer. Met ervaring sien ek dat dit baie help, want die studente wil nie graag vir ses maande daardie dissipline op sy rekord hê nie. So, daar is darem verbeteringe.

RS Hulle voel dat dit vir hulle ŉ verleentheid is, basies, as ek dit so kan stel. Is dit reg, as ek dit so sê?

VS Ja, ek sal sê hulle besef nie die belangrikheid van die professie nie. Hulle besef nie dat ŉ mens, dat gedrag so ŉ groot rol speel nie. Maar hulle verwelkom dit. Dit hang ook af van die manier hoe ons die student *counsel*, of die manier hoe hy ge-*discipline* word. Ek praat gewoonlik uit my hart uit, en ek praat asof ek met my dogters praat, of my seuns praat, en ek bring terug waarvandaan die pad ek kom, en waarvandaar staan. Dit is hoekom, ongelukkig moet ons maar die streep trek en maar die toutjies styf span, dat hulle nie kan aan die einde van die dag, verstaan, dan nou kan ontwikkel in dit waarin ons hulle oplei. Ons het mos ŉ opleidingsbeleid.

RS Ja, dis reg. So, net ter samevatting dan wil ek net gou weer seker maak dat ek alles daar reg verstaan. Jy't gepraat oor deelname, jy't gepraat oor die leemtes was julle identifiseer. Dan het jy gepraat oor die *coaching* en *guiding*, en die oefening van vaardighede, voordat hulle in realiteit in die praktyk gaan. Met ander woorde, in die *sim lab,* wat julle vir hulle leer. Ook julle kliniese *accompaniment* wat julle toepas, ook met betrekking tot hulle leefstyl, of hulle *life skills* wat julle vir hulle leer, hoe hulle moet optree in die professie, want hulle kom natuurlik rou van die skool af. So dis ŉ ander wêreld waarin hulle isntap, nè?

Die dissipline wat julle vir hulle leer, hoe julle hulle ontwikkel op die ou end van die dag, hulle aktiwiteite wat gemonitor word om aan die einde van die dag hulle kompetent te bevind, en dan die manier van kommunikasie, hoe hulle moet kommunikeer, hulle gedrag, en dan hoe hulle opgelei word. Is dit wat ek ter samevatting kan sê?

VS Ek sal net daar byvoeg, as ons praat van die rol van die *clinical educator* sal ek sê ek moet ŉ rolmodel wees, want hulle moet na my kan opkyk.

RS Dis reg ja.

VS My manier van praat, my hele *conduct*, my [onduidelik 00:12:40] speel ŉ belangrike rol, my voorkoms speel ŉ belangrike rol, en my *body language*, want dit is die dinge waarna hulle kyk, en hulle *adapt* dieselfde styl, en dan sê baie, "O Suster, ek sal graag soos Suster wil wees eendag, want Suster is altyd netjies; hare is altyd op sy plek." Verstaan?

RS Die voorbeeld wat jy vir hulle stel, hulle vat dit, hulle sien dit.

VS Hulle vat dit ja, en hulle wil graag ook so wees. So dis belangrik dat ons as *educators* ŉ goeie rolmodel moet wees sodat hulle kan opsien na ons. Ons moenie onbeskof praat met ŉ student nie. Ons *ways* van ons dinge doen, ons moet kennis ook *updated* hou sodat *whatever* ek demonstreer, moet ek korrek demonstreer. Ons

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word so dopgehou, dat die student doen presies soos jy dit vir hom demonstreer. Ek kan ŉ staaltjie vertel. Kan ek maar praat?

RS Yes, reg.

VS Toe ek nou die twee jaars gevat het in ŉ *septic technique*, nou, daardie is my veld, *washing of hands, gloving*, en hoe om ŉ wond nou op ŉ septiese manier skoon te maak, en hoe jy jou *equipment* oopmaak, en hoe jy *glove*, en al die aksies. Nou, elke aksie wat ek vir hulle wys soos ek, beweeg, toe hulle eksamens gedoen het, dan sê die *educators*, die evalueerders, jy kan sommer sien dis Mercy, hier kom Merc deur, want hulle doen presies, soos ek my hande hou, soos ek my *conduct*, soos ek van my trollie afstaan, want hulle het dit so geleer, verstaan, hoe hulle daardie *glove* insit, hoe hulle die een handjie so voor hou, hou die ander handjie so, maar presies net so.

So dis baie belangrik, die studente hou vir ons dop, en presies soos wat ons vir hulle wys, so doen hulle dit in die praktyk, en as hulle verkeerd gewys word, dan gaan hulle dit verkeerd doen. So dis belangrik dat ons, ek, moet weet wat ek doen, en my *knowledge* moet ten alle tye *updated* wees.

RS Okay, en hoe *update* jy jou *knowledge*?

VS Ek *update* my *knowledge* deur op hoogte te wil bly met wat is die nuutste tegnologie. Dinge verander, en dinge word nie meer gedoen soos 20 jaar terug nie.

RS Dis reg ja.

VS Dan doen ek ook navrae by Worcester Hospitaal, *clinical educator facilitator*, ek sien in die sale doen hulle die wonde op so ŉ manier, want ons doen mos die wonde so, wat is die verskil, wat het dan hier gebeur, en dan gaan ons na die *protocols* toe, en ons woon dan inligtingsessies by, sodat ŉ mens op hoogte kan bly met die veranderinge.

RS Dis reg. *Okay*, goed. Die volgende vraag dan, wat dink jy, in jou opinie verhoed ŉ positiewe leer ervaring oor die algemeen? Wat voel jy oor die algemeen, as jy oor die algemeen dink en jy praat, wat verhoed dit dat die ouens, die studente in die praktyk, as hulle in die praktyk gaan, wat verhoed daardie positiewe leerervaring? So wat maak dit dat daar nie ŉ positiewe leer ervaring plaasvind nie?

VS Ek sal sê as daar nie samewerking is nie, dit breek die student se moed, want die *permanent staff* het die neiging om, sodra hulle sien daar is studente, dan skyf hulle ŉ bietjie uit, en dan kan die student nie dit doen wat die student graag moet doen nie, want dit is ŉ student wat nog baie stadig die ding korrek doen. Maar as gevolg van die permanente *staff*, jammer dat ek aanmekaar permanente *staff* moet sê, is daar ŉ groot *absenteeism rate*, en dit maak ook dat die student nie ŉ *positive learning experience* kan hê nie, want die student kan nie doen wat die student moet doen nie.

Daar is verkeerde rolmodelle in die saal. Die studente kry nie die korrekte *guidance* nie. Daar is baie minder onderig vanaf die saal *staff* self, en die student moet maar nou so op sy eie aangaan, en ons kan nie 24/7 in die saal wees om die student van

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die oggend af te begelei tot vanaand sewe uur toe nie. Ek sal ook sê wat ook kan verhoed, is nou die tekorte in die saal. Daar is baie dae wat jy in die saal kom dan is die handdoeke op, die lakens is op...

RS Die bronne wat daar is, wat daar moet wees.

VS Die bronne wat daar moet wees is nie daar nie. Die *dynamaps* is dalk stukkend, die *thermometers* werk nie, die *equipment* is stukkend. So dit is ook wat ek sal sê verhoed dat die student, verstaan, *'n positive learning experience* kan hê, en dan natuurlik die houding van die dokters. Die dokters is ook baie keer baie onbeskof. Dit skrik die student baie af. Die student het nog nie daardie vrymoedigheid om met die dokter, of *even* met die suster te praat nie.

Ek dink die suster, soos ek vir die studente ook sê, jy moet kan besef wat beteken dit om in beheer te wees. Ons lei julle op as die suster in beheer van 'n saal, en as jy in beheer van 'n saal is, is jy in beheer, en jy moenie *allow* dat 'n ander persoon in jou saal kom en hier kom reëls maak wat nie inlyn is met die *protocol* of die beleid van die saal nie. So daar is baie faktore wat 'n rol speel ook.

Ek dink as die *unit manager* nie *approachable* is nie, en sy het nie 'n manier om met die student te praat nie, of sy het nie daardie gevoel nie, kan dit ook verhoed dat die student positief kan leer, want die student is mos nou te bang om vir die suster iets te vra, want die suster se manier van praat, daar is 'n manier hoe 'n mens 'n student benader. Sou 'n student lelik praat, of die *attitude* is nie reg nie, glo ek is dit die suster se verantwoordelikheid om die student aan die hand te vat en vir die student in die privaat uit te sorteer.

RS Ja, want sy is die leier van die saal.

VS Sy is die leier van die saal, sy moet haar funksie vervul. As sy haar funksie vervul, dan dink ek sal daardie student ook, want die student voel maar net sleg, as die student 'n fout gemaak het, die suster praat nie met die student nie, die suster bespreek dit dalk met die *permanent staff*. Nou kom dit by die student uit, dan sny die student af. Ek praat nou uit ondervinding, en ek praat van ervaring. Dan moet ons nou weer die stukkies gaan optel om daardie student weer *positive* te maak, want sy is net af ge-*shut*, en sy wil maar net klaarkry, en nou het sy 'n *attitude* want die suster het 'n *attitude*, want waar kom dit vandaan? Ek voel die student is mos nog nie 'n suster nie.

RS Dis reg, ja.

VS So, in my opinie sal ek sê die suster wat al klaar opgelei is moet haar rol vervul in die saal. Dis hoekom sy die suster in beheer is, en dis wat ek wil verhoed in hierdie spanne wat ek nou oplei, om nie dieselfde foute te maak nie. Ek sê altyd vir die student, die fout wat die suster maak moet vir julle 'n leergeleentheid wees, en jy moet vir jouself kan sê ek sien wat Suster doen, maar sê vir jouself, ek wil nie daardie fout maak nie, want ek weet hoe voel ek as die suster vir my nou so antwoord. So ek sal nie 'n student so antwoord nie, want ek weet wat dit aan my doen, jy sien?

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RS Ja. *Okay*, is daar nog iets wat jy daar wil sê oor die algemeen, of is dit reg?

VS Ek sal sê dis mos nou die verkeerde rolmodel, absenteeism, dit speel 'n rol, daar is nie samewerking in die saal nie. Daar moet 'n goeie *harmony*, daar moet 'n goeie gees wees, ja. Die atmosfeer speel ook 'n belangrike rol in die saal. Die student moet kan voel, "Man, ek wil vandag kom werk!" Maar as daar nie 'n goeie atmosfeer is nie, as daar 'n somberheid is in die saal, verstaan jy, en 'n hele geskindery en lelikpraat of geskreeu in die gange, dan is dit ook 'n negatiewe iets wat 'n invloed op die student het.

RS Goed, *okay*, baie dankie. Reg, so teropsomming, net gou van daardie eerste gedeelte, dit gaan oor die samewerking van die personeel, die permanente personeel wat nie in die saal is nie, of wat hulleself uitskuif omdat die studente, hulle sien die studente staan, hulle weet die studente moet leer en hulle moet die goed doen, en wat hulle nie kans kry om te doen nie, as gevolg van die permanente *staff* wat net die goed aan hulle oorlaat om te doen nie, en dan ook die verkeerde rolmodelle, die suster in bevel se houding, en hoe sy die studente benader, en haar funksie vervul deur die student ook welkom te laat voel in die saal, nè?

Dan ook dat die student nie dieselfde foute maak soos die suster wat in bevel is nie, sodat hulle nie eendag soos sy is nie, dat hulle weet wat dit aan hulle doen en hoe hulle voel op die ou end van die dag, nè?

VS Ja.

RS Goed, ons volgende vraag dan, as jy kan uitbrei met betrekking tot pasiëntsorg, wat verhoed 'n positiewe leerervaring met betrekking tot pasiëntsorg?

VS Wat verhoed 'n positiewe leerervaring?

RS Ja, met betrekking tot pasiëntsorg. So wat maak dat daar nie 'n positiewe leergeleentheid plaasvind vir die student, wanneer dit by pasiënt sorg kom nie?

VS Ek sal sê as die student moet die pasiënt holisties benader, want as die student nie die pasiënt se status ken nie, die student moet weet was is die pasiënt se mediese diagnose, sodat die student die pasiënt mos nou kan verpleeg *according* die pasiënt se mediese diagnose. Die student moet *okay* die history van die pasiënt ken, die agtergrond, sodat die student 'n beter begrip kan hê teenoor die pasiënt.

Die student moet weet as hy/sy na die pasiënt se lêer toe gaan, watter ondersoeke is gedoen op die pasiënt; , Mevrou was vir 'n *scan* weg, of die pasiënt moet nou 'n *social worker* sien, of die pasiënt gaan vir 'n *gastroscopy*, sodat die pasiënt ingeligte kennis het wat op hom/haar wag en wat gedoen gaan word. Ek dink dis baie belangrik dat die pasiënte ingelig word, en nie net gesê word of hulle prosedure gedoen word nie, maar verduidelik aan die pasiënt wat nou gedoen gaan word.

Dis ook belangrik dat die student moet weet wat sy/haar *gut feeling* rondom, sê nou die pasiënt is 'n hipertensie pasiënt met 'n hoë bloeddruk, dan moet die student die

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pasiënt kan *educate*, en sê, "Mevrou, dis baie belangrik dat u u medikasie neem." Die voorligting is ook belangrik, dat die pasiënt die regte voorligting kry, verstaan?

RS En as ’n student nie daardie voorligting kan gee nie, dan het hulle miskien nie daaroor opgelees nie?

VS Ja, so die student moet ook op hoogte wees van die pasiënt se siektetoestand. Akademies moet die student weet wat sy doen, en vir wie sy verpleeg, want as sy nie die geskiedenis van ’n pasiënt ken nie, baie pasiënte is emosioneel, baie pasiënte gaan deur egskeidings, baie pasiënte is *addicted* to *whatever*, maar as sy nie die geskiedenis ken nie, dan hoe gaan sy ’n pasiënt benader? So daar moet ’n *compassion* wees, en nie net *judgementalness* nie.

Ek dink hulle leer in psigiatrie ook hoe om die pasiënt se optrede te verstaan, want as jy die optrede verstaan en jy ken die siekte toestand, dan sal jy verstaan, dan sal jy nie onbeskof met die pasiënt praat nie, want jy verstaan meer, jy ken mos nou haar verhaal. Ek sal sê dit kan ook verhoed dat die pasiënt nie die sorg kry wat hy moet kry nie, en die kennis wat toegepas moet word, en as ons nie die pasiënt, soos ek sê, in totaliteit verpleeg nie, dan mis ons die bal.

RS Goed, baie dankie. Met betrekking tot onderrig en leer het jy al so stuk-stuk uitgebrei daaroor, maar wat verhoed daardie positiewe leer geleentheid ten opsigte van onderrig en leer?

VS Ek sal sê kennis moet *updated* wees.

RS So as hulle nie die kennis het nie, dan kan hulle nie, ja, dan vind dit nie plaas soos wat dit moet nie.

VS Ja, en die aanbieding, ek sal sê dit wat aangebied word, moet op so ’n manier aangebied word dat die student kan verstaan ’n mens lees nie net uit ’n boek uit nie, of ’n *slideshow* en net *bullet points* nie. Uitbrei en gebruik eenvoudige, fisiese voorbeelde, demonstreer vir die studente, wys die koppie, wys dit en dit en dit, dat die student dit kan snap en kan onthou, en ek dink die student sal dit nooit vergeet nie. Dis die manier hoe dit aangebied word, wat die student gaan baat vind.

Ons het 80% *mentoring* kapasiteit in die hospitaal, en ons het 20% klas gee, so ek dink die groter polis in die hospitaal om die studente reg te kan leer, dat hulle die prosedures reg sal doen, soos dit gedoen moet word, en nie die *shortcut* vat nie.

RS Goed. Is daar nog iets wat jy daar wil byvoeg, wat dit verhoed?

VS Ek sal ook sê *learning*, ’n mens moet jou kennis, ek moet my feite ken. As ek vir studente uit die boek uit meedeel, of prakties, dan moet ek weet wat ek doen. Ek moet my werk ken, en ek moet my *knowledge update* ook, en ek moet voor die tyd, ek moet vir my goed gaan voorberei. Jy kom nie onvoorbereid na ’n klas toe nie, ook nie in die *sim lab* of wanneer ons ’n demonstrasie doen in die hospitaal, moet jy ten volle voorbereid wees, en die prosedure moet korrek gedoen word sodat die student kan sien dit is hoe Suster daardie trollie gepak het, en dis hoe Suster dit gedoen het,

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want alles was daar gewees, en nie ŉ "halfpad ding" nie, want die student gaan presies dieselfde doen.

RS *Okay*, goed. So met betrekking tot onderig en leer gaan dit oor kennis, aanbieding, uitbreiding, gebruik van fisiese voorbeelde, nie net uit ŉ boek uit lees byvoorbeeld nie. So dit gaan oor daardie hele aspek van hoe jy dit kan kry vir die student om te leer, en as dit nie so plaasvind soos wat jy gesê het nie, dan vind daardie leer nie rêrig so plaas soos wat dit moet nie. Studente neem dit nie so in nie, nè?

VS Ja, mens moet voorbeelde noem, dat die student kan onthou. Soos byvoorbeeld, ek sal net ŉ voorbeeld noem, ŉ mens raak deurmekaar met *diastolic* en *systolic*, nou verstaan hulle nie, ek het gehoor onder mekaar. Nou sê ek vir hulle dink net aan *systolic is up in the sky*, S is die boonste, en die *diastolic is down, down, down*. Nou wys ek vir hulle, *S up in the sky, systolic, and the D is the down, down, down*. Nou weet hulle, Suster het gesê S is *systolic*, die boonste getal is 180, daardie D, *diastolic*, dis onder, hy is 80.

RS Okay, so hulle kan identifiseer daar.

VS Nou onthou hulle hom!

RS Okay, so hulle het iets waaraan hulle dit kan heg.

VS Hulle het iets waaraan hulle dit kan heg, ja, en as ons praat van *systolic* en *diastolic*, want hulle moet die waardes vir my kan sê as hulle die bloeddrukke doen, dan sê hulle, "Suster, dan kom dit minder," want hulle het dit geleer, en tot vandag met my vierde jaar studente kan hulle nog sê, "Suster, in die eerste jaar het Suster vir ons gesê *systolic is sky* en *diastolic is down*, so *systolic* is die boonste en *diastolic* is die onderste." Dit is sekere goed wat ŉ mens maar net vir hulle kan deurgee om hulle te help om beter te kan verstaan. Hulle moet verstaan waaroor dit gaan.

RS Ja, dit help nie as hulle nie verstaan nie.

VS As jy *understanding* het en jy snap hom, want hy moet in die brein vasgelê word. Jy moet hom so deurbring, dat hy verstaan wat ek sê.

RS Dan kan hulle dit toepas.

VS En op ŉ baie plat, eenvoudige manier. Hulle moet ons hou uit die boeke uit, want eers uit die boeke, dan gaan lees ek dat ek hom kan verstaan, sodat ek hom so aan ŉ student kan leer, maar ek gaan nie uit die boek lees nie, en dan verstaan ek ook nie, en die student verstaan ook nie. *So I must come to an understanding so that they can understand*. Ek moet dit so deurbring dat hulle my moet verstaan, waarvan ek praat [lag].

RS Goed, *okay*, dankie. Goed, die volgende vraag gaan oor administratiewe verantwoordelikhede. Wat verhoed daardie positiewe administratiewe verantwoordelikhede? So wat verhoed dat daardie administratiewe verantwoordelikhede plaasvind?

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VS Ons het baie min tyd, want dis mos *time-consuming*.

RS Dis reg, ja.

VS Want vir elke gesprek wat jy met die student voer moet jy dit dokumenteer, en ons het nie altyd die tyd om, want jy het nie net die funksie van *coaching* nie, jy is die maatskaplike werkster, jy is die *counsellor*, jy moet die *deficit* ure uitwerk, hulle het nie kom werk nie, jy moet daardie dokumenteer.

RS En julle doen dit alles self?

VS Ons doen dit alles self, ja, en julle moet dit rapporteer aan die *HoD*, en jy moet rapporteer aan die *subject head*, en dis mos nou nie net een student nie, elke saal het sy kapasiteit van studente, en jy moet in die, ons het 'n *progress*, 'n *progress* boek van die student, en alles wat ons met die student gepraat het, moet ons in die boek kom skryf.

RS Ja, dis tydsaam.

VS Wat het ons gedoen met die student wat ons gaan inskryf. So alles moet gedokumenteer word dat ons *evidence* het. Ons is baie op *evidence-based*, daarom moet ons akkurate rekordhouding hê van elke iets wat gebeur het, of wat die student vir jou gesê het, of as die suster gekla het, dan moet jy dit maar neerskryf, want 'n mens kan nie alles onthou nie. Maar dit is baie *time-consuming*. Baie administratiewe verantwoordelikhede, en dit vat baie van ons tyd in beslag.

RS So dit verhoed ook dat julle, die tyd wat julle by die student...

VS Ja, die tyd wat jy aan die student kan *spend*, dis dalk minimaal want jy het 'n klomp studente wat jy moet deurvat, plus jy het nog administrasie werk ook, en die dag gaan mos maar gou om. Mens moet die tyd *cost-effective* kan gebruik.

RS Goed, *okay*, en dan met betrekking tot jou navorsingsverantwoordelikhede, wat verhoed dat daar positiewe, ja dat navorsing verantwoordelikhede kan nagekom word?

VS Wat verhoed dit nou?

RS Wat verhoed dat daar navorsing kan plaasvind? Sê maar van jou kant af, of voel die studente of so?

VS Dit kan ook wees dat 'n mens het nie, soos ons het nie toegang tot die internet nie, en dit is nogal 'n groot leemte. Ons sukkel mos nou al hoe lank al, nou moet 'n mens nou jou tyd gebruik, want jy moet kollege toe ry om daar die internet te gaan *search*.

RS So dis tyd wat jy op die pad spandeer wat lank vir jou vat om eintlik te kan navors wat jy moet.

VS As jy biblioteek toe gaan om 'n boek daar te gaan kry, want ons het nie *desk copies* nie, en dit is nog 'n leemte wat ons aan werk, wat ons vra dat ons *desk copies*

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moet kry, sodat ons in ons kantoor die *resources available* het om dan die navorsing te doen. En ons se tyd is mos maar min, maar ons weet dit is deel van ons werk om navorsing te gaan doen. As ons sien iets werk nie in die praktyke nie, wat gaan ons nou doen om hom beter te laat werk, en dit neem tyd. Daar is baie tyd daaraan verbonde.

RS *Okay*, so daar is nie eintlik baie tyd vir die navorsing nie?

VS Daar is nie baie tyd vir navorsing nie.

RS En dit is ook nie op dieselfde perseel as waar jy moet werk en waar jy moet gaan, jou bronne en goed is op ŉ ander perseel.

VS Ja, ja.

RS En dit vat tyd om daar uit te kom.

VS Dit vat tyd, ja.

RS *Okay*, dankie. Die volgende vraag gaan oor wat dink jy maak ŉ positiewe leer geleentheid beter in die algemeen? So, wat maak dit positief? Wat maak dat ŉ positiewe leergeleentheid beter gemaak kan word oor die algemeen? Hoe kan ŉ mens dit verbeter?

VS Ek sal sê *assertiveness*, ŉ mens moet kan praat op ŉ regte manier. ŉ Mens moet die leemtes kan aanspreek, die vrymoedigheid het om daaroor te praat en dit te *discuss* met die *unit manager* op ŉ baie professionele manier. Ja, dit wat ŉ mens identifiseer wat ŉ hindering is vir die student, die student moet ook aangespreek word, om die student se kennis byvoorbeeld rondom die mediese diagnose, die student moet dan gaan leer.

Ons moet nie die student *spoon-feed* nie, want jy gee die student opdragte en jy gee die student huiswerk sodat jy môre terugkom, dan verwag jy die student moet kan naslaan werk ook gaan doen om dan terug te kom met die kennis wat jy van die student verlang.

Soos ek ook rondtes doen, dan wil ek weet, die student moet my kan vertel van die pasiënt se diagnose, en as die student dit nie weet nie, dan sê ek gaan soek dit vir my op, en dan die patofisiologie van daardie met die diagnose wil ek graag weet, en dan moet jy môre weer ŉ draai kom maak, want ek is nie die student nie, ek moet jou kennis net toets en kyk of jy die goed praat, sodat ek kan weet. Maar ek wil van jou af weet, dat sy op datum is, en dat sy weet, sy moet mos nou weet wat van haar verwag word.

RS So dis nie net jy wat dit oordra, die kennis nie, sy moet haar kant bring.

VS Ek sal my deel doen wat ek moet doen, en van daar af moet die student self verantwoordelik wees om te gaan leer, dat sy haar kennis kan verbreed en opskerp.

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RS Goed, dankie. Dan met betrekking tot pasiëntsorg, so wat kan pasiëntsorg daar rondom dit positief maak? So, watter positiewe, omtrent pasiëntsorg, maak dat daar ŉ positiewe leergeleentheid plaasvind?

VS Ek dink die student moet dit wat sy in die kollege leer, die akademie, moet sy kan kom toepas in die kliniese afdeling, want as sy haar knowledge kan apply, dan sal sy mos beter verpleegsorg vir daardie pasiënt kan gee. Maar as sy nie haar *knowledge* en haar *skills* kan apply nie, dan gaan daar mos ŉ leemte wees. So as sy dit op datum het, dan het ons ŉ baie beter uitkomste, want ons moet kyk dat die student, hoe sê mens, *will meet the outcome*.

RS *Okay, the criteria*.

VS Ja, daar is sekere uitkomste wat hulle moet bereik, volgens SANC se reëls. Nou, ons moet toesien dat die student, dié moet uitkomsgebaseer wees, sodat ons op ŉ kompetensie kan kom. Sy sal nie gebring word tot *competency* toe nie as sy nie *competent* verklaar word nie, want dit gaan oor die pasiënt. Alles gaan oor die pasiënt.

RS Ja, so as hulle nie die pasiënt kan versorg nie.

VS En *compassionate* wees, daardie *character* van haar moet baie sterk vorendag kom, sal ek sê, *to have a positive effect on a patient. So you need to have loving, caring friendly*, ŉ oor om te luister.

RS Dit is tog waaroor verpleging gaan. As sy dit nie het nie, of sy *lack* dit, dan...

VS Want sy moet kan luister, sy moet die *passion* ken het, sy moet die pasiënt kan verstaan, sy moet liefde, *you know, friendliness, smile on the face, pat on the back*, maak asof die pasiënt die belangrikste mens op aarde is, om net daardie aandag aan die pasiënt te gee. Dit bevorder ook die gesondheid van die pasiënt. Sy moet omgee vir haar pasiënte. So haar *character* moet ook baie sterk vorendag kom.

RS Goed, *okay*.

VS Bevorder ook tot hulle genesing.

RS Dis reg ja. Gesondheid, omgee, pasiënt verstaan, net daardie bietjie liefde en aandag wat jy aan daardie pasiënt gee.

VS *Tender loving care*, ja. *Just be there for the patient*.

RS Wat dit positief kan maak, veral rondom pasiënt sorg.

VS Ja, en ŉ pasiënt voel baie goed as ŉ verpleegster net vra, "Hoe gaan dit vanoggend, Meneer?" met ŉ *smile* op die *face*, iemand stel belang. Hulle het mos *needs*, kyk na die pasiënt se *emotional needs*, jy moet kyk na die pasiënt se *spiritual needs*. Die pasiënt het ook ŉ *social need*. Is die pasiënt eenkant, lê hy alleen, dan moet sy die pasiënt voorstel aan die medepasiënt sodat hulle met mekaar kan *socialise*.

RS Ja, want baie pasiënte het ook nie familie wat naby is nie.

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VS Ja, en dit is hoekom 'n student se oë moet oop wees, haar ore moet oop wees, sy moet 'n *sense of observation* hê, *and she must use her powers of observation*, en as sy iets identifiseer hier by 'n pasiënt, dan moet sy vir daardie pasiënt voorspraak kan maak en kan dink vir die pasiënt, en dan nou maar medepasiënte voorstel en praat maar met mekaar. Ek sê, maak so 'n grappie nou en dan met die pasiënte om hulle gelukkig te laat voel.

RS Dis reg. *Okay*, goed. Dan met betrekking tot onderig en leer, wat maak dit 'n positiewe leerervaring? So wat maak onderig en leer vir die student 'n positiewe leerervaring?

VS Onderig en leer, die klimaat, soos ek sê. Die atmosfeer in die saal, die *attitude* is ook belangrik. My *attitude* as mentor is baie belangrik, teenoor die studente. Die student moet mos nou oop ook wees vir korreksie. Sy moet 'n leerbare gees hê, en wys dat die student meer gierig is, nuuskierig ook, voorbarig ook 'n bietjie, wys my die suster, want as 'n student nie gaan praat nie, dan gaan die suster dink die student *knows it all*, en 'n student moenie 'n *know it all attitude* hê nie. Sy moet wys sy wil leer, en dan sal die suster daardie pad met daardie student stap as die student ook wys van haar kant af dat sy wil, sy stel belang, en sy wil graag meer weet hoe dinge gedoen word.

RS Ja. So die student, met betrekking tot die leer, om dit positief te ervaar, en van julle kante ook af, as ek dit so reg opsom; hulle moet belangstel, hulle moet wil leer en hulle moet nuuskierig wees, en hulle moet oop wees vir enige korreksie, en hulle houding teenoor die leergeleentheid of teenoor die *clinical educator* moet van so 'n aard wees dat dit wat jy vir hulle gee, dat hulle dit ontvang.

VS Ja, ons moet ook mos *approachable* wees vir hulle, en hulle moet vir ons *approachable* wees, want wat ek in die oriëntasie gewoonlik deurgee, dan sê ek vir die studente, ek het 'n oop deur-beleid, demokraties, verstaan. Ek *shut* nie *off* nie, *because I'm a human being*, en ek kan foute maak, ek mag miskien my afdag gehad het. Maar as die student voel ek was nou nie, ek het nou nie reg gepraat nie, of Suster was nou bietjie daar verkeerd, het die student 'n verantwoordelikheid om na my toe te kom en vir my te sê, "Suster, maar ek voel ongelukkig," of haar hart net oopmaak sodat ons tot 'n *understanding* kan kom, en dit kan 'n *hindering* blok wees. Dit verhinder haar groei ook, want sy hou die ding teen my, en ek weet nie hoe sy voel teenoor my nie, en in die *meantime* is dit vir haar negatief, 'n negatiewe ervaring.

RS Goed, *okay*, en dan wat dink jy kan administratiewe verantwoordelikhede meer positief maak? So wat kan help om daardie baie administratiewe verantwoordelikhede wat julle het meer positief te maak?

VS *Administrative*?

RS Ja, wat kan dit maak om dit meer positief te maak?

VS Ek dink mens moet meer dinge prioritiseer, en 'n *timetable* hê waar ons sekere, ek gaan nou net fisiese *headings* inskryf, sodat as ek terugkom na die kantoor toe, dat

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ek ’n volledige verslag kan skryf in die student se boek in, as wat ek heeltyd in die hospitaal alles neerskryf. Maar ek gee net my hoofpunte, dat ek net kan onthou, en sodat ek dit binne daardie twee dae afhandel, want as ek dit nou nie afhandel binne twee dae se tyd nie, dan vergeet ’n mens dit, en dan moet jy weer terug dink volgende week, wat het daar gebeur, wat het daar gebeur. Maar onmiddellik dit nie laat ophoop nie, maar dit vinnig, sodat mens dit kan afhandel, sodat jy weet, daardie *easiness* is daar, my administrasie werk is op datum.

RS Goed, *okay*, en dan met verantwoordelikheid van navorsing, wat kan dit positief maak. Hoe kan ’n mens daardie positief maak?

VS As ons die regte hulpbronne het. Ons het mos nou toegang tot die internet. Ons het die nodige boeke wat ons kan gebruik, en ons het die regte handleidings vir *updatedness*, en ons kan mos nou deesdae ook ingaan, as ons die internet en alles wil deesdae ingaan op Google, dat ons die geakkrediteerde *references* gebruik en nie, ons gebruik glad nie Google en Wikipedia nie, want hulle is mos nie geakkrediteerd nie, maar ons gebruik geakkrediteerde netwerke wat vir ons die korrekte inligting kan gee, want as ’n mens weet waar om in te gaan en jy ken jou tegnologie, dan gaan dit baie makliker.

RS Dit help ook met julle navorsing.

VS Dit help ook, ja, en die navorsing.

RS Die regte hulpbronne, toegang, die nodige boeke, die regte handleidings en dan julle geakkrediteerde bronne wat tot julle beskikking gestel word.

VS Ja, ’n mens weet waar, veral as jy liassering, die *different files* is, en jou *files* is genommer en gemerk, dan weet ’n mens presies na watter *file* toe om te gaan om die gesoekery uit te skakel.

RS Ja, met ander woorde dit spaar ook tyd.

VS Dit spaar tyd, ja. Jou rekordhouding moet akkuraat wees.

RS Goed, en dan die laaste vragie, wat dink jy, in jou opinie as ’n kliniese opvoeder, maak die fasilitering van studente-ervaring in die kliniese omgewing meer suksesvol? So wat maak dat dit meer suksesvol is vir die studente in die kliniese veld, of in die kliniese praktyk?

VS As daar meer kliniese *educators* kan wees, dan sal dit ook baie suksesvol wees in die *environment* as die susters ook hulle funksie sal vervul, hulle rol as die susters, en hulle het ’n onderrig funksie. As hulle dit ook dalk kan vervul, sal dit ook bydraend wees tot ’n positiewe leergeleentheid. As daar ook ’n goeie interaksie sal wees met die studente en as die suster meer *assertive* sal wees met die studente, sal daar ook ’n goeie leergeleentheid plaasvind.

Ek sal sê daar moet geduld wees. Die permanente personeel moet geduldig wees met die studente, want dit is studente want nog leer, en hulle moet die studente die

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geleentheid gee om tyd, hulle moet tyd kry, veral as hulle moet voorberei vir hulle evaluasies, dat hulle daardie tyd gegee word om hulle reg voor te berei, en nie die werkslading alles op hulle te plaas nie, sodat hulle nie by dit kan uitkom wat hulle moet doen nie, want dan word die student benadeel, want sy het nie die tyd gekry om haar reg voor te berei nie. So daar moet die *unit manager* baie oop wees, en die student daardie geleentheid gee om te kan doen wat sy moet doen.

RS En dis ŉ opleidingshospitaal.

VS Dis ŉ opleidingshospitaal, en dit moet hulle kan verstaan, dat die student is hier om opgelei te word. Ek verstaan daar is ŉ verhouding, dat hulle mos nou geplaas word om ook te help met die werkslading, maar die werkslading moenie heeltemal op die student geplaas word nie. Die permanente *staff* moet hulle funksies verrig, en ek dink daar moet ook gewerk word op die *absenteeism rate* van die permanente *staff*, want volgens my, soos ek al agtergekom het, die permanente *staff* kyk alreeds na die af-dienste, en dan sien hulle daar is vandag vyf studente aan diens, dan sit hulle sommer ŉ verlof dag in, of hulle bel net hulle kom nie werk nie, want hulle weet daar is studente.

Die gevolg is dat daardie student nie die geleentheid kry om te doen wat sy moet doen nie, en ek dink die suster moet ook kan voorspraak maak by die dokter en vir die dokter ook verduidelik, veral as dit ŉ eerste jaar student is, hulle het nog nie daardie vrymoedigheid nie, hulle is nog bang vir die dokter. Maar die suster moet vir die student begin praat, en nie die student voel sy is ŉ [onduidelik 00:50:21] want die dokters het baie, hulle is ongeduldig. Hulle het nie geduld met die studente nie, en hulle maak asof hulle nou nie bestaan nie en dan het hulle uitlatings en goed. Maar die suster moet daardie ding kan verhoed, dat die student nie voel sy is ŉ “niks” nie, want dit is hoe die dokters die studente laat voel, want die suster kom nie vir die student op nie, en as daardie nou kan verbeter, sal ons ook ŉ student kry wat weet iemand staan agter my.

Die *unit manager* moet *approachable* wees. Die student moet kan voel as ek ŉ probleem het, ek kan gaan na my *unit manager* toe, ek kan met haar gaan gesels, sodat sy my kan verstaan en my probleem op die tafel sit. As die student ŉ versoek ook het, ŉ redelike versoek, dan moet die suster dit vir haar kan toestaan, want dinge gebeur mos maar onverwags, en dan moet die suster kan verstaan en nie net in ge-*zoom* wees op *operational requirements* nie, ek is jammer. As jy maar ŉ *understanding* kan hê, jy moet daardie verhouding kweek met daardie student, verstaan, en die student nie onmiddellik afsit met haar *attitude* nie. So die *unit manager* moet ŉ baie positiewe *attitude* het. Al kners sy op haar tande, moet sy dink, “Dit is ŉ student, laat ek maar verstaan.” Hier moet ek maar mooi praat, want dis ŉ student.

RS Toe jy gepraat het van die student wat nie die geleentheid kry om te doen wat hulle moet doen nie, wat het jy daarby bedoel?

VS Omdat die student haar moet voorberei vir haar evaluasie of haar praktiese eksamen, nou kom jy in die saal, dan vra jy vir die student, ek kom mos nou vir die *prac*, Suster, ons kon nie *prepare* het nie want ek is op teater vandag, en heeldag

moet ek pasiënte gaan haal in-en-uit, so ek kom nie by dit uit nie, of ek is heeldag gesit op observasies, of ek kom nie by die medikasietrollie uit nie, want die *staff nurse* is alleen met die trollie, die *staff nurse* is eie met die trollie.

Nou daar moet die Suster mos kan opkom, en die student mos nou saam met daardie *staff nurse* sit, want die student is mos nie net hier, die derde jaar is mos nie net hier om elke dag, ek sê hulle mag dit nie doen nie, maar ook vir hulle vra, gee die student die geleentheid. *Expose* die student byvoorbeeld aan die medikasietrollie, dat die student kan gewoond raak aan die medikasietrollie, want nou kom ons in die praktyk, die student is nou in haar vierde jaar al, dan het sy baie min *exposure* gehad, dan kla ons hier buite oor die student wat nie vinnig daardie medikasie uitgee nie, want ons wil hê sy moet hardloop met daardie trollie.

Maar ons het haar nie die geleentheid gegee om te oefen om die medikasie – dis maar net ŉ voorbeeld – want die student moet dan nou net heeldag en aldag observasies doen, en *intakes* en *outputs*, verstaan, waar daar is, want die permanente mense is nie daar om dit te doen nie, nou moet die studente net dit doen. So, as die susters meer aandag sal gee aan hulle *outcomes*, dan sal sy ook weet wat was die student se uitkomste, en ons bespreek dit met die unit managers, hulle kry die boekie van die student se jaarboek, maar dis asof hulle nou net nie daarvan notisie vat nie.

RS Ja, so hulle gee nie aandag daaraan nie.

VS Hulle gee nie aandag nie, en daarom weet hulle nie wat van die student verwag word nie. Dis hoekom dit belangrik is, ek handhaaf ŉ goeie verhouding, en ek sal die vrymoedigheid neem om na die suster toe te gaan in privaat, en vir haar te gaan vra wat ek identifiseer wat ŉ leemte is, onder haar aandag bring, sodat sy daarvan kan werk maak, en sou ek op iets afkom wat negatief is, dan sal ek dit onder haar aandag bring, en sê dit en dit is gesien, en dit is ontoelaatbaar, want die student kan nie aan so en so en so blootgestel word nie. So dit gaan om die student te help, maar ek bly nie stil as ek ŉ *wrong* sien nie, want dis my rol om die student reg te laat leer, dinge reg te doen in die saal.

RS Ja, en natuurlik om dit meer suksesvol te maak moet jou student voorbereid wees.

VS My student moet voorbereid wees.

RS En daar moet ŉ goeie verhouding wees, soos jy gesê het, en die suster van die saal moet ook saamwerk en voorspraak doen vir die student. Ek som dit op, dit wat jy vir my gesê het. As daar enige probleem is, moet daaroor gepraat kan word. Daar moet positiewe houdings wees van die personeel se kant af, sowel as van die student se kant af, nè?

VS Ja.

RS En ook die feit dat dit ŉ opleidingshospitaal is, dat die student die geleentheid gegee moet word om opgelei te word en te kan oefen, want dan, soos wat jy self gesê

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het daar in jou voorbeeld rondom die voorbeeld van die medikasie, hulle word net daardie eenkeer blootgestel wanneer hulle die prosedure moet doen, en dan wanneer hulle later in hulle derde jaar kom en hulle moet medikasie uitdeel, dan deel hulle nie vinnig genoeg medikasie uit nie, omdat hulle nie genoeg blootstelling gehad het nie, nè, dis reg, dis wat jy gesê het?

VS Dis korrek, ja.

RS Goed. Is daar enigiets anders wat jy nog wil byvoeg?

VS Wat ek ook wil sê, om my te beskerm, in die geval waar ek 'n student boek vir 'n *practical*, ek boek hulle vir die evaluasie, dan tik ek my lys uit en ek gee dit vir die *unit manager* al twee weke voor die tyd, die lys met die datums, en dan bring ek dit onder die *unit manager* se aanda,g dit is die datum wat die student moet gereed wees vir 'n *practical*, en as die student nie gereed is nie, dan gaan ek die suster blameer, want die suster moet toesien dat die student die geleentheid kry om haar voor te berei.

Dit is die evaluasie datum wat ek nie gaan kanselleer nie. So die suster moet sien dat die student die tyd het, kry maar iemand anders om daardie werk te doen, maar daardie dag moet die student haar evaluasie doen, en as daar enige kansellasie is, dan moet daar 'n brief aan Mevrou Strauss geskryf word om te vra of die student dit kan doen op 'n ander datum. Maar andersins, ons kanselleer nie evaluasies nie.

RS Ja, *okay*.

VS En daarby vind ek uit dit werk nou, maar dit gebeur elke keer wat ons dit moet doen, dis een ding oor-en-oor wat onder hulle aandag gebring moet word.

RS Ja. Goed, en dis ook maar deel van julle *admin* op die ou end van die dag, om kontrole in beheer te hou, dat julle program reg volg.

VS Ja, ons moet kyk as die student, as hulle nou *absent* was, dat hulle daardie *deficit* ure inwerk, ons moet kyk dat hulle ure *updated* is, ons moet kyk dat hulle die regte ure werk in die verskillende afdelings soos die medikasie ure, trauma, pediatrie, *ICU*. So dit is ook waarna ons moet kyk, en soos ek sê, ons kyk na die *performance* van die student. As daar enige negatiewe verslae is van die student, dan met dit opgevolg word.

Alle dissiplinêre aksies wat ons doen, moet ons mos nou stuur na Julia toe, die senior administrative *clerk*, en dan kry Liesel 'n kopie daarvan en ek het ook 'n kopie. Ons het ook 'n kopie van die student se *discipline* of *whatever* met die student gebeur het. Maar alles wat met die student gebeur moet ons *liaise* met die kollege sodat hulle ook op hoogte kan wees van wat in die praktyk aangaan.

RS Goed. *Okay*, baie dankie vir jou tyd. Dit gaan baie help, dankie.

VS Dis 'n plesier, en alle sterkte met dit wat jy moet doen.

RS Dis nou amper 'n uur. [Einde van opname en onderhoud 00:58:29]

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Appendix 7: Declarations by language and technical editors

TO WHOM IT MAY CONCERN
I, Barbara English, declare that I have copy edited Reinet Shipman's Masters dissertation. I am responsible for any changes I made to Reinet's dissertation but not for any changes that might have been made without my knowledge.

Barbara English

Director: Wordsmiths English Consultancy

Date: 29 November 2016

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Anelle Smit

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16 February 2017

DECLARATION

Language editing of Master's thesis

"Experiences of clinical educators on barriers and enhancers

in the facilitation of nursing students' clinical learning"

A thesis presented in partial fulfilment of the requirements for the

DEGREE OF MASTER OF NURSING SCIENCE

FACULTY OF MEDICINE AND HEALTH SCIENCES

STELLENBOSCH UNIVERSITY

by

Reinet Shipman

It is hereby declared that prior to publication, the above thesis was language edited by Anelle Smit.

A Smit

Durbanville, 16 February 2016